UNITED HEALTHCARE
RIC/RAC Spring Meeting
March 19, 2018

1. Can UHC please provide a single summary authorization list for patients hospitalized in the acute setting? Every other Commercial/Medicare HMO with similar patient volume provides hospitals with a single list of in-house patients, authorization type, authorization number, and any additional comments that may need to be communicated to the facility from the payer. UHC/AARP is the only company that has declined to provide a similar list. Instead, we receive calls throughout the day that are having to be tracked and managed by multiple areas. This is creating duplicate requests from the payer and significant more time for both the UHC rep and the UR department to discuss each and every patient individually. We do receive written requests for clinicals and formal denials via fax from UHC; however, a summary of the authorizations for patients in-house would be immensely helpful. [Example of a daily auth update from another Medicare HMO was attached for clarification.]

   Response: **United Healthcare offers through UHCprovider.com a Prior Authorization/Notification Application that allows the following:**

   - **Determine if prior authorization or notification is required for United Healthcare Commercial,**
   - **United Healthcare Medicare Solutions, United Healthcare Community Plan and UnitedHealthOne members.**
   - **Complete your request for notification or prior authorization if it is required and can be completed online.**
   - **Upload medical notes or other attachments when required and add messages for the reviewer when attachments are required.**
   - **Check the status of your notification and prior authorization requests – including those made by phone**

   How to access the Prior Authorization and Notification app
   Sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com. Then, select the app from your Link dashboard. UHCprovider.com/pann.

2. Claims selected for prepayment review denied for missing/non-receipt of medical records before the due date. This happened on at least two claims and when the records were received within the initial allowable time frame the receipt of the records was treated as the first appeal. The two claims identified were for PEEHIP Medicare Advantage members. [UH Call Reference 1331/ Optum Reference #1988762] This seems to be more of an issue with timely transfer of medical record documents between UHC and Optum. What remediation measures will UHC take to prevent invalid denials for non-receipt of records when records were sent to UHC prior to due date?

   Response: **Without specific examples, it is difficult to drill down and determine specifically what occurred, as we would need to see when the bill came in and when the records were scanned. If the providers are sending them in at this last minute, and the provider didn't allow for processing time.**

The process for PAR provider:
When new records are received, they are routed for review upon receipt, and are treated as a 1st review. If the records are not received timely, the claim system will issue a 1018 denial (no medical records received), but records will be routed for review upon receipt.

Process for non-PAR providers:
If the records are not received timely the claim system will issue a 1018 denial (no medical records received). The provider will need to follow the formal appeals process. Optum is unable to touch the claims as these need to be tracked and monitored by the appeals team and worked by the appeals clinical team per CMS guidelines. This is CMS protocol, not Optum protocol.

Provider(s) are encouraged to use LINK for records submission. If a provider chooses to mail in records, the provider should allow plenty of time for scanning.

3. We have received a large number of recoupments from UHC for claims billed with IV iron HCPCS codes, J1439 (Injectafer) and Q0138 (Feraheme), when the patient does not have a dual diagnosis of anemia and chronic kidney disease. These patients are receiving IV iron due to intolerance to oral iron which is documented in the medical record. We submitted reconsiderations through the UHC portal; however, all of the cases were closed stating the claims were paid correctly. Is this something we can have reviewed by clinical staff or medical director?

   Response: NCD110.10 –requires reporting of anemia diagnosis and a chronic disease diagnosis. The example above has been addressed and resolved.

4. Please provide guidance on the most appropriate CPT code for subcutaneous infusion of deferoxamine mesylate (Desferal) via CADD pump. For example: A patient presented to our outpatient facility for initiation of a subcutaneous infusion of J0895- deferoxamine mesylate (Desferal) via CADD pump. The infusion was started at the facility and ordered to continue at home over 96 hours. The needle became dislodged at home so the patient discontinued the infusion after 76 hours. What CPT code(s) would be used for the initiation of the subsequent infusion via CADD? Would any subsequent visits for the same drug by CADD be reported using CPT 96521?

   Response: As we cannot advise a Hospital on how to bill services. Our Reimbursement Guidelines and Medical policies are located at www.UHCprovider.com >Tools& Resources> Policies/Protocols and Guides

5. This question is for United Medicare Advantage. Please provide guidance on how to bill claims for Medicare Advantage (MA) enrollees when services are involved in a data registry.

   A) An example would be implantable cardioverter-defibrillator procedures with rejection code U5233. Do we need the clinical trial information if we are only entering the patient into a data registry? Where would we get this information? Should we append the Q0 modifier to the procedure, add dx code Z00.6, and split bill the services as described in CMS Claims Processing Manual Chapter 32, Section 69.9? Would labs, drugs, supplies, etc. used for the procedure be billed to Medicare or the MA?

   B) Is it appropriate to bill traditional Medicare for claims where the services are reported to a data registry (indicated by modifier Q0), e.g. Implanting cardiac defibrillators for **primary prevention** (NCD 20.4)? There were prior CMS transmittals directing providers to bill traditional Medicare for these services then a revised transmittal to bill the MA when the services are for secondary prevention. But there is no guidance to bill the MA when the services are for primary prevention of cardiac arrest.

   Response: As we cannot advise a Hospital on how to bill services. Our Reimbursement Guidelines and Medical policies are located at www.UHCprovider.com >Tools& Resources> Policies/Protocols and Guides

6. We are experiencing retrospective denials for the diagnosis of sepsis when accounts are reviewed for both coding and clinical validation. Documentation supports the diagnosis of sepsis; however, reviewers are using SOFA criteria score of 2 or more. A sepsis protocol was implemented several years ago in compliance with CMS quality indicators and requires patient screening by specified criteria with implementation of specific therapeutic measures if appropriate. The physician must document the diagnosis of sepsis in the medical record before this diagnosis is coded; sepsis is not coded based upon positive screening. The rationale documented in the review results letter states "According to up-to-date criteria, in order to validate the diagnosis of sepsis, evidence of organ dysfunction caused by a dysregulated response to infection as measured by a SOFA score of 2 or greater must be demonstrated." Of course, this reduces reimbursement. The references do not actually validate Cotiviti's rationale. [example was provided]

   Response: The example provided needs to be sent thru United Healthcare's Service model for review and appropriate response. Inquiries can be submitted thru www.uhcprovider.com >claims link or reach out to their Hospital Facility Advocate who can also assist with bringing resolution through United Healthcare's standard channels at Alabama_pr_team@uhc.com