12/1/2023

Dear Valued Provider,

VIVA HEALTH is committed to providing access to high quality, medically necessary health care services and building a collaborative partnership with providers in our network. In 2024, VIVA HEALTH will continue to ensure timely and appropriate access to medically necessary care for your patients and our members.

This letter serves as notice of changes to VIVA HEALTH's policies and procedures regarding acute care reviews for inpatient stays for Medicare members and provider appeals for claims related to Medicare and commercial members. **Effective January 1, 2024** the following changes will be implemented:

- **Medicare Medical Acute and Post-Acute Retrospective Reviews:** Medicare medical inpatient acute care admissions will be reviewed upon notification of member's discharge or by day 10 of the stay (for early claims payments). Determination decisions will be provided to the facility each day by end of business on "authorization sheets." Post-acute admissions will be reviewed upon notification of member's discharge. Determinations will be provided to the facility via email. VIVA HEALTH Case and Care Managers are available to assist with Transitions of Care and coordination of care.
- **Commercial and Medicare 2nd Level of Appeal:** For dates of service beginning January 1, 2024, provider appeal denials regarding level of care determinations will be eligible for 3rd party review. This second level of provider appeal is available only after the provider has received an adverse determination from Viva Health for the first level provider appeal. Administrative denials are not eligible for this additional level of appeal. VIVA HEALTH has selected MCMC as the 3rd party reviewer for eligible appeals. MCMC has over 30 years of experience in providing evidence-based independent medical review services and holds both a URAC (IRO Comprehensive) and NCQA (Utilization Management) accreditation. The initiating party will be responsible for the cost of the second level review by MCMC. Fees range from $210 to $375 per hour depending on service type, review complexity and requested turnaround time. More information regarding both retrospective reviews and 2nd level of appeal will be available via the 2024 Provider Manual that will be published January 2024. Additional questions may be directed to VIVA HEALTH Provider Services or Medical Management.

Thank you for your continued partnership.

2024 Acute Care Retrospective Review FAQ

VIVA HEALTH is committed to providing access to high quality, medically necessary health care services and building a collaborative partnership with providers in our network. In 2024, VIVA HEALTH will continue to ensure timely and appropriate access to medically necessary care for your patients and our members.

This FAQ outlines changes to VIVA HEALTH's policies and procedures regarding acute care reviews for VIVA Medicare members. **Effective January 1, 2024** the following changes will be implemented:

1. **Will the new retrospective review process impact hospitals?** Yes. VIVA HEALTH will need to be notified of all inpatient admissions within 24hrs or by close of business the following business day. For Commercial and Behavioral Health admissions, processes will remain the same; cases will be reviewed at admission and concurrently. For Medicare members, cases will be reviewed at discharge or approximately day 10 of the stay.

2. **Will authorizations now be required for Observation admissions?** No. There is no change in this process.

3. **What criteria will be used to determine inpatient medical necessity?** The medical necessity criteria Viva utilizes are available publicly and are available on our website through the InterQual Transparency tool, free of charge to our providers and members. The InterQual Medicare Navigator criteria align with CMS policies. This InterQual tool does no additional research or content development beyond translating the CMS text. For Medicare members, licensed nurses and physicians conduct reviews. Determinations are made on inpatient level of care based on the presentation of the patient, evidenced based criteria, and expected length of stay. VIVA will continue to adhere to the Medicare Inpatient Only List. For Commercial members, InterQual guidelines are utilized.

4. **Will there now be a peer-to-peer option?** No. There is no peer-to-peer option available.

5. **If an admission is not approved, will there still be an appeal option?** Yes. As exists today, Viva Health offers providers and facilities an appeal process conducted by Viva Health **free of charge** for all denied claims. Once a claim has been denied, facilities have 180 days to file an appeal with Viva Health.

6. **What may a facility do if Viva Health upholds the denial of the inpatient acute care admission upon appeal?** Appeals of hospital admission claims for dates of service January 1, 2024 and after that are denied due to inpatient criteria not being met are eligible for a second level appeal reviewed by an accredited independent review organization. If the outside reviewer agrees with Viva Health's decision and upholds the denial, the facility will be responsible for the cost of this outside review. Instructions on filing requests for such outside reviews will be provided if Viva Health upholds a denial after it reviews the initial provider appeal.

7. **How will we receive approval or denial determinations?** There will be no change to this process. Once a VIVA HEALTH clinician reviews a case, the facility will receive a determination notification via authorization sheets.

8. **Is a prior authorization required for post-acute admissions?** For *Medicare members*, a prior authorization will not be required for post-acute transfers beginning on or after Jan 1, 2024. For *Commercial members*, a prior authorization will continue to be required for all post-acute transfers.

9. **Is the new process for SNF only?** No. This applies to Skilled Nursing Facilities and Inpatient Rehabilitation

The CMS Final Rule may be found here: https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f#:~:text=In%20this%20rule%2C%20CMS%20finalizes,with%20certain%20social%20risk%20factors