VIVA
RIC/RAC Spring Meeting
March 19, 2018

1. Follow up to Question #1 from November 6, 2017, regarding IP readmission denials. During the November meeting, Mr. Barrow indicated you are trying to put a process in place where the medical director would provide an explanation stating why it was deemed a remit and why it was preventable. Please provide a timeline for when this will start.

   Response: **At this time Viva's Provider Appeals has transitioned to another department. The director of their new department is aware of this issue and has scheduled meetings with other department leaders to discuss.**

2. Follow up to Question #5 from November 6, 2017, regarding why your entity only offers one level of appeal. Please provide a timeline when VIVA will start applying the same multiple appeal rights that are currently being provided by all other Medicare Advantage plans.

   Response: **There is currently no timeline regarding changes to Viva's level of appeal process.**

3. 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: **In this situation you would not use code 96521. Code 96521 is used for refilling the medication in the pump or a malfunction of the pump. This was not a malfunction of the pump. Since the needle became dislodged and that's all that was done it would be non-billable just as if they came in to have it removed and it was flushed. The removal and flush is included in the original service. Use an E&M code for the visit and no subsequent infusion since the initial infusion was not completed.**

4. This question is for VIVA 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?

Response: **Providers should reference Medicare Publication 100-4, chapter 32 – section 67 for guidance on billing services involved with clinical trial or for data registry collection purposes to Medicare/ Medicare Advantage Plans. In order for claims to be considered for payment they should be billed with the appropriate diagnosis, modifiers, and clinical trial numbers. Claims not billed with the appropriate information will be returned to the provider requesting claim be rebilled with the required information.**

B) Is it appropriate to bill traditional Medicare for claims where the services are reported to a data registry (indicated by modifier Q0), eg. 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: **Providers should reference Medicare Publication 100-4, chapter 32 – section 67 for guidance on billing services involved with clinical trial or for data registry collection purposes to Medicare/ Medicare Advantage Plans. In order for to be considered for payment they should be billed with the appropriate diagnosis, modifiers, and clinical trial numbers. Claims not billed with the appropriate information will be returned to the provider requesting claim be rebilled with the required information.**

5. 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 attached]

Response: **Using the example given Viva's Medical Management team would have authorized an inpatient level of care. Viva's claim department would have processed and paid the claim according to the parameters of the authorization given. Had this scenario then proceeded to our Risk Adjustment team for retrospective review their findings would have been in agreement with the provider's assessment concerning the coding of sepsis.**