VIVA MINUTES
July 17, 2017 RIC/RAC Meeting

VIVA REPRESENTATIVES PRESENT:
Mr. Chris Barrow
Ms. Carol Davis

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: Today, we have Chris Barrow and Carol Davis with VIVA here. Before we get into the questions, I'll turn it over to Chris to introduce them.

MR. BARROW: Hello, everybody. My name is Chris Barrow. I am the manager of provider engagement for the south region for Viva Health.

MS. DAVIS: Hi, I'm Carol Davis. I am executive director provider engagement for Viva.

1. How do hospitals handle discharge dispositions when a patient is discharged and presents to another acute care facility within 72 hours or less?

   Response: **After being discharged from one facility, if a patient presents to a different facility it would be considered a new admission or encounter.**

   Discussion at meeting

   MR. BARROW: If a patient presents to a different facility it would be considered a new admission or a new encounter. So from there you would just be another prior authorization for a new facility.

2. Our hospital is considering the use of the Automated Breast Ultrasound (ABUS), which is to be used adjunct to mammography. The vendor suggests using CPT codes 76641 and 76642 to bill for this service. The aforementioned CPT codes represent 2D ultrasound, when the ABUS is 3D. There are no specific examples to provide at this time as we have not purchased the equipment. Prior to purchasing equipment, we would like to determine the appropriate codes to bill for this service.

   Response: **VIVA does not advise providers what codes to bill for services. Claims should be submitted using valid CPT's which best describe service rendered to the patient.**

   Discussion at meeting

   MR. BARROW: I'm afraid we're not going to be much help to you on this particular question. We don't normally tell people how to bill. What we do is we have a specific system, our claims check system, that's designed to go according to CMS guidelines. You'll follow your regular CMS guidelines for appropriate coding in this case. As far as the two codes in question go that you have here, I did a little homework before we came over here, and there are a lot of various different codes that you can use for

that particular procedure since it is fairly new. As of right now, I can't tell you yea or nay on those particular codes in question but always follow your coding guidelines, follow your CMS guidelines, and the claim check system should pick up there. This particular procedure, however, will require prior authorization so you will have to get that first prior to the procedure anyway. I know that's not the answer you were looking for. Sorry.

3. If a Psych patient seen in the Emergency Room has an order to admit to Psych but is being held in the acute care Hospital for more than 1 day while waiting on a Psych bed, how should providers bill for the charges from the patient's initial presentation until the Psych bed is available?

   Response: **If the facility has a separate provider number for the psych portion of the hospital, services should be billed using that NPI. The UB-04 form should include R&B days for both the medical and psych beds.**

Discussion at meeting

MR. BARROW: It will all be lumped into one claim. The reason you want to use your NPI number for the psych portion of that is because Viva contracts the mental health and behavioral health separately from the medical. So you would want to make sure you billed under that site so that you would get the appropriate reimbursement.

AUDIENCE: In this case, the patient is being held in an acute care facility because they're waiting for the bed to open up in a psych facility. It does have its own separate NPI, but they end up physically being located in the acute care setting. In this case, let's say they're being held in the ED. Sometimes it so happens it would be one day or two days that they're being held. They're not getting any medical services. They are just getting the psych medication or whatever, but they don't transfer to the psych unit until after two days.

So in that case, we wanted to know when does the psych care start. Is it while they were in the ED, a day or two maybe, or when they actually physically transferred to the psych unit? That's the question.

MR. BARROW: Was the initial admission for psychiatric care and he was just waiting for a bed?

AUDIENCE: They just come to the ED for their medical evaluation kind of stuff and then they get an admission order to the psych unit, but there's no beds available so they're being held.

MR. BARROW: So that would just start day one.

MS. DAVIS: Well, it would start day one if that was a psych diagnosis and they were being treated. That's the key, but that does have to go through medical management and they actually would make that determination based on the treatment of the patient.

AUDIENCE: So it's day one?

MR. BARROW: Yes, ma'am.

4. Providers are getting IP readmission denials in the following situations. Please provide explanation as to what criteria is being used by VIVA while processing these claims:
    a. Onsite Viva Case Manager clears patient for discharge during the first visit and when patient gets readmitted Viva is denying for readmission.

        Response: **Our case managers are on-site to help with the transition of care. It's not a discharge. A discharge can only come from the physician who upon the treatment would actually clear the patient for discharge, but our nurses are there just to help with that transition of care.**
        They're not actually giving a discharge order. Now, if for some reason the discharge order comes through and the nurse or case manager, whoever it may be, deems there's something amiss with the order, they do have regulations requiring them to speak up and say, this doesn't look appropriate. But they are not the ones who are discharging the patient.

    b. Viva HMO is denying IP readmissions for unrelated diagnosis. Do they not follow Medicare rules?

        Response: **Claims are paid or denied for readmissions occurring within 30 days of discharge based on the authorization approval status and instructions from our Medical Management department. However, Claims & Medical Management worked together to development an internal policy based on the CMS rules.**

    c. Providers have only a single level of appeal with Viva with no Peer to Peer review provisions. Do they not follow Medicare rules?

        Response: **Viva does allow a Peer to Peer review. Providers may request a Peer to Peer review at any time prior to member discharging from the facility. It is true however that with Viva there is only one level of appeal.**

Discussion at meeting

MR. BARROW: On the second part, it says we are denying for an unrelated diagnosis. Each particular admission has to have its own prior authorization. So in all these cases here, there was a general theme as I was going through these I noticed, but Viva does everything according to prior authorization so each one is going to be taken individually. Prior authorization would have already been approved or denied at that point whether or not it was related or unrelated according to the notes and all that were turned in. So I was kind of confused when it said the unrelated diagnosis.

AUDIENCE: I can speak to that. Here's the crux of the issue with Viva and readmissions from our perspective, and it may resound with other people in the room. CMS has a readmission review process not a readmission denial process. In the Viva administrative guide, it does list that they're

modeling CMS guidelines. Well, the CMS guidelines are for the payer to order both of the records from the readmitted claim and from the anchor claim, and I'm talking about those that are not same calendar day readmit. Same calendar day, we all get it, it's combined.

Anything outside of that that's within 30 days, the payer is supposed to order the medical records, review those medical records, and then the burden is on the payer to provide a clinical rationale back to the provider if they see that that was a preventable readmission. But what we're seeing in our shop is that Viva is just rubber stamping these as something to the effect on the remit that says provider will just cover this admission. Well, no, we don't just cover that admission because it was within 30 days.

Viva is not giving us a clinical rationale to say here is why Jane Doe was a preventable readmission. Here's why we think in our clinical judgment, whoever reviewed those two records, Jane Doe was a preventable readmission. Then it's to the provider to take the medical records and then come back to the payer and say, okay, well, on this page of the medical record, here's how we can disprove what you're saying in your rationale because here is why she was stable at discharge the last time. Here were the medical facts. We are supposed to be able to rebut and then you are supposed to be able to come back to us after that. That's not currently the state of the state with Viva, and again that's in our shop so there might be others around the room that can resound that.

AUDIENCE: It's the same for us.

AUDIENCE: But that is not what CMS defines as a readmission review process. Viva is just rubber stamping denying anything that's readmitted within 30 days, and that's not the proper procedure with CMS.

MS. DAVIS: Thank you, Jennifer. All I can tell you is that we don't have anybody from medical services here with us, but it's my understanding that they do request records and that the on-site nurse or the nurse that reviews in the facilities should be getting the medical records. And if that's not happening and you have cases, you can certainly send them to us.

AUDIENCE: There are some other payers who are also Medicare Advantage that while we don't agree with them on everything they actually are using a readmission review process, and that is to send out an ADR request for additional documentation; that ADR comes to you and it says I need the records for this readmitted claim plus the records for any claims for admissions 30 days prior. Then we respond to that ADR within a certain amount of time.

Then once they get those records via a portal or however, then they issue a findings letter, which could be this was not preventable or whatever their clinical rationale from a medical reviewer stating how they thought that was preventable. That then opens up the appeals process for us to be able to go back to our medical director and whoever reviewed the charts, formulate what we're going to do, what our response is. We could come back and tell you we agree with you, whatever the case is. But what's happening in the current state of the state Viva just denies everything on the remit, and it says on the remit that the provider will just cover this.

That's not a readmission review process. Now, they did start issuing some letters while the patient was in-house and sometimes, correct me if I am wrong, but very soon thereafter saying we just need the medical records within three days. You're not going to necessarily have the entire medical record yet because the patient may either still be in-house or the discharge is not finalized yet. So they

sort of made it seem as if they were trying to put it through a review process, but that's not really a fair expectation on the provider, and then they were saying, well, if you don't meet that, then you're just going to have to wait for it to deny and then just go appeal it. But again we're missing the clinical rationale because you've never issued a clinical rationale as to how you thought the prior admission was preventable. So that's where we are right now.

MS. DAVIS: Okay, is this something that somebody from Viva could come visit and talk to you about from medical services?

AUDIENCE: We had a couple of phone meetings over the last two years, and we laid all of that out with the medical services people. Without going too far into specifics, they did not really know what was in their readmission process at the time that we spoke with them, and I'll just sort of leave it there. We just have not gotten any further with them on that yet.

I've had multiple conversations myself with some people in medical services, and they don't really seem to understand what CMS truly says is a readmission review. They sort of made up their own format and rule for that while still saying that they're going to follow CMS guidelines.

MS. DAVIS: I hate to hear that. Could we talk afterwards?

AUDIENCE: Sure.

AUDIENCE: It's the same with us. We meet with them every month with the medical services. It's the same issue. We've given enough examples and everything has been provided. This is Baptist Health.

MS. DAVIS: So you're saying that we're doing it differently than everybody else?

AUDIENCE: Yes. What we're seeing in our facility is that we get denials for the readmission, but Viva is also applying the reimbursement penalty that Medicare does as well. They will adjust our reimbursement based on the readmissions that they've looked at for the prior period.

Is that not double dipping when you deny the claim and then you also adjust it on the reimbursement? I feel like that's not appropriate, but I haven't been able to get a direct answer about that.

MR. BARROW: That's new on me. Okay.

AUDIENCE: That is an accurate statement. We have seen that as well, and it is somewhat of a double dipping.

MS. DAVIS: I'm taking notes.

AUDIENCE: And it would really help if we could get somebody from medical services maybe.

MR. BARROW: Yes, ma'am.

AUDIENCE: I was just going to say that if we are truly going to quote CMS, that we are following CMS, we need to follow CMS, and I think that's really just the rock bottom line of what the issue is, is that part of the documentation says you're following CMS but in real world it's just what Viva wants to do and we understand that payers have rules, regulations, and things that they require, but if that's the case, they're also quoting CMS out of the other side of the mouth. That's what we've got to come to an agreement with among all the providers in the state because again it's multiple people. That's the bottom line. If we're quoting CMS, we've got to follow what CMS says.

MR. BARROW: We will give med management all that, and we will get back to you guys.

MR. BARROW: And now on to Part C of the question. You do get a peer to-peer on that. It has to be of course prior to discharging of the facility. But Viva does allow peer to peer. We do have our physicians on staff there, our medical executive.

MS. DAVIS: Chief medical officer.

MR. BARROW: She looks at those, and Dr. Hood will too as well. It is true, though, you get the one level of appeal, but we do allow peer to peer.

AUDIENCE: The question is when we have a denial on any claim, not just acute care, but outpatient, when we want the claim to be reviewed, is there not a reconsideration level first prior to appeal. Because we've been told that there is no reconsideration. The claim has to go directly to appeal, and we only have one level.

MR. BARROW: That is correct. But the claim does go to the chief medical officer on that whenever you request that, but there is only the one level of appeal. That is correct. There is no, I guess, review on the --

AUDIENCE: Reconsideration.

MR. BARROW: Yeah, exactly.

AUDIENCE: That's not Medicare either.

5. In instances where the patient doesn't provide the relevant insurance information during upfront registration but ends up providing it when they get a bill from the Hospital or when it is with collections:
    a. What is our recourse on appealing this?

        <u>Response:</u> In this case the claim would have denied for no authorization. As such it may be appealed. A detailed appeal letter with appropriate documentation supporting the fact that other or no insurance was provided would be required. Medical records supporting the medical necessity of the visit would also be needed.

b. Can providers bill the patient since Viva is denying for Timely filing?

Response: **As a contracted provider you cannot bill the member for timely filing. In a situation such as this please contact Viva Customer Service or your local Provider Services Representative. Cases such as this may still be eligible for an appeal even though it is past timely filing.**

Discussion at meeting

MR. BARROW: Part A, on the recourse on appealing this, every admission will require authorization. Prior authorization is going to deny because obviously you didn't know to bill Viva or to get a prior authorization from Viva because they may not have known what insurance they have. They may have an altered mental status when they come in. No telling what happened when they came in. But for whatever reason, they did not get the correct insurance, but since it was going to be denied as an authorization, it is subject to an appeal. So at that point, you would appeal it and provide the documentation and proof that you did not know the insurer. They'll come in no insurance provided or was told Medicare at time of admission or private pay or whatever. So just submit that documentation along with your clinic notes for medical necessity, and we will look at that during our appeals committee. That is looked on. We do review that, and that is something you can appeal.

AUDIENCE: They're always denied. We do all of that, and it's still denied. I've went through representatives through Viva to try to get the claims paid, and the answer that we get back is that because it's not within 180 days. Sometimes you won't have that information within 180 days.

MR. BARROW: We're going to address that in part B. You're right. It will deny, and if it does go to timely filling, it's going to deny. That's when you really need to contact your customer service, which is the 205-558-7474 number we have, or you can get in touch with your local provider services rep because that is something that we can address - not always, but if it's case marked, then we can't override the timely filing on that.

You're absolutely correct. I've seen several cases where people have come in, and they're appealing the claim because it's already reached timely filing and the account has gone into collection. That's way past due. So we do take that into account.

I'll give you a piece of advice that my boss here is going to get mad at, but whenever you do your letters, please be very specific. Give detailed instructions on this is what happened, because I see sometimes whenever we're doing our appeals committee meetings, we get the generic letter sometimes, hey, we didn't get an auth for this, and it's just like a little stamped letter like you're saying we give you guys. Sometimes we get that too, and in that case, it's hard for us to make a decision on that. I can tell you we get some from some people that go straight through, and they will give you detailed information like he came in with an altered mental status, he told me he had this. It's beautiful. We're like, yeah, not their fault. Approved.

So please be very detailed in your letters on those, and if it's past timely filing, please contact customer service. Please get in touch with your rep and let them know what's going on so we can circumvent that. Otherwise, it will be denied for timely filing.

6. In April, CMS requested recommendations for innovation and improvement of the MA program. This Request For Information (RFI) came as a part of the annual Part C and Part D Announcement and Final Call Letter. In response to this RFI, the American College of Physician Advisors (ACPA) issued a position paper that was submitted to CMS, dated April 24, 2017. This position paper outlined many challenges observed by the ACPA and included recommendations for improvement.

   In light of the above statement, and with specific regard to one of the items listed in the position paper by the ACPA, we would like for you to review and respond to one specific challenge that the ACPA reported to CMS. Please respond with what your health plan can do, has done or is doing to address the specific challenge of misinterpretation/misapplication of the CMS readmission review process?

   Implementation of 30 day readmission denial policies:
   a. MAOs claim that these policies are based on the Quality Improvement Organization (QIO) Manual provision whereby the QIO may deny payment for a readmission within 30 days if an identified quality of care issue resulting in premature discharge from the first admission may have reasonably caused the second admission.
   b. In issuing these denials, the MAOs generally fail to demonstrate any quality concern on the part of the healthcare facility – denying payment solely because the readmission occurred within the 30-day window and was for the same or similar DRG. CMS has recognized that some readmissions are unavoidable (and inevitable); the **CMS Hospital Readmissions Reduction Program only penalizes facilities for excess readmissions**.
   c. These MAO denials are not called "denials" by the MAO, but rather claims in which payment for the first admission includes payment for the readmission. However, the diagnoses and procedures from the two admissions are not combined onto a single claim. The second claim is merely not paid. By not calling it a "denial," reporting of these "denials" to CMS may be averted by the MAO.

   (***ACPA Position Paper,* filed April 24,2017**, Baker, Emkes, Field, Fore, Hegland, Hirsch, Hu, Johar, Locke, Myerson, Mothkur, Rejzer, Hopkins, Zirkman)

   Response: **Viva Health will only combine admissions for two scenarios: Re-admit to the same facility on the same day for related diagnoses and for planned readmissions. All other re-admits will require a separate authorization. As each will require a separate authorization, they will be reviewed as such by our Medical Management department. If a re-admit authorization is found to be due to related diagnoses and was preventable, then the authorization will be denied and the facility informed of the denial.**

   Discussion at meeting

MR. BARROW: To that, I guess we might need to get back to our medical review team since you are saying we aren't following the rules on that one, when it comes to readmits – it mentioned in here the combining of the two saying that we're not necessarily denying but just saying that it was covered. There's only two scenarios where Viva will actually combine the two, and that is a readmit

same day, same facility, diagnosis, or for a planned readmission. All others fall under their own separate prior authorization. So you will have an approval or denial for that prior authorization. It won't be a combining of the two. It will be an actual denial.

AUDIENCE: I agree with you that it has a separate auth, but that auth is denied to be combined with the prior admission, so, yes, it is a denial.

MR. BARROW: But I thought the question here said they were combining two and not calling it a denial but ours is actually called a denial.

AUDIENCE: It's denied as a separate admission. There's not going to be two separate DRG payments. There's only going to be one for the two admissions so that second admission is being denied to be combined with the first for a single payment.

AUDIENCE: Even if there's an auth.

AUDIENCE: Yes. Regardless of whether there's an auth or not.

AUDIENCE: I think what they're saying is there is an authorization for that second admission, but once the claims go through, it is paid as a single admission even though you have two separate auths.

AUDIENCE: And that is what I was referring to. On your remit code that you're running through, it says the provider is just going to cover this admit. They're just dropping it in this bucket that says the provider is just going to cover this.

MR. BARROW: Again we'll have to get with med management on that one too. I'm sorry.

7. Please provide clarification on whether VIVA requires NDC codes on all the drug codes submitted on a UB claim. If yes, providers need to get official notification on a workable effective date since this requires programming changes by providers that will take time.

   <u>Response:</u> Effective July 1st of this year, we did start requiring that for all of our physicians; for hospitals, no, not as of yet. That is something that may come down the line, but currently, no. When it does or if it does, we will communicate that several different ways. One, first and foremost, is the Viva Health website. We will have that listed there. We will also have it on provider newsletters that go out. You may get a personal visit from your provider services representative. There will be e-faxes, e-mail blasts, and that sort of thing. But we will definitely let you know prior to that you'll have plenty of time for that.

MR. ASHMORE: I'd like to thank Chris and Carol for being with us today. Thank you.