VIVA Voice

SUMMER 2016

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NON-PARTICIPATING LAB USAGE

Viva Health is dedicated to working with you to ensure quality care is provided at the lowest cost possible to our members. We need help from you to continue this effort. According to your provider contract, you should only refer patients to participating providers, including participating labs. **If you use a non-par lab, look for communication from Viva Health regarding a change in our policy that may negatively affect your fee schedule.** Our participating laboratories are as follows:

PARTICIPATING LABORATORIES:
Labcorp
Quest Diagnostics
Accupath Diagnostics Laboratories Inc
American Esotertic Laboratories
Assurance Scientific Laboratories
Sequenom Center for Molecular Medicine
Regional Biomedical Lab
All Participating Hospital Labs

If you have a question regarding participating laboratories, please contact our Customer Service Department at 205-558-7474 or your Provider Representative.

READMISSION POLICY

Our readmission review process utilized for facilities is reimbursed at MS-DRG pricing methodology. Key elements of the process are listed below and can be found in the Viva Health Provider Manual located on our website at http://www.vivaprovider.com/Resources/Manuals.aspx.

Hospital Readmission Review Readmission review involves admissions to an acute, general, or short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, or short-term hospital.

Viva Health reviews the following readmission categories:

- Same day readmission for a related condition (see section below for more information);
- Same day readmission for an unrelated condition;
- Planned readmission/leave of absence; and
- Unplanned readmission in less than 31 days following the prior discharge.

Denial of the readmission may occur for, but is not limited to, the following reasons:

- Same day readmission for a related condition (see section below for more information);
- Same day readmission for an unrelated condition;
- Planned readmission/leave of absence; and
- Unplanned readmission in less than 31 days following the prior discharge.

Same Day Readmission:

- If readmission of a patient to a hospital occurs on the date of discharge for symptoms related to or for evaluation and management of the prior stay's medical condition, the hospital should combine the original and subsequent stays into a single claim.

If you have questions, please contact our Customer Service at 1-800-294-7780.

ICD10 DOCUMENTATION TIPS

Major Depressive Disorder

ICD-10-CM classifies "depression" without further description or specification as major depression. When a diagnosis of major depression is appropriate, not documenting all applicable descriptors will result in inaccurate code assignment.

Remember to document:

- Episode – single or recurrent
- Severity – mild, moderate, severe
- Presence or absence of psychosis/psychotic features
- Remission status – partial or full

Do not use the descriptor "history of" to describe current major depressive disorder or major depression that is still present, active and ongoing. In diagnosis coding, the phrase "history of" means the condition is historical and no longer exists as a current problem.

Major depressive disorder or major depression that is in remission but still has impact on patient care, treatment and management should be included in the final Assessment or Impression with the current status noted as "in remission."

Major depression classifies to the following categories with fourth and fifth characters to provide further specificity, i.e., mild, moderate, severe with and without psychotic features and whether the condition is in partial or full remission.

Major depressive disorder, single
F32.0 Major depressive disorder, single episode, mild
F32.1 Major depressive disorder, single episode, moderate
F32.2 Major depressive disorder, single episode, severe without psychotic features
F32.3 Major depressive disorder, single episode, severe with psychotic features
F32.4 Major depressive disorder, single episode, in partial remission
F32.5 Major depressive disorder, single episode, in full remission
F32.8 Other depressive episodes
F32.9 Major depressive disorder, single episode, unspecified

"Recurrent" is having at least one previous episode. Recurrent, according to ICD-10, would also apply to a patient who receives treatment to reduce the risk of further episodes.

Major depressive disorder, recurrent
F33.0 Major depressive disorder, recurrent, mild
F33.1 Major depressive disorder, recurrent, moderate
F33.2 Major depressive disorder, recurrent, severe without psychotic features
F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40 Major depressive disorder, recurrent, in remission, unspecified
F33.41 Major depressive disorder, recurrent, in partial remission
F33.42 Major depressive disorder, recurrent, in full remission
F33.8 Other recurrent depressive disorders (document the specific "other" recurrent depressive condition, as in "recurrent brief depressive episodes")
F33.9 Major depressive disorder, recurrent, unspecified

SARCOIDOSIS EDUCATION

Sarcoidosis is the abnormal growth of inflammatory cells that form granulomas. The disease usually begins in different parts of the body, most often the lung, lymph nodes and skin, but can appear in almost any body organ. When ICD-9 transitioned to ICD-10 on October 1, 2015, the ICD9 code changed from one code assigned for all Sarcoidosis sites, 135/Sarcoidosis, to multiple Sarcoidosis sites, D86.0- D86.9. Physicians must document with greater specificity the appropriate site for Sarcoidosis and bill accordingly.

Remember to document:
D86.0 Sarcoidosis of lung
D86.1 Sarcoidosis of lymph nodes
D86.2 Sarcoidosis of lung with sarcoidosis of lymph nodes
D86.3 Sarcoidosis of skin
D86.8 Sarcoidosis of other sites
D86.81 Sarcoid meningitis
D86.82 Multiple cranial nerve palsies in sarcoidosis
D86.83 Sarcoid iridocyclitis
D86.84 Sarcoid pyelonephritis
D86.85 Sarcoid myocarditis
D86.86 Sarcoid arthropathy
D86.87 Sarcoid myositis
D86.89 Sarcoidosis of other sites
D86.9 Sarcoidosis, unspecified

STAR RATINGS UPDATE – PROVIDERS PLAY A KEY ROLE IN OUR SUCCESS

CMS rates Medicare Advantage plans on a five star scale. Plans that earn 4 or more stars are eligible for quality bonus payments. The quality bonus dollars are used by Medicare Advantage plans to reduce out-of-pocket costs or improve benefits for patients.

VIVA HEALTH is currently a 4-star plan. We need your help to maintain or improve our rating. Some key areas participating providers are asked to focus on with us include:

- Offering timely access to appointments. The member satisfaction survey CMS uses for this measure asks how often your patient was able to get needed care right away, or as soon as they thought they needed it.

- Maintaining short in-office wait times. The member satisfaction survey CMS uses for this measure asks how often your patient saw the person they came to see within 15 minutes of their appointment time.

- Tell your patients about how you have reviewed their medical records and the care they have received from other providers. Tell your patients how you are coordinating their services with other providers when multiple people are involved in their care. The member satisfaction survey CMS uses for this measure asks how often you have their medical records or other information about their care, and their care from other providers. CMS also asks if you helped your patients manage their care among different providers.

- Assisting patients in securing routine preventive services:
    - Breast Cancer Screening –Mammogram every 2 years for females age 52-74
    - Colorectal Cancer Screening – adults age 51 to 75 who have one of the following screenings:
        - Fecal occult blood test (gFOBT or iFOBT/FIT) each year, or
        - Flexible sigmoidoscopy every five years, or
        - Colonoscopy every ten years
    - Diabetes Care- adults 18 to 75 years of age with diabetes (type1 and type 2) who had a who had each of the following:
        - Hemoglobin A1C (HbA1c) test at least annually and more frequently as needed
        - Eye exam (retinal) performed annually if positive for retinopathy or every two years if negative for retinopathy
        - Nephropathy monitoring – kidney test or screen for nephropathy annually

- Actively managing patients with high blood pressure, high cholesterol, or high blood glucose to get their levels under control. Having levels that reflect these conditions are in control and patient adherence to prescribed medicines for these conditions are heavily weighted by CMS in the star ratings.

- Scheduling follow-up appointments quickly after hospital discharge (within 7 days if at all possible, always within 30 days). Perform a medication reconciliation and submit on your claim using CPT code 1111F, or transitional care codes 99495 or 99496 as appropriate.

- Managing chronic conditions in the physician's office to prevent avoidable hospitalizations. The conditions CMS reviews include:
    - Diabetes short-term complications (ketoacidosis, hyperosmolarity or coma)
    - Diabetes long-term complications (renal, eye, neurological, circularity or unspecified complications)
    - Uncontrolled diabetes
    - Lower-extremity amputation among patients with diabetes
    - COPD
    - Asthma
    - Hypertension
    - Heart failure
    - Bacterial pneumonia
    - Urinary tract infection
    - Cellulitis, and
    - Pressure ulcer

CDC PAIN GUIDELINES

VIVA HEALTH would like to call attention to the CDC Guidelines for Prescribing Opioids for Chronic Pain released in March 2016. VIVA HEALTH monitors utilization patterns and has noted concerns in this area. Please review the full guidelines at http://www.cdc.gov/drugoverdose/prescribing/guideline.html. The recommendations are below:

CDC Recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care:

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

IMPORTANT COMPLIANCE REMINDER: ISSUING THE NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs) are required to issue a Notice of Medicare Non-Coverage (NOMNC) to VIVA HEALTH Medicare Advantage enrollees at least two (2) days prior to termination of SNF, HH or CORF services (with few exceptions). The NOMNC is a standardized OMB-approved notice that informs members of their right to an immediate, independent review of the proposed discontinuation of services.

In order for the Centers for Medicare & Medicaid Services (CMS) to consider the NOMNC content valid, providers must include the following information in the notice:

- Provider's name, phone number and address
- Member's name
- Member's VIVA HEALTH ID number or medical record number (HIC number cannot be used);
- Type of services ending (e.g. skilled nursing, home health, or comprehensive outpatient rehabilitation)
- Last date services will be covered
- Name and phone number of the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): KEPRO 1-844-430-9504 (TTY users, call 711)
- VIVA HEALTH'S Medicare contact information:

VIVA Medicare
417 20th Street N.
Suite 1100
Birmingham, AL 35203
1-800-633-1542 (TTY users, call 711)

The standardized language included in the notice cannot be omitted or modified. The NOMNC must also remain on two (2) pages.

CMS requires valid "delivery" of the notice. This means the member must be able to understand that he or she may appeal the termination decision. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. If a member is able to comprehend the notice, but is either physically unable to sign it, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. If a member refuses to sign the NOMNC, the notice is still valid as long as the provider documents that the notice was given, but the member refused to sign.

CMS requires that notification be made to a member's representative if the member is incapable of receiving or is incompetent to receive the notice. If the provider is unable to deliver the NOMNC to the representative personally, the provider must telephone the representative to advise him/her when the member's services will no longer be covered. The provider must describe the purpose of the call and provide, at a minimum, the following:

- The date services end, and when the member's liability begins
- The right to appeal the termination decision
- A description of how to appeal to the KEPRO (the BFCC-QIO)
- The deadline to appeal as well as what to do if the deadline is missed
- KEPRO's contact information

Providers must document the following information in the member's record/chart to confirm the telephone call with the representative:

- The name of the staff person initiating the contact
- The name of the representative

- How the representative was contacted (by phone)
- The date and time the representative was contacted
- The phone number that was called
- A notation that full appeal rights were given to the representative

Providers must also immediately mail the NOMNC to the representative and place a copy of the dated notice in the member's record/chart. It is also imperative to document the reason the NOMNC was issued to a representative instead of to the member (e.g. due to the member's incapacity or incompetence). This information must be noted in the member's chart or under the "Additional Information" section of the NOMNC. Failure to document this information can lead to an overturned appeal if the representative disputes the last covered day of SNF, CORF or HH services.

It is important for Viva Health to receive a copy of the NOMNC in the event the member (or representative) files a fast-track appeal with KEPRO. **Providers should email or fax a copy of the signed/ completed NOMNC to your Viva Health UM Nurse or Case Manager as soon as possible.**

Viva Health wants to work collaboratively with you to help ensure our members receive timely and clear communication about their fast-track appeal rights. Should you have any questions concerning the NOMNC requirements, please do not hesitate to contact your Provider Service Representative.

You can find a copy of the NOMNC template and instructions on CMS' website at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.

For more detailed information about the NOMNC requirements, see 42 CFR 422.624, 42 CFR 405.1200(b)(1) and Chapter 13 of the Medicare Managed Care Manual at www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms.html.

ATTENTION: PRIMARY CARE PHYSICIANS

Viva Health is expanding our Connect for Quality (C4Q) program in 2016 to practices with 50 or more Viva Health Medicare Advantage patients. Please contact your Provider Service Representative for incentive details and information on how to engage in the program.

NOTE: The Comprehensive Review Form (CRF) is based on a face-to-face visit with the PCP, which is validated by claims submission. We pride ourselves on paying incentives to our engaged physicians quickly. Not filing a corresponding claim confirming a face-to-face visit could result in delayed incentive payment.

CHRONIC CARE MANAGEMENT - CPT CODE 99490

Viva Health is the exclusive provider for Chronic Care Management Services for our members. We provide this through our team of in-house nurses and social workers and therefore will not contract with additional providers for this service at this time. Providers may refer any patient that may benefit from chronic care management to our Care Management Department. Because the health plan is the exclusive provider of these services for our members, claims we receive from other providers for the chronic care management code are not payable and are not billable to the member. You may contact your Provider Service Representative if you have any questions.

UPDATES TO PROVIDER PORTAL

Viva Health is excited to introduce our new Provider Portal. Viva Health invested in our own development team to create a new provider portal that we built around your needs. The new portal shows real time claims information, real time eligibility information, and real time authorizations. Additionally, the provider portal allows Primary Care Providers to enter pain management referrals online. Also, C4Q Providers can see their quality measures in real time and from previous years. We hope you find this new portal a more convenient way for you to collaborate with Viva Health and we welcome your feedback.

HEDIS CHART AUDITS – THANK YOU

Viva Health appreciates all the cooperation with providing access to medical records for the Viva Health annual HEDIS reporting process. Viva Health depends on the provider community's support to improve HEDIS measure rates, which ultimately affect Viva Health's CMS Star Rating for Medicare Advantage plans.

HOLIDAY SCHEDULE

Monday, July 4th (Independence Day): Closed
Monday, September 5th (Labor Day): Closed

QUICK REMINDER

Change Healthcare (formerly Emdeon) is Viva Health's electronic payment and remittance administrator. There is no fee to use Change Healthcare (formerly Emdeon) ePayment. Enrollment is simple and free.

By enrolling with Change Healthcare, you can accelerate your reimbursement cycle, eliminate paper based claims payments, sorting mail, and making trips to the bank. In addition to receiving payments electronically, Change Healthcare ePayment users can search, view, and print electronic remittance advices (ERAs).

To get started contact Change Healthcare:

Phone: 1.866.506.2830
Fax: 615.238.9615
Online: www.emdeon.com/eft
Mail: Attention: Emdeon Electronic Payment Service Enrollment
P.O. Box 148850 Nashville, TN 37214

NOTE: Providers contracting with the Regional Care Organizations will be required by Medicaid to enroll in EFT. Enrollment can be easily done via phone, online, mail, or fax. Please have your contact, organization, financial account information, NPI # and Tax ID# available upon enrollment.

VIVA HEALTH®

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Important VIVA HEALTH information inside.