VIVA MINUTES
November 6, 2017 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Debbie Rubio

MS. RUBIO: We want to welcome from VIVA Chris Barrow, Carol Davis, and Donna Thomas.

1. Follow up to Question #4 from July 17, 2017, regarding IP readmission denials. What is an update on your readmission review processes to ensure that CMS regulations are being followed per the VIVA Administrative Guide?

Response: **VIVA MEDICAL Management and Compliance have reviewed all Readmission processes, and assured that all are within CMS, QIO, and State Operating Manual guidance. These processes are included in the Provider Manual, as well as the letter sent to the provider with the identification of each individual readmission. If a provider or facility elects not to receive the letter, or open the encrypted email containing the letter, the guidance is still available on the Provider Portal at all times. The excerpt from the Provider Manual, and example of the letter sent with each individual readmission case are attached.**

Discussion at meeting
MR. BARROW: So each of one you should have two attachments. One is the readmissions process, and one is a copy of the letter that is sent whenever a readmission is deemed possible for a 30-day readmit.

AUDIENCE: Here's our problem with that. They quote CMS, but they are misapplying the final determinations, just upholding them, saying they're just same or similar diagnosis. That's the problem.

MR. BARROW: Yes. And you and I've talked about this several times, and we recently had a meeting, where we are looking at revamping the responses that you get, because we understand that that is probably some more information you need. And you're absolutely right on that. So what we're trying to do now is trying to get a process in place, where we will give you an explanation from our medical director, stating why it was deemed a readmit and why it was preventable.

2. Follow up to Question #6 from July 17, 2017, regarding misinterpretation/misapplication of the CMS readmission review process. Did you get a response from your medical review team?

Response: **See answer above in Question 1.**

3. We have an issue with VIVA Medicare 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 VIVA 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 VIVA taking to correct this issue and to accurately pay these types of services in the future?

   Response: **VIVA has updated the Clinical Trial policy to reflect certain procedures as covered by the plan. The guidance also requires specific data requirements are submitted, they include diagnosis, Q0, Q1, condition code, value code, and the assigned clinical trial number. Claims received without these data elements should be rejected by the plan.**

   Discussion at meeting
   MR. BARROW: This is from our claims department. But they have updated the system to reflect the payment of those procedures.

4. In readmission review, are all diagnosis billed on the claim considered or just the primary?

   Response: **All.**

   Discussion at meeting
   MR. BARROW: And that was a simple all. All diagnoses are considered.

5. Why does your entity only offer one level of appeal, when Medicare and other MA payors offer an informal reconsideration level and then a formal level of appeal?

   Response: **Will discuss at meeting.**

   Discussion at meeting
   MR. BARROW: All right. You have to remember VIVA is still a young company. We're still growing. We're also Alabama only. We're not a multistate plan, like many of the other carriers, so we don't have a full department for this. Now, what we do have are you have provider reps, and you have our customer service line. That's technically your informal review. I have meetings with some of you guys here monthly, and we go over some of these as well. We can do that for anybody. You got your provider reps, and you have the customer service line, and that's for now what we're using as the informal review process.

   AUDIENCE: For the informal reconsideration form, if we're agreeing that the provider rep and customer service would be used as an informal review; specifically, with your customer service department, I'm comfortable with the fact that we can reach out to you and other

facilities can do that. But if they're using customer service as that line of communication, is VIVA recording those calls so that if it was our word against VIVA's that they could go and pull a call tape when -- let's just say whatever we were told does not pan out in the long run? Again, with the actual reps, I don't have a problem, but customer service, that would be an issue that that can come back to haunt us.

MS. THOMAS: All calls are recorded.

MR. BARROW: All calls are recorded.

6. 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: **VIVA uses editing software which identifies inappropriate billing in terms of the allowance for the same code billed more than once daily. It has been advised that providers can bill this service more than once daily, however they should bill units separately and append the 76 modifier.**

Discussion at meeting
MR. BARROW: This is from the claims department.

7. 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: **Medicare Advantage plans would be responsible until the patient is enrolled in hospice. Based on the question above it appears the patient has not yet been enrolled by a hospice carrier, and if that is case the services would be covered by the MA plan.**

Additional discussion at meeting
AUDIENCE: Does VIVA have a payer ID number where we can submit the claims electronically?

MR. BARROW: Yes, 63114.

AUDIENCE: Thank you.

AUDIENCE: When can we start expecting the explanation of why the readmission was denied, the letter you described?

MS. THOMAS: That is going through our process right now, and it will have to also be submitted to CMS. So I really don't have a projected date for you. I'm thinking it's going to take at least six weeks. We're into the holidays. So I would project that out into January right now. We're working on it as we speak.

AUDIENCE: I was just curious as to whether or not you have or VIVA has something as far as metrics? Like, is there something reportable on how many readmissions you are denying verses your overturning compared to the other insurance companies, or is that something only reportable to CMS, it's not for the providers to know?

MS. THOMAS: We know how many we are denying or how many readmissions per facility in this state. Your question about do we have the number as compared to other payers, that's not anything that we currently will audit on an ongoing basis.

AUDIENCE: We just seem to have a lot of issues with VIVA in that respect. And I talked to somebody at one time, and they were like, it's a great weight as to whether or not the patient follows up on their discharge. You know, we could properly discharge them, but if they don't show up for their physician's visit and subsequently are readmitted, where does that play into it, that kind of things.

MS. THOMAS: Sure.

AUDIENCE: I guess, if you are going to have some kind of narrative to tell us why, that might help. It’s hard whenever you hear, but because I said so.

MS. THOMAS: Right. And I understand. Is your facility currently making follow-up discharge appointments for your patients as they’re leaving?

AUDIENCE: Yes.

MS. THOMAS: Then as long as that is documented, that's what we're looking for.

AUDIENCE: When the patient goes to the physician's office, do you request that from the physician at any time? I mean, if it's one of our physicians that we own the practice, I guess, we could probably technically get the records and send it with it, to show what their follow-up visit results were, because we get a lot sometimes that they go to the doctor, and they're in another condition or having an exacerbation and something, and they have to come right back. So do you get the physician records, or do you ask for physician records?

MS. THOMAS: We do have physician records. Again, from our network physicians, we do have access to that. If it's an out-of-network physician, it would just depend on whether or not we could access those records.

AUDIENCE: It would be an in-network physician. But I'm just wondering if that has any bearing on it. You know, if we're sending in our records trying to appeal readmission, how does that play into it? Can we ask that you get those from the doctor? Can we get that from the doctor, that kind of thing? Because to me, that paints a little bit bigger picture of what the patient is experiencing at home. You know, they get all the follow-up information. We don't necessarily have that at the facility.

MS. THOMAS: Okay. So if I'm understanding you, and maybe can talk afterwards, this is a scenario where the patient has been discharged, they've seen the physician with a follow-up appointment, they've either had an exacerbation of the same condition or a separate episode is occurring due to another diseased process?

AUDIENCE: A lot of times, it's exacerbation. The physicians are quick to want to send them right back down to the ER. And that's where we're getting bounced back at, and that's really out of our control.

MS. THOMAS: Sure. I understand, and I hear what you're saying. I'm happy to talk with you afterwards and kind of step you through the process that we go through when we're looking at some of this, and I may can answer your question more specifically.

AUDIENCE: I have another question on readmissions. And mine kind of goes back to just the whole basis for the policy. We're always told this is Medicare's policy, you're following Medicare, but this is not how Medicare handles readmissions. I can think of one time that we've been audited and a readmission has been denied by Medicare either by the MAC or QO, the RAC, or anyone. I can send in readmissions all day long to Medicare, and they're going to pay the second claim. There's no question. Where Medicare does guess is that on certain procedures, like AMIs, and like the specific DRGs and conditions they look at, pneumonia, if we have higher readmissions rate, then there is a factor that goes into our payment calculation, where we get penalized, and we get paid less globally because we have higher readmissions. It has nothing to do with the granular level of auditing two claims. So, I guess, my question is, as a payer that follows Medicare, which I know is slightly different, how do you reconcile the fact that we're already being penalized by Medicare by this readmission factor, because we have -- you know, it varies by hospital -- possibly have higher readmissions. You're already being penalized on your payment, but then VIVA is turning around and also denying an entire DRG payment on top of that. So it seems like Medicare Advantage program, just like VIVA, are double punishing the hospitals with their readmissions.

MS. THOMAS: I felt the exact same way when I was sitting out there and not up here. I used to be where you are right now. Our readmission policy is based on the Quality Improvement Organizational Manual. If you'll reference exactly in Chapter 4, we're really focusing here on

quality, and we're looking for the quality and outcomes. This really started as we were partnering with our facilities and our partnering hospitals to try and help improve the overall quality levels for what you just referenced, because you are being penalized by CMS and others. And we were hoping by a focus on this and by looking at this, but if you will look at the QIO Manual, Chapter 4, and specifically Case Review 4240, you will see where this is. This has nothing to do with medical necessity. This is strictly a focus on quality and outcomes for our members.

AUDIENCE: You know, it's certainly within the purview of VIVA to do these reviews. I understand that. But, again, it's this kind of trying to equate what you're doing or what CMS does. It just doesn't happen on the Medicare side, not in the way that VIVA handles it. So you don't see that as double penalizing the providers by denying an entire DRG payment on top of the readmission that they were already receiving from CMS?

MS. THOMAS: No. That is not the way it is viewed. I understand your point, and it is well taken, and I will take it back. But, no, that is not the way we are viewing it.

AUDIENCE: And the other thing I have is since VIVA is not currently providing sufficient documentation to understand the decision that's being made on readmissions, would you consider holding off until you actually provide providers the information they need to adequately understand and respond to these denials? It seems to be an automatic process, which is confusing enough in itself. But then when you question it and you get back a form letter, it's kind of hard for the provider to even know where to start to try to have those conversations with VIVA to get that overturned.

MS. THOMAS: Well, we do have the process in place, and we are happy to discuss it at any time. When you receive a denial, there is the informal review process that is in place. And please feel free to reach out to us until we do have the letters in place that has a deeper explanation.

AUDIENCE: Going back to question number five, on having only the one level appeal, and you said you could go with the reconsideration through customer service. Would that person that I get with customer service, would they have the skill set to talk with me about medical necessity or whatever through customer service? Would they be able to a do that?

MS. THOMAS: They're not going to address your medical necessity, but they will refer it to someone who can.

AUDIENCE: And this will be in reference to question number four, regarding all of the diagnoses being considered. Based on that, if I'm a patient with heart failure or end stage renal disease, I'm going to always have that. So if I come to the hospital, it's going to always be a readmission. If it's within 30 days of penalty, the hospital runs the risk of being denied; is that correct? Whether it's primary or not, I may be in for a fractured femur, but if you consider all of the diagnoses, that heart failure is going to be there.

MS. THOMAS: No. We're looking at the driving diagnosis on the readmission. I mean, to your point, if I'm an end stage renal patient, and I pull out of the driveway and two blocks down I'm in a motor vehicle accident and brought back to the emergency department, that is not considered a readmission, even though I still have end stage renal failure.

AUDIENCE: So then you are just looking at the primary?

MS. THOMAS: We're looking at the driving factor for the readmission, if that makes sense.

AUDIENCE: Should be your primary.

MS. THOMAS: It should be. But documentation on these are key.

AUDIENCE: Lending to what Rosie is talking about, Cynthia and I have a habitual offender of noncompliance. Chris knows him by name, we know him by name, and y'all know him by name.

MS. THOMAS: I know him by name.

AUDIENCE: We've got specific documented cases where he is stable when he walks out the door, his blood sugars are in line, he has all the medications he needs. I'm trying to understand and wrap my mind around why VIVA continues to uphold denials after that, even though he left. He let the blood sugars get out of control. He went and sold the medication. He did all those things, and we are being penalized for that. So I'd like for you to speak to that, because I know other people in the room are experiencing that.

MS. DAVIS: Sure. Again, I will go back to documentation and your discharge planning. If the discharge planning documentation is in place with what the follow-up plans are, but you have a failed discharge time and time again. So, the same discharge plan two and three times is certainly not succeeding. So we would be looking for what resources are available. What are we reaching out for?

AUDIENCE: Okay. So that being the case, what is VIVA doing with these patients? What is his managed care company, insurance company, doing to help keep him in his home and not coming back to ED? It is not just the hospital's responsibility.

MS. THOMAS: Absolutely, it is not.

AUDIENCE: We can only do so much. We give him meds, when he can't afford them. We set up those appointments. We follow up with him. Home health is following up with him. I don't know anything else we can do. So why are we being penalized?

MS. DAVIS: We do have a case manager who knows this individual well and works with him also out in the community and works with discharge planning in your facility, and I think has been in touch with them pertaining to what is necessary in documentation for us to see. I'm

happy to talk with you about specific cases and get you some more specific information as to what we would be looking for.

MS. DAVIS: I was just going to say Donna is being very kind here. And not bragging, but Donna has a wonderful department of care managers that actually visit in the home, which kind of sets us apart from other insurance companies. We also have a pay for performance type program. It's called Connect for Quality. That's out in the physician's offices, working with the doctors and the Medicare members, the Medicare population. So we're in here with you. We're owned by a hospital. We understand hospitals probably better than most health plans. So I just want you to know that we're in the midst with you and with our members, and we have a very, very robust program between Donna's department and mine. And we are out there in the field. We've got provider reps in the field, nurses. You know, we're very easy to get in touch with, so please call on us. We are a four and a half star plan. We're the only one in Alabama, and we are very, very proud. And thank you for letting us come and talk with you today. We really appreciate you.

MS. RUBIO: We thank you for coming today.