

2024 PROVIDER MANUAL



Toll-Free: **1-800-294-7780**

Hours: Mon - Fri, 8 a.m. - 5 p.m. | Visit us online at www.VivaHealth.com

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Property of VIVA HEALTH®

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Important Contact Information



Medical Management

- Specialty Referrals
- Case Management
- Medical Procedures
- Inpatient Admissions
- Drug Authorizations
- Other Prior Authorizations



(205) 933-1201 or 1-800-294-7780

FAX: (205) 933-1232

**DRUMMOND: (205) 558-7445 or
1-866-300-0297**

You can reach a licensed VIVA HEALTH staff member 24 hours a day, 7 days a week in case of emergency. Regular Office Hours: 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday.

Customer Service for Providers and Employer Groups

- Assistance with Benefits
- Claims Inquiry
- Assistance with Payment Questions
- Assistance with Eligibility
- Provider Portal Setup



(205) 558-7474 or 1-800-294-7780

**DRUMMOND: (205) 558-7545 or
1-866-300-0297**

You can reach a licensed VIVA HEALTH staff member 24 hours a day, 7 days a week in case of emergency. Regular Office Hours: 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday.

Credentialing

- Application Status
- Credentialing/Application Questions
- Contracting and Development Questions



(205) 558-7474

FAX: (205) 558-7477

email: vivacredentialing@uabmc.edu

email: vivaparticipation@uabmc.edu

Medicare Member Services

- Member Assistance with Benefits
- Member Assistance with Claims and Payment Questions
- Member Assistance with Eligibility



(205) 918-2067 or 1-800-633-1542

TTY: 711

Regular Office Hours: 8:00 a.m. to 8:00 p.m., Monday through Friday (October 1 to March 31: 8:00 a.m. to 8:00 p.m., 7 days a week). You can reach a VIVA HEALTH on-call nurse 24 hours a day, 7 days a week in case of emergency.

Information is subject to change. Please visit our provider website at www.VivaHealth.com/Provider for the latest information.

Important Contact Information



Provider Services

- Changes to Provider Information
- Changes to your provider status including change of address, federal tax ID #, NPI #, licensure status, office hours, or practice member(s) should be sent to the e-mail, fax, or address on the right.



(205) 558-7474 or 1-800-294-7780

FAX: (205) 558-7477

email: vivaproviderservices@uabmc.edu

VIVA HEALTH Provider Services
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

Pharmacy Department

- Medicare Part D Prescription Drug Prior Authorization Requests
- Medicare Part D Prescription Drug Exception Requests
- Commercial Prescription Drug Prior Authorization Requests
- Commercial Prescription Drug Exception Requests



(205) 558-7474 or 1-800-294-7780

FAX: (205) 449-2465 for Medicare Part D Coverage Determinations

FAX: (205) 872-0458 for Commercial Coverage Determinations

Regular Office Hours: 8:00 a.m. to 5:00 p.m.,
Monday through Friday

Internet Resources

- **www.VivaHealth.com/Provider**
VIVA HEALTH website for providers. This page includes a link to the VIVA HEALTH Provider Portal, VIVA HEALTH's Internet access to check member eligibility, authorization information, and claims status.
- **www.VivaHealth.com**
General VIVA HEALTH website with links to all sites including information for VIVA HEALTH commercial members.
- **www.VivaHealth.com/Medicare**
VIVA HEALTH website for VIVA MEDICARE members and Medicare beneficiaries to learn more about VIVA MEDICARE.
- **www.cms.hhs.gov**
CMS website. Go to "Medicare" and then "Health Plans" for information on Medicare Advantage plans like VIVA MEDICARE.

Introduction to VIVA HEALTH



Managed Care Expertise:

VIVA HEALTH, Inc. is an Alabama-based health maintenance organization that provides quality, accessible health care. VIVA HEALTH Administration, L.L.C., is its sister company that offers third party administration (TPA) services. Managed by professionals with years of experience in the health care industry, VIVA HEALTH is also part of the renowned University of Alabama at Birmingham (UAB) Health System. All individuals and organizations connected with VIVA HEALTH work hard to simplify and improve health care through a network that includes many of the most respected providers and hospital providers in the market.

Community:

Joining VIVA HEALTH links you to a community that spans the state of Alabama. Currently one of the fastest growing managed care companies in Alabama, we have partnered with a large number of employer groups representing a variety of industries. Each month we add new health care providers to our expanding network.

Continuum of Care:

VIVA HEALTH's extensive provider network offers a continuum of care that covers everything from routine office visits, emergencies, and major and minor care to adult, obstetrical, and pediatric care. VIVA HEALTH has the full backing of the UAB Health System, a world leader in quaternary and tertiary health care services. This allows VIVA HEALTH to deliver a broad scope of care.

Extensive Provider Network:

VIVA HEALTH's growing provider network includes many of the finest providers and hospitals in communities throughout the state. Our Primary Care Providers guide members to the most effective health care options available. Since providers are pivotal in the delivery of excellent health care, we strive to make VIVA HEALTH a provider-friendly organization. We give health care professionals who are part of our provider network a voice in how VIVA HEALTH is managed through our Utilization Management/Quality Improvement, Credentialing and Pharmacy and Therapeutic Committees. Your valuable suggestions and comments are always welcome and serve as a check and balance, ensuring that we never waver from our commitment to providing quality health care.

Along with providers and hospitals, the VIVA HEALTH provider network includes durable medical equipment providers, home health agencies, skilled nursing facilities, urgent care clinics, pharmacies, and a wide variety of other providers and vendors that provide a complete range of health care services.

VIVA HEALTH's Commitment:

We commit to set the standard in health care excellence, promoting high quality and outstanding value for all of our members.

VIVA HEALTH Product Descriptions & Benefit Plans



VIVA HEALTH offers several different commercial products and benefits plans tailored to the needs of particular employers and member populations. Some benefit plans are limited to certain provider systems and some plans may even require a PCP referral to see a specialist, while others are open to the entire VIVA HEALTH network and no PCP referral is needed to see a specialist. Benefit levels and costs also may vary from employer to employer. For example, copayment levels and prescription drug coverage limits may be different or certain services may be carved out to another company (such as mental health and substance abuse or prescription drug coverage). The employer-specific benefit design is included on the Attachment A, Schedule of Copayments, and is available to members along with the Certificate of Coverage. Some of the most common copayment and deductible amounts are printed on the member's VIVA HEALTH identification card. Providers may also look up benefit information through the VIVA Provider Portal, VIVA HEALTH's internet access for participating providers. The VIVA HEALTH Provider Portal may also be used to look up authorization information and claims status. This is discussed in more detail on page 7.

All VIVA HEALTH and VIVA MEDICARE products require members to utilize participating providers for services to be covered except in emergency situations, for urgently needed care when traveling, and for VIVA MEDICARE members requiring out-of-area dialysis. Some products limit members to sub-networks called Provider Systems within the VIVA HEALTH network of participating providers. All VIVA HEALTH and VIVA MEDICARE products require prior authorization for hospital admissions, surgeries, and other procedures, tests, and services as described later in this manual under the heading "Procedures Requiring Prior Authorization from VIVA HEALTH." For plans that require PCP to Specialist referrals, referral requests must be approved by Medical Management prior to the member's visit.

Employer Group Plans:

VIVA HEALTH offers both "open access" and "limited network" plan designs for employers. Members in open access plans may see any VIVA HEALTH participating provider, while those in limited network plans will be limited to a sub-network of VIVA HEALTH providers. Some plan designs also have a tiered network benefit design in which members have access to the entire VIVA HEALTH network, but their cost-sharing may be lower at a sub-network of providers.

Some plans may also require a referral from a PCP for a specialist visit to be covered. We refer to these plans as "Gatekeeper." If a plan does not require a PCP referral then the member's ID card will indicate that on the back of the card. If a PCP referral is required, then the member's PCP will be listed on the back of their ID card. Even on Gatekeeper plans, no PCP referral is required to visit a participating OB/GYN, optometrist, ophthalmologist, and certain other specialties.

For more details on network coverage and access by plan visit www.VivaHealth.com/Provider/resources/ and choose the "Provider Access Matrix" under "Provider Manuals and Guides." Employer group plans' information is included on page 2 of the matrix.

VIVA HEALTH Commercial PY 2024 Provider Access Matrix



| Commercial Group | General Network | Podiatry | Optometry | Ophthalmology | Oral Surgery | Pain Mgmt | Dermatology | Rheumatology | Allergy & Immunology | Endocrinology | Chiro | Mental Health | OB/GYN | Peds | |
|---|-----------------|---|-----------|---------------|--------------|-----------|-------------|--------------|----------------------|---------------|-------|---------------|--------|-------------------|--|
| Med West ¹ (UAMW & MWHB) | Closed | Open | Open | Open | UAB Only | Open | Open | UAB Only | Open | UAB Only | Open | Open | Open | Open | |
| Montgomery Baptist ² (MONT & MON3) | Closed | Open | Open | Open | Closed | Open | Open | Closed | Open | Closed | Open | Open | Closed | Both ² | |
| Montgomery Baptist (MON2 & MON4) | Open | Montgomery Baptist employees who reside outside Montgomery, Elmore, Autauga, Lowndes, Butler, Crenshaw, Pike, Bullock, Macon, and Jefferson counties have access to the entire VIVA HEALTH network (MON2 benefit package- same benefits as MONT but with an open access network). | | | | | | | | | | | | | |
| VIVA UAB ³ | Closed | Open | Open | Open | Closed | Open | Closed | Closed | Open | Closed | Open | UAB Only | Closed | Open | |
| Drummond | Open | These plans have 3 networks. The primary network is VIVA HEALTH doctors in Alabama. For that network members pay their standard plan cost-sharing. For doctors in Alabama but not in the VIVA HEALTH network, we cover 80% or 90%, depending on the plan. For doctors outside of the state of Alabama, there are copays for some services and others covered at 100% of UCR. | | | | | | | | | | | | | |
| HSF & Health System (HSFD & UAHS) | Open but tiered | Certain services have a higher copay for outside of UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, Callahan Eye Foundation, UAB Spain Rehabilitation Center, and all UAB satellite clinics. Med West is not included in the definition of "UAB" for lower cost sharing. | | | | | | | | | | | | | |
| HCAA-RMC (RMCA) | Open but tiered | "RMC" means Regional Medical Center Anniston, Stringfellow Memorial Hospital, and all RMC satellite clinics. The UAB+ network (Tier 2) includes UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, all UAB satellite clinics, and Children's of Alabama. The VIVA HEALTH network (Tier 3) includes hospitals and health centers contracted with VIVA HEALTH but outside of RMC and UAB. | | | | | | | | | | | | | |
| Infirmiry Health (IHMS) | Open but tiered | Tier 1 cost-sharing applies to the Infirmiry Health Clinically Integrated Network (CIN). The CIN means Mobile Infirmiry, Thomas Hospital, North Baldwin Infirmiry, and all other Infirmiry satellites and UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, and all UAB satellite clinics. Tier 2 cost-sharing applies to the more expansive VIVA HEALTH network. The VIVA HEALTH network includes all other hospitals, health centers, and other providers contracted with VIVA HEALTH but outside of the Infirmiry Health CIN. Tier 1 cost-sharing applies to covered dialysis services received from DaVita and Fresenius dialysis clinics, to both CIN and VIVA HEALTH network inpatient mental health and substance use services, to all in-network DME, including wigs, and all VIVA HEALTH network dermatology and pediatric sub-specialty services. | | | | | | | | | | | | | |
| Triton Health (TRIZ) | Open but tiered | For care delivered outside of Jefferson County, the UAB cost sharing will apply. Inside Jefferson County, UAB cost sharing will apply at UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, all UAB satellite clinics, Children's Hospital, and the hospitals and clinics in the Ascension St. Vincent's Health System. | | | | | | | | | | | | | |
| VIVA Access (UAB) | Open but tiered | Coverage is generally cheaper within the more limited UAB network, with the exception of a few limited services where the cost-sharing is the same for both the UAB network and the general VIVA HEALTH network. The lower UAB network cost-sharing applies to all in-network pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA HEALTH network or the UAB network. The VIVA HEALTH network includes hospitals and health centers contracted with VIVA HEALTH but outside of UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, and all UAB satellite clinics. UAB Network cost-sharing applies to employees in Huntsville, Selma, and Montgomery under benefit package VHU2 even when accessing care in the more expansive VIVA HEALTH network. | | | | | | | | | | | | | |
| UAB Post-Doctoral | Open | Needs referral for specialists for subscribers and dependents, except for vision and OB/GYN. | | | | | | | | | | | | | |

NOTES:

- ¹Med West All providers who admit to Med West & UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklín Clinic of UAB Hospital, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, and all UAB satellite clinics.
- ²Montgomery Baptist All providers who admit to Baptist. Pediatrics OPEN to UAB, Children's, and The Pediatric Clinic, LLC in Opelika, otherwise it is CLOSED. The Montgomery Baptist network includes Baptist Medical Center East, Baptist Medical Center South, Prattville Baptist Hospital, and UAB Hospital (including UAB Callahan Eye Hospital and The Kirklín Clinic of UAB Hospital) for inpatient and outpatient care, and the Participating Physicians who admit to these facilities for Physician services. It also includes access to the entire VIVA HEALTH network of optometry and ophthalmology, dermatology, mental health, podiatry, pain management, allergy and immunology, and chiropractic providers.
- ³VIVA UAB All providers who admit to UAB. "UAB" includes Medical West. VIVA UAB members 18 and older may see providers at Medical West for any service, open or closed, including OB/GYN. Dependents under 18 may use any VIVA HEALTH participating Hospitals and Physicians and no referral is required to specialists for dependents under 18. No specialty, open or closed, requires a referral from VIVA HEALTH **except for** Chiro for members 18+. Closed: Physical Medicine and Rehabilitation.

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VIVA HEALTH Product Descriptions & Benefit Plans



Medicare Advantage Plans:

VIVA MEDICARE

VIVA MEDICARE is VIVA HEALTH's Medicare Advantage Program for Medicare eligibles residing in Autauga, Baldwin, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, DeKalb, Elmore, Etowah, Fayette, Franklin, Geneva, Henry, Houston, Jackson, Jefferson, Lauderdale, Lee, Limestone, Lowndes, Macon, Madison, Marshall, Mobile, Montgomery, Morgan, Pike, Shelby, St. Clair, Talladega, Tallapoosa, Tuscaloosa, or Walker counties. Identification cards for VIVA MEDICARE members indicate the name and phone number of the member's selected PCP and Provider System. While VIVA MEDICARE members each choose a PCP, no PCP referral is required for a member to see a specialist within their selected Provider System.

VIVA MEDICARE *Infirmiry Health Advantage*

In partnership with Infirmiry Health, VIVA MEDICARE has offered this plan in the Mobile market since 2022. This plan is only offered in the following counties: Baldwin and Mobile. Members in this plan will receive their care within the VIVA MEDICARE Infirmiry Health Advantage network. VIVA MEDICARE offers other plans in these counties that have larger networks, but the member may have higher cost sharing for some services.

Please see the VIVA MEDICARE section of this provider manual for more information on VIVA HEALTH's Medicare plans.

Note: Please visit www.VivaHealth.com/Provider for the most current listing of sample identification cards and a brief product description of the different VIVA HEALTH Benefit plans.



VIVA HEALTH's New Provider Portal

VIVA HEALTH's new provider portal features an updated design and the ability to create certain pre-authorizations with automatic approvals and check member eligibility and claims status, all with improved security. Only one portal account administrator can self-register per practice or facility. We highly encourage portal administrators to set up additional users and designate roles as needed. If you are not the provider portal administrator, you will need to contact that designated person for end-user access.

Are You a Third-Party Administrator?

If you are a third-party administrator (TPA) handling the billing and/or filing of claims for a provider or multiple providers, you will have the ability to self-register; however, self-registration will only allow access to a non-active account. Once you create your account, notification will be sent via the portal to the practice/facility portal account administrator for review. A TPA will not have access to any provider or member data until the practice/facility account administrator grants final approval. VIVA HEALTH will not grant TPAs direct access to the provider portal.

Accessing the Provider Portal

To access the new portal and self-register, please go to <https://vivaproviders.com>.

The following information is required to self-register:

- Tax ID number
- Group billing NPI number (This will not be the individual NPI number.)
- Claim number, primary TCN or ICN for a date of services within the last 3 years
- VIVA HEALTH provider number
- Cell phone number (This is a required field needed for security authentication purposes)

Your provider number can be found on the top right-hand corner of your VIVA EOB. If you receive 835 electronic remits from a clearinghouse, your provider number should be on your remit, but it may be called something else. You will need to check with your clearinghouse to get the location of your provider number.

Linking Tax ID Numbers

If you need to link multiple tax ID numbers for single sign-on access, please send all tax ID numbers with the associated Billing NPI to the VIVA HEALTH provider portal email at vivaproviderportal@uabmc.edu.

Portal Access Problems or Related Questions

Please email portal access problems and related questions to vivaproviderportal@uabmc.edu. **This mailbox should only be used for that purpose.** Claim and appeal status can be obtained by contacting provider customer service at 205-558-7474 or by faxing your status request to the TPA fax line at 205-449-7849.

VIVA HEALTH's Accessibility Standard



VIVA HEALTH monitors the accessibility of our providers for appointment availability, in office wait time, and after hours care. Accessibility means the ability or ease with which members can reach their provider during and after practice hours.

VIVA HEALTH requires our participating providers with applicable specialties to also make necessary and appropriate arrangements to assure the availability of provider services to their patients 24 hours per day, 7 days per week, including call coverage with a contracted provider to assure coverage after-hours or when the provider is otherwise absent. Solely directing members to an emergency room is not recommended. Providers with applicable specialties must return telephone calls related to medical issues and should be accessible within 1 hour for emergencies.

PCPs after-hours/weekends/holidays telephone number must:

- connect the patient to the PCP or an authorized provider OR
- connect to a live voice call center system (answering service) OR
- connect to an answering machine/voicemail that gives a number to call for immediate response OR
- connect to a hospitalist group that is aware of the 24/7 coverage protocol.
- An office telephone line not answered after hours, or answered after hours by a recorded message instructing the recipient to call back during office hours or to go to the emergency department for care, is not acceptable. It is also not acceptable to refer recipients to the PCP group's home telephone if there is not a system in place as outlined above to respond to calls. In addition, systems designed to refer all requests to go to the Emergency Room are not acceptable.

Specialists after-hours/weekends/holidays telephone number must:

- connect the patient to the PCP or an authorized provider OR
- connect to a live voice call center system (answering service) OR
- connect to an answering machine/voicemail that gives a number to call for immediate response OR
- connect to an answering machine/voicemail that is monitored hourly to address concerns OR
- connect to an answering machine/voicemail that directs the member to the nearest urgent care OR
- connect to a hospitalist group that is aware of the 24/7 coverage protocol.
- An office telephone line not answered after hours, or answered after hours by a recorded message instructing the recipient to call back during office hours or to go to the emergency department for care, is not acceptable. It is also not acceptable to refer recipients to the Specialist group's home telephone if there is not a system in place as outlined above to respond to calls. In addition, systems designed to refer all requests to go to the Emergency Room are not acceptable.

If a VIVA HEALTH Provider chooses to stop accepting new patients, the decision must apply to all patients regardless of the patient's source of health coverage (Commercial, Medicare, or Medicaid). Providers shall not discriminate against patients based on the type of health coverage they have in place. The decision to not accept new patients must be made in writing with a 60 day advanced notice. The written notification should be emailed to vivaproviderservices@uabmc.edu. If a member selects a participating provider as their PCP prior to the effective date the provider stops accepting new patients, the provider must honor the member's election. VIVA HEALTH defines a new patient as one who has either never been seen by you or not seen within the last 5 years. Otherwise, the patient is considered established. A participating provider may not close their panel to established patients who elect a VIVA HEALTH or VIVA MEDICARE plan.

VIVA HEALTH's Accessibility Standard



Appointments must be available to VIVA HEALTH members within the prescribed standard listed below and must be expedited based on medical need.

| Appointment type: | Time Elapsed Standard: |
|---|--|
| Emergent /Urgent Services | A patient with a life threatening situation, an unforeseen illness or an injury: Appointment available/patient seen immediately. |
| Post Discharge Follow Up | A patient who is discharged from the hospital: Appointment available within 7 calendar days of the discharge notice. |
| Non-Emergent/Non-Urgent Services | A patient requiring services that are non-emergent or non-urgent, yet the patient requires medical attention: Appointment available within 7 business days of request. |
| Routine/Preventive Care | A patient with a routine care or preventive health need: Appointment available within 30 business days of request. |
| In Office Wait Time <i>(CAHPS Surveys inquire if members are usually seen by their provider within 15 minutes of the scheduled appointment. Providers are urged to adopt this as a best practice.)</i> | For scheduled appointments, the wait time from the time the member is triaged to seeing the provider should be 15 minutes or less (except if a provider is called away for an emergency). If wait time is greater than 15 minutes, the member should be informed of the circumstance and/or provided an alternative appointment. |

VIVA HEALTH's Practice Site Visit Standard



VIVA HEALTH may conduct a site visit whenever deemed necessary and if we receive a VIVA MEDICARE member complaint regarding:

- Physical Accessibility – e.g., handicapped accessibility, ease of entry into building
- Physical Appearance – e.g., cleanliness, orderliness, adequate lighting, visible signage of practice
- Adequacy of waiting room and examining room space
- Adequacy of treatment record keeping
- Hours of operation

VIVA HEALTH uses a standardized site-visit survey form that incorporates office-site criteria. A site visit will be performed within 30 calendar days of the member complaint. Site visits with a score of 85% or greater is passing. If the score is below 85%, the site must develop and implement an action for improvement. For all scores below 85%, a second site visit will be scheduled within 60 days to verify if site improvements meet our site standard.

Site Visit Standards:

Physical Accessibility:

- Adequate general parking
- Designated disabled parking space
- Wheelchair accessible ramps
- If office is located off main level, an elevator is available for public use
- Restrooms are accessible to all patients including physically disabled

Physical Appearance:

- Practice location identified by visual signage
- Visual cleanliness of restroom, waiting room, and treatment room
- Well lit waiting and treatment area
- Exit sign is visible
- Exits and hallway are clear from obstruction
- Fire extinguisher visible and checked annually
- Biohazard disposal system
- Needle disposal system

- Medication/laboratory refrigeration is kept separate from food

Adequacy of Waiting and Examine Room Space:

- Adequate seating in waiting area
- Adequate privacy at registration
- Treatment room has adequate treatment space
- Seating available in treatment room

Medical Records / Security:

- Patient medical records are in secure/confidential filing system
- If using electronic records, medical records are password protected
- Patient medical records are legible
- Patient notification of Privacy Policy
- Patient notification of HIPAA Policy
- Prescription pads are secure at all times
- Narcotics are under lock and key at all times
- Medications are accessible by staff only

Your Role in Improving Member Satisfaction



VIVA HEALTH's contracted providers play a key role in our members' satisfaction with the health plan. We ask that you join with us in our mission to continuously improve the services we provide. This includes both medical services and administrative services. VIVA HEALTH's customer service mission statement begins "We commit to treat our customers the way we would expect to be treated ourselves." It's a simple concept and one we hope you will consider when designing your quality improvement initiatives. Some areas where performance is critical to member satisfaction are described below.

Access Standards

Members should be able to obtain services in compliance with VIVA HEALTH's Accessibility Standards listed on page 8. CMS has placed an increased emphasis on the member's experience with access to their provider through timely appointments and office wait times. The following questions are part of the CAHPS survey administered each year on VIVA HEALTH members:

- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check up or routine care as soon as you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Some tips for improving the member experience in this area include:

- **Appointments Accessibility and Availability:** Communicate clear and simple avenues for patients to set appointments. If appointment lead time is an issue for your practice, consider implementing a priority call list when there are cancellations to help patients get in sooner than their scheduled appointment dates. Remind patients timely about upcoming appointments. If telehealth is an option to see patients soon give clear instructions on how they can participate in a remote visit.
- **Appointment Wait Times:** After a patient arrives, make sure they are initially seen by an office staff member within 15 minutes of their designated appointment time. If wait times are expected to be long, try to notify members ahead of their appointment time to give them an opportunity to plan for the delay. If working a member in for an unscheduled appointment, set their wait time expectations accordingly at the time of scheduling.

Cultural Competency

As a VIVA HEALTH provider, we ask that you continually assess the impact of cultural differences in patient care and look for ways to improve the cultural competency of your office. As Nelson Mandela said, "You win a person's mind when you speak a language they understand. You win a person's heart when you speak to them in their language." Diversity can take different forms – ethnic background, religion, language, literacy levels, income, disabilities, etc.

- Remember that cultural gaps can lead to miscommunications. Take steps to better understand your patients' perspectives by studying the health-related beliefs of cultures represented in your patient population. Be willing to listen and learn from your patients with diverse cultural backgrounds.
- The more closely your staff reflects the diversity of your patient base, the better you will be able to serve your patients. For example, if a high percentage of your patients speak a particular foreign language, you may wish to consider having someone on staff who also speaks that language.

Your Role in Improving Member Satisfaction



- Even if you don't have great knowledge of a patient's culture, you can still take steps to win the patient's trust by listening to the patient, showing empathy and warmth, and customizing your communications to better meet the patient's needs.

Respect for Members' Privacy

Working in health care day in and day out, we must keep in mind the sensitive nature of medical information. We must constantly remind our staff and ourselves that patients put their trust in us to safeguard their medical information. Some steps you should take to protect patient information include:

- Keep patient files under lock and key and limit access to those persons for whom access is required to perform job responsibilities.
- Adopt confidentiality policies and procedures and train all staff on them. Have each staff member agree in writing to abide by the procedures and not disclose medical information for purposes not related to work.
- If you keep patients' medical information in an electronic format, strict confidentiality policies and limited access are even more critical.
- Federal regulations related to the confidentiality and security of patient information have been implemented under the Health Insurance Portability and Accountability Act (HIPAA). VIVA HEALTH and contracted providers must stay abreast of the regulations and comply with their requirements.

Communication

CMS surveys VIVA MEDICARE members each year using the Medicare satisfaction survey developed as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS). VIVA HEALTH also conducts its own survey of its employer group membership. Several of the questions on the survey relate to how well doctors communicate, such as:

1. In the last 6 months, how often did your personal doctor listen carefully to you?
2. In the last 6 months, how often did your personal doctor explain things in a way you could understand?
3. In the last 6 months, how often did your personal doctor show respect for what you had to say?
4. In the last 6 months, how often did your personal doctor spend enough time with you?

Additionally, communicating what you have done to prepare for the member's visit and coordinate their care with other providers is very important. Intentional communication regarding these goes a long way towards positive member experience and building a good doctor-patient relationship. The following questions are areas members are specifically surveyed on:

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did they have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

Your Role in Improving Member Satisfaction



- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

The scores on these above questions are among the most important indicators of whether VIVA HEALTH is delivering a quality product to our VIVA MEDICARE members. VIVA HEALTH encourages providers to communicate openly with our members, to allow them the right to participate in decision-making regarding health care, and to provide information on available treatment options or alternative courses of care. We urge you to discuss medical conditions and treatment plans with the member and take the time to explain potential complications and side effects and what the patient should do if they arise. Patients should also be made aware of when follow-up services need to be scheduled. Finally, we ask that specialist providers communicate findings and treatment plans back to the PCP to enhance continuity of care. These findings should be communicated to the PCP within 30 days of the last visit to the specialist for a course of evaluation or treatment.

Prevention of Discrimination

All VIVA HEALTH providers agree by contract not to discriminate in the treatment of members based on race, color, national origin, ancestry, religion, marital status, sexual orientation, gender, age, or disability. Providers agree to make services available to all VIVA HEALTH members in the same manner, in accordance with the same standards, and with the same availability as to non-members. We ask that providers work with office staff to promote an accepting environment for all patients. We also ask that providers adopt and distribute an office policy supporting non-discriminatory practices.

The Centers for Medicare & Medicaid Services standards strictly prohibit health screening of eligible enrollees at the time of enrollment. Similarly, encouraging the disenrollment of a member in poor health based on financial motives (i.e., to avoid liability for the member's claims) is equally prohibited. The standards apply to both VIVA HEALTH and VIVA MEDICARE contracted providers.

Under 42 C.F.R. §422.504(g)(1)(iii), Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. QMB billing prohibitions may also apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits.

Your Role in Improving Member Satisfaction



Access to Medical Records

VIVA HEALTH members have the right to access their own medical records in accordance with state and federal law. Furthermore, with appropriate patient authorization, contracted providers should provide a copy of the patient record to the new provider if the patient changes providers. Records should be provided promptly and in a manner that safeguards the privacy of the patient.

Proper Billing Practices

Contracted providers agree to accept VIVA HEALTH's payment as payment in full for covered services. Providers should collect applicable copayments due at the time of service. Providers may not bill patients for the difference, if any, between the contracted amount paid by VIVA HEALTH and the provider's billed charges. This practice, commonly known as balance billing, is prohibited. Providers may bill patients for copayments and coinsurance, if any, as indicated on VIVA HEALTH's explanation of payment. If a claim is denied for failure to comply with VIVA HEALTH's utilization management procedures (i.e., secure prior authorization or referrals), the provider may not bill the member for these services.

VIVA HEALTH Provider Participation Requirements

Credentialing Required for Initial Appointment and At Least Once Every 3 Years

- Complete provider demographic form – requests can be sent to vivaparticipation@uabmc.edu
 - Current CAQH Proview application and attestation required
 - Current medical or professional license, controlled substance license, and DEA, as applicable
 - Applicable call coverage, as designated on page 8

Send Provider or Practice Updates Promptly

- Send notification of changes to provider demographics, location, practice TIN, or billing information to vivaproviderservices@uabmc.edu.
- Advance practice providers: Send notification of changes to collaborating or supervising physicians to vivacredentialing@uabmc.edu.

Provider Data Attestations through Better Doctor

- Validate/update your information with VIVA HEALTH, Inc. every 90 days. Quest Analytics' BetterDoctor will prompt you for updates as they are due.
- Data elements that must be attested include:
 - Provider name, practice address, phone number, specialty
 - If applicable: indicate if you are accepting new patients (Yes or No)

Medicare Providers

- Complete annual SNP Model of Care training and attestation by visiting www.vivahealth.com/provider/snp-provider-training/.

The Role of the Primary Care Provider



The Primary Care Provider (PCP) is a participating provider who has the responsibility for directing the complete care of their members. The PCP will provide the care themselves or refer the care to an appropriate VIVA HEALTH participating provider.

PCPs Include the Following Specialties:

1. Family Practice
2. Internal Medicine
3. Geriatrics
4. Pediatrics
5. General Practice
6. OB/GYN (when requested and contracted as a PCP)

The PCP manages the health care needs of VIVA HEALTH members who select them as their personal provider. The PCP provides the patient with emergency, urgent, routine, and follow-up care within that provider's scope of medical training and practice. In addition to managing all services for office care, PCPs are responsible for obtaining referrals to specialists (SCPs) when required by the member's plan, coordinating emergency, urgent and/or out-of-area care when possible, and maintenance of the member's complete medical record.

The Basic PCP Services and Responsibilities Are:

1. Provide services in the office, home, hospital, emergency room, or other appropriate settings, including those primary care services customarily rendered by general practitioners, family practitioners, internists, and pediatricians.
2. Maintain and operate their office in a manner protective of the health and safety of office personnel and the VIVA HEALTH member and in accordance with state regulations.
3. Provide or arrange newborn care.
4. Provide or arrange for EKGs with interpretation.
5. Provide or arrange for immunizations and injections, including Polio, MMR, TB Tine Test, DPT, Tetanus, Pneumovax, Hemophilus, influenza vaccine, and other office injections.
6. Provide Tympanometry.
7. Provide vision screening (eye chart).
8. Provide routine hearing exams.
9. Provide routine physicals.
10. Advise members regarding their future health care needs and options for treating those needs.
11. Coordinate care when a patient is referred to a specialist, including ensuring that specialist notes are entered in the chart and acted upon as needed, and that the appropriate follow up care is provided.
12. Provide office visits during regular office hours for evaluation/management of common areas of medicine. Patient education functions may be delegated to appropriately trained staff under the provider's supervision.
13. A sole proprietor must be in their office location at least 32 hours per week in order to be a Primary Care Provider.
14. Participation of PCPs in the Connect for Quality (C4Q) program is highly encouraged if their Medicare membership is within the required guidelines.

For Members:

Arrangements for coverage while off duty or on vacation must be made with participating providers. The PCP is responsible for the management of all medical services for their VIVA HEALTH patients, including the management of referrals to Specialty Care Providers (SCPs) when required by the member's plan, facilities, or other providers. Services to be coordinated by the PCP include, but are not limited to:

1. Surgery
2. Physical, occupational, and speech therapy
3. Hospital visits
4. Diagnostic x-ray and laboratory
5. Specialist services (when PCP referral is required)
6. Home health care

Responsibilities of the Primary Care Provider



Referrals/Prior Authorizations:

It is the responsibility of the Primary Care Provider (PCP) to obtain proper referrals for VIVA HEALTH members in plans that require specialty referrals. They must also manage the overall care of members by directing them to the appropriate VIVA HEALTH contracted provider, as well as notifying the patient and contracted provider of the referral/prior authorization number. PCP referrals are not required for VIVA Access members.

If the patient's appointment is 7-10 days away, fax or mail referral requests by completing the Referral Authorization Form (see following page for sample form). Be sure to include the following:

- Patient name
- Member identification number
- PCP name
- PCP fax number (w/ area code)
- Referred to provider name
- # visits requested
- Type services requested
- Diagnosis
- Pertinent clinical information

Mail referral requests to:

VIVA HEALTH
Attention: Medical Management
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

Fax referral requests to:

Birmingham (205) 449-7049

In an effort to reduce the amount of time provider office staff spends on hold waiting to obtain an authorization from our Medical Management Department, it is recommended that requests with a scheduled date of service at least 7 days in the future be faxed to (205) 449-7049. Please remember to include the above information in the fax. Requests with a scheduled date of service within the next 3 days may be phoned in by calling (205) 933-1201 or 1-800-294-7780. Providing all pertinent clinical information will allow faster processing of requests. The goal of the Medical Management Department is to turnaround all faxed requests within 7 days of receipt.

- The VIVA HEALTH Medical Management Department will inform the requesting provider of the prior authorization approval for approved services. The PCP notifies the patient and specialist of the approval. Additionally, VIVA HEALTH sends Medicare members an approval letter notifying them of the approved services. If services are denied, the requesting provider will be notified verbally and the member will be notified in writing.
- Reports from tests and x-rays performed by the PCP should be copied and sent to the specialist to prevent duplication of testing.
- Providers may check the status of an authorization or referral request by calling VIVA HEALTH's Medical Management Department at (205) 933-1201 or 1-800-294-7780 or by using the VIVA HEALTH Provider Portal as described on page 7 of this Provider Manual.
- Submit claims timely following complete and accurate coding guidelines appropriately capturing the acuity and complexity of a member's condition while maintaining the proper documentation in the medical records to support codes submitted along with a treatment plan and care coordination actions. Notify VIVA HEALTH for any codes that are determined to have been submitted in error.

Responsibilities of the Primary Care Provider



Advanced Practice Providers:

VIVA HEALTH recognizes and credentials the following Advanced Practice Providers (APP) as eligible network participants: a certified registered nurse practitioner (CRNP), a physician assistant (PA), a surgical physician assistant (SPA), and a certified nurse midwife (NMW). An APP is a specially trained, certified, and licensed provider who renders medical services within the scope of their license. VIVA HEALTH requires that the APP's collaborating or supervising physician be a contracted provider with VIVA HEALTH. An APP and their collaborating or supervising physician must have a matching specialty. For Primary Care APPs seeing Medicare members, the following specialties are acceptable matches: Internal Medicine, Family Practice, Geriatrics, Emergency Medicine, Hospitalist, and Urgent Care. For APPs seeing non-Medicare members or pediatric patients, the APP may have a collaborating or supervising physician specializing in Pediatrics.



VIVA HEALTH IS ACCEPTED IN EVERY MAJOR HOSPITAL IN OUR SERVICE AREA

VIVA HEALTH maintains a comprehensive network throughout Alabama and covers over 100,000 Alabamians every day.



Referral Authorization Form

Attention:

This facsimile transmission is private, confidential, and intended only for the recipient named here on. If you receive this transmission in error, please contact VIVA HEALTH's Medical Management Department at (205) 933-1201 or (800) 294-7780.

FAX THIS COMPLETED FORM TO: (205) 449-7049

Referral #: _____ **Expires:** _____

| | | | | |
|--|-----------|--|---|------------|
| Member Name: | Member #: | DOB: | Refer to Provider: | Specialty: |
| Please check the requested services: | | <input type="checkbox"/> Evaluation and Recommendation | <input type="checkbox"/> Evaluate and Treat | |
| <input type="checkbox"/> OPS | | <input type="checkbox"/> One Follow-Up Visit | <input type="checkbox"/> Send Report to PCP | |
| Number of Visits: (If Pain Mgmt, Limited to 6 visits/6 months) | | Appointment Date: | | |

MEDICAL INFORMATION

| | |
|--|--------------|
| Diagnosis: | ICD-10 Code: |
| Symptoms: _____ _____ _____ | |
| Previous Treatment (if pertinent for referral): _____ _____ | |
| Lab/X-Ray Finding (if pertinent for referral): _____ _____ | |
| Medical Record #: | |

AUTHORIZATION

| | |
|--------------|-----------------|
| PCP Name: | Phone #: () |
| Contact Name | Fax #: () |

FOR OFFICE USE ONLY

| | | |
|------------------------|--------------------|-----------------------|
| PCP Provider #: | Refer to Provider: | |
| Member Effective Date: | Auth Type: | Extent of Care: |
| Auth Start Date: | Auth End Date: | # of Visits Approved: |
| Approved by: | | Date: |
| Entered by: | | Date: |

This referral does not constitute a payment agreement. Coverage is based on the eligibility of the member at the time service is rendered.

Responsibilities of the Specialist



For members of plans that require a PCP referral, participating Specialty Care Providers should be sure the patient has been referred to them by the member's PCP. For the visit to be covered, the referral must have been approved by VIVA HEALTH prior to the visit to the Specialty Care Provider. No PCP referral is required for office visits with a participating OB/GYN, optometrist, or ophthalmologist. VIVA UAB members must use UAB OB/GYNs.

The Specialty Care Provider's obligations include the following:

1. Accept all patients referred to them by participating PCPs.
2. Submit to VIVA HEALTH required claims information, including source of referral and authorization number.
3. Sign and abide by the Participating Specialty Provider Agreement.

Participating Specialty Care Providers provide specialty services within the scope of their specialty and training. Specialists are required to maintain communication with the patient's PCP, including written consultation reports, to ensure the PCP is made aware of all diagnoses and treatments recommended or provided to the patient. Specialists will be compensated for those services authorized by VIVA HEALTH. In the event that further services are necessary, the Specialty Care Provider must obtain a separate authorization from VIVA HEALTH prior to rendering additional services.

Participating Specialty Care Providers with applicable specialties are required to provide 24-hours per day, seven days a week coverage for members. Arrangements for coverage while off duty or on vacation must be made with participating provider of the same specialty.

For those plans that require a PCP referral to a specialist, referral requests must be approved by VIVA HEALTH Medical Management prior to the member's visit to the Specialty Care Provider. VIVA HEALTH will not approve requests for retroactive referrals after the visit has taken place. Claims associated with specialty visits for which a prior referral was not obtained will not be paid and the patient cannot be billed for those services unless the patient signed a specific waiver (see next page for a sample).

Initial referrals may only be requested by the PCP. A specialist cannot refer to another specialist without the approval of the PCP.

Specialists are responsible for keeping up with the number of authorized visits and the expiration date of the referral. If additional visits are needed or services that require prior authorization need to be performed, you should contact Medical Management for prior approval.

For ALL VIVA HEALTH plans, services requiring authorization must be approved by VIVA HEALTH Medical Management prior to the services being rendered. VIVA HEALTH will not approve requests for retroactive authorizations after services have been performed. Claims for services that require authorization and for which an authorization was not obtained will not be paid and the patient cannot be billed for those services, unless the patient signed a specific waiver (see next page for a sample).

Responsibilities of the Specialist



Termination of VIVA HEALTH Members with Prior Authorizations/Covered Services

Services received between the date a member's coverage is terminated by the employer and the date VIVA HEALTH is notified by the Employer of the termination are not covered services even when such services have been authorized by VIVA HEALTH or a participating provider. Authorizations are not valid for services received after the date coverage terminates.

If a VIVA HEALTH member comes into your specialist's office for treatment without a referral, you may:

- If this is the patient's first visit with you, give the patient the opportunity to contact their Primary Care Provider (PCP) by telephone and attempt to obtain a referral. If the PCP's office agrees to refer the patient, the PCP should provide you with a referral number.
- If your office has seen the patient before, your office may call VIVA HEALTH directly to request a referral.
- Refuse to see the patient until the appropriate referral has been obtained, except in emergencies; or
- Inform the patient that they may be seen by your provider, but they will be financially responsible for any incurred charges that VIVA HEALTH would have normally covered. If you select this option, you must have the patient sign a waiver specifying the date of service and indicating the CPT code(s) and charges for the services rendered, acknowledging the patient understands they will be responsible for the charges (see example below). The patient must be made aware prior to being seen that they will be responsible for the incurred charges. A general form stating a patient agrees to pay any charges not covered by insurance is insufficient to allow you to bill for services that would have been covered with an appropriate referral.

SAMPLE WAIVER

I, **(patient's name)**, verify that I have been informed by **(provider/facility name)** that because I do not have a referral/authorization, I will be responsible for all services rendered to me in association with this episode of care on **(Date)**, including the following procedures and/or services:

CPT _____ \$ _____

CPT _____ \$ _____

CPT _____ \$ _____

In order for VIVA HEALTH to pay for covered services in relation to future visits to **(provider/facility name)**, I must obtain proper referral/authorization from VIVA HEALTH's Medical Management Department.

Patient's Signature

Date of Signature

Responsibilities of the Hospital



Authorizations:

It is the responsibility of the hospital to confirm proper authorization has been obtained for all non-emergency admissions and outpatient procedures/services, prior to service being rendered. Failure to do so may result in the denial of all claims associated with the admission or outpatient procedure, including related provider claims. Participating hospitals may not bill VIVA HEALTH members for services denied due to lack of proper authorization.

ER Visits:

- Check member's ID card or the VIVA Provider Portal at www.VivaHealth.com/Provider for applicable ER copay amounts.
- Waive ER copay if patient is admitted within 24 hours from ER and apply appropriate copay.
- Notification of admission must be received for all emergency inpatient admissions within 24 hours or by 5 p.m. the following business day.

Admissions:

- Except in emergencies, admit VIVA HEALTH patients only from participating providers.
- Except in emergencies, VIVA HEALTH must approve all hospital admissions in advance.
- Notification of admission must be received for all emergency inpatient admissions within 24 hours or by 5 p.m. the following business day.
- When a Medicare patient is admitted to the hospital and insurance information cannot be verified, the hospital should check Medicare's Common Working File to see if the patient is a member of VIVA MEDICARE so that proper authorization of the admission can be obtained timely.

Obstetrical Admissions:

- No authorization is needed for mother and baby for 48 hours (if vaginal delivery) and 96 hours (if C-section) after the baby is delivered. Authorization must be obtained for longer stays.
- Mother and baby's claim must be submitted together, unless mother is discharged before baby. In this case, contact VIVA HEALTH for a separate authorization for the baby and file claims separately. The baby's claims will only be covered if baby is added to the plan within 30 days. A separate inpatient copay applies to the baby's stay if the mother is discharged before the baby.

Claims Filing:

- To be considered for payment, claims must be received within 180 days from the date of service (*Members may not be billed for claims denied due to late filing*).
- Include authorization and tax ID number.
- Mail claims for employer groups to:
 - VIVA HEALTH Claims
 - P.O. Box 55926
 - Birmingham, AL 35255-5926
- Mail claims for Medicare members to:
 - VIVA MEDICARE Claims
 - P.O. Box 55209
 - Birmingham, AL 35255-5209
- Submit EDI claims to Change Healthcare payer ID 63114

Hospital Prior Authorization



Except in emergencies, contact VIVA HEALTH for certification prior to the patient being admitted to the hospital at (205) 933-1201 or 1-800-294-7780.

Guidelines for Inpatient Admissions:

Recognizing the significance of hospital costs, VIVA HEALTH does not rely upon financial incentives to contain inpatient expenses, but works with the provider to ensure the appropriate setting and medical necessity of the services.

- Notify VIVA HEALTH within 24 hours or by close of business the following business day for emergency admissions. There is a licensed VIVA HEALTH staff member on call nights and weekends that can be paged by contacting the answering service at the numbers listed above to handle appropriate emergency calls or request an expedited complaint/appeal. The ER copay is waived and the appropriate hospital copay applied if the patient is admitted. Lack of notification within 24 hours or by close of business the next business day may result in a denial for lack of timely notification and the patient cannot be billed.
- Provide the coordinator with the following information:
 - Member's name
 - Diagnosis/procedure requiring hospitalization
 - Admitting provider's name
 - Name of hospital
 - Pertinent clinical information
 - Member's ID number
 - Date of admission
 - Anticipated length of stay
 - Other health coverage
 - Plan of treatment
- Review is performed on all inpatient admissions. During the member's hospitalization, a VIVA HEALTH staff member will contact the hospital staff to obtain additional medical information for review.
- Participating hospitals and providers who do not comply with the notification policy will be subject to the VIVA HEALTH sanction process. Members may not be billed for claims denied due to lack of notification.
- VIVA HEALTH may not pay for services related to medical errors, readmissions within 30 days of a previous inpatient hospitalization, and/or "never events."

All Non-Emergency Hospital Inpatient Admissions Require Prior Authorization.

Procedures Requiring Prior Authorization



All VIVA HEALTH and VIVA MEDICARE members require the Primary Care Provider or Specialist to contact the Medical Management Department in advance for the following:*

- Some VIVA HEALTH plans require a PCP referral to see a specialist. See VIVA HEALTH Product Descriptions on reverse-side of Provider Reference Guide.
- All pre-planned hospital admissions **(For emergencies, a notification of admission must be received within 24 hours or no later than 5 PM the next business day.)**
- Outpatient surgery, including wound care
- For obstetrical admissions, notification is required only if the hospitalization spans longer than 96 hours.
- Non-emergent out-of-network, out-of-panel, or out-of-area services
- Non-emergent ambulance transport
- Transplant services
- Some sinus or nasal surgery (copies of medical records required), **excluding in-office scopes**
- All Plastic Surgery regardless of the place of service (copies of medical records, pre-op photos and letter of medical necessity required)
- Some scopes performed outside the provider's office **excluding Colonoscopy and EGD**
- Skilled Nursing and Rehabilitation Facility and Long Term Acute Care Facility admissions.
- Rehabilitative and Habilitative services (Physical, Occupational, & Speech Therapies)*
- Some in-office surgeries
- Cardiac and pulmonary rehab*
- Applied Behavioral Analysis (ABA)
- Sleep Studies: C-PAP, MSLT, PSNG (copies of medical records with symptoms listed required)*
- Pain clinic care
- All Ancillary Services (home health, IV therapy, hospice care, orthotics, prosthetics, etc.)
- DME: If DME equipment is distributed by the provider's office but billed by the DME provider, an authorization is required. However, DME equipment with charges less than \$500.00 and billed by a provider does not require an authorization, **except** diabetic shoes/inserts, which always require an authorization.
- Photodynamic therapy regardless of place of service
- Residential Treatment
- Psychological and Neuropsychological testing for 9 hours or more
- Partial Hospitalization Programs (PHPs)
- Imaging services including, but not limited to, MRIs, MRAs, CT scans, myelograms, nuclear medicine, discograms, PET scans, some angiograms, and 3D and 4D imaging (including ultrasound).
- Prescriptions requiring prior authorization: www.VivaHealth.com/Provider/Resources/#Viva_Health_Coverage_policies_and_criterion
- Intensive Outpatient Programs (IOPs)
- Proton beam radiotherapy
- Genetic and Genomic testing

* Commercial Only

Authorizations Disclaimer: This authorization is not a guarantee for payment. Payment is determined by the member's eligibility at the time services are rendered.

Procedures Requiring Prior Authorization



Extended Referrals:

Specialist Referrals:

- For plans that require a referral to see a specialist, referrals must be requested by the member's PCP for the initial visit(s). Additional visits may be requested by the specialist.

**The Prior Authorization lists for VIVA HEALTH and VIVA MEDICARE plans are subject to change. For the most current version of the authorization list, please refer to VIVA HEALTH's provider website at www.VivaHealth.com/Provider.*



VIVA HEALTH PROVIDER PORTAL

The VIVA HEALTH Provider Portal gives you the real-time ability to go online and track the status of pending claims and verify member eligibility and benefits.



Inpatient and Outpatient Precertification Form

VIVA HEALTH, Inc.
417 20th Street North, Suite 1100
Birmingham, Alabama 35203
Phone: (205) 933-1201
Fax: (205) 449-7049

VIVA HEALTH USE ONLY

Commercial

TO BE COMPLETED BY ADMITTING PROVIDER:

Patient Name: _____ Date of Birth: _____ Other Insurance: _____

Member Number: _____ Group Number: _____

Person Completing Form: _____ Phone: _____ Fax: _____

Admitting MD: _____ Facility Name: _____

NPI: _____ Tax ID: _____

| | | | |
|------------|--------------|-------------|-------|
| Diagnosis: | ICD-10 Code: | Procedures: | CPT: |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Admit Date or Procedure Date: _____ Requested Length of Stay: _____

Prior Level of Function: _____

Current Level of Function: _____

Past Medical History: _____

Summary of Previous Outpatient Treatment (attach clinical info and number of pages): _____

Medical Indication for Requested Service: _____

Treatment Plan: _____

FOR DELIVERY ADMIT EDC: _____ Expected Type of Delivery: _____

This approval does not authorize services not covered by the benefits currently provided under the member’s benefit plan. For the services to be covered, the member must be enrolled and effective at the time the service is provided.

This facsimile is private, confidential, and intended only for the recipient named hereon. If you receive this transmission in error, please contact VIVA HEALTH’s Medical Management Department at (205) 933-1201.

Procedures That Do Not Require Prior Authorization



Most diagnostic tests ordered by the PCP or specialist with a current valid referral (when applicable) DO NOT require prior authorization. The following procedures do not require prior authorization from VIVA HEALTH:

- Allergy testing
- Alpha fetoprotein
- Emergency ambulance services
- Audiograms
- Blood work
- Bone scan/DEXA scan
- Cardiac Caths
- Carotid doppler
- Chemistries
- Colonoscopy
- Dialysis (both hemo and peritoneal)
- Doppler studies
- Echocardiogram
- ECT/TMS
- EEG (electroencephalogram)
- EGD (esophagogastroduodenoscopy)
- EKG (electrocardiograph)
- EMG/Nerve conduction
- Gastric motility studies
- Gastrointestinal contrast studies
- Group B Streptococcal screening
- GXTs
- HIV screening
- HTLV III antibody detection
- IVP
- Loop/Leep lasers of cervix (in office)
- Routine mammogram
- Manometry studies
- Pulmonary Function Test (PFT)
- Routine eye exam (every 12 months)
- OB/GYN exams
- Routine hearing exams (not associated with speech) performed by the PCP
- Routine lab
- Routine x-rays
- Thyroid scan
- Tilt test
- Tympanograms
- Urodynamic studies
- Ultrasounds
- Venogram

Diabetic Supplies: Update for 2024



At VIVA HEALTH, we encourage good health habits for our members and are working to minimize barriers to quality health care. As part of this effort, we have eliminated the requirement for prior authorization for the following diabetic testing supplies effective January 1, 2019: non-continuous glucose monitors (HCPCS codes E0607, E2100, E2101), spring-powered device for lancets (HCPCS code A4258), lancets (HCPCS code A4259), and test strips (HCPCS code A4253) when such supplies are provided in accordance with Medicare coverage guidelines. VIVA MEDICARE members have the added option of getting Accu-Chek brand diabetic supplies from a network pharmacy. Additionally, commercial members have access to One Touch and Free Style brand supplies through a network pharmacy.

The Medicare guidelines apply for both the commercial and Medicare lines of business. These guidelines currently include the following CMS local coverage determinations and will encompass future revisions or new determinations as they are issued.

Retrospective reporting will be used to identify supplies provided outside the Medicare guidelines without supporting documentation of medical necessity. Such claims may be reversed and the patient must be held harmless.

For questions about this information, please contact Provider Customer Service by phone at (205) 558-7474.

Services Covered Under the Global Delivery Fee

- Provider services including prenatal, delivery, and postnatal care
- OB stay after delivery
- Urinalysis
- Glucose testing
- Non-stress test (one)
- Alpha Fetoprotein
- OB ultrasounds
- Hct / Hgb
- Well Baby

Women's Access to Health Care Act:

Under the Women's Access to Health Care Act, female members of VIVA HEALTH do not need a referral from their PCP to visit a participating OB/GYN. The patient can see a participating OB/GYN for any problem pertaining to obstetric or gynecological care without obtaining a referral from their Primary Care Provider.

Statement of Rights under the Newborns' and Mother's Health Protection Act:

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. Stays beyond 48/96 hours and newborn placement in an intensive care nursery still require prior authorization.

Ambulatory Surgical Authorization Guidelines



Ambulatory surgery includes those surgical procedures that are performed in freestanding surgical facilities or outpatient departments of hospitals. All such surgeries require prior authorization and must be performed in VIVA HEALTH contracted facilities. If the member's network is a provider system, surgeries generally must be performed at facilities within that provider system.

The following table outlines certain, but not all, ambulatory surgical procedures for which specific information is required by VIVA HEALTH in order to perform prior authorization:

| If You Are Requesting These Services: | Under These CPT Codes: | VIVA HEALTH Will Need This Information To Evaluate Your Request: |
|--|------------------------|--|
| Auditory (Ear) | | |
| • Otoplasty | 69300 | • A letter of Medical Necessity and photographs. |
| Breast | | |
| • Mastectomy for Gynecomastia | 19120, 19300-19307 | • A letter of Medical Necessity, including height and weight, photographs, and symptoms. |
| • Breast Reduction | 19318 | • Requires a letter of Medical Necessity and frontal and lateral view photographs, weight/height, and medical complications. |
| • Breast Reconstruction | 19340-19350 | • Excluded except when required after mastectomy surgery. Covered only as related to reconstruction due to malignancy. Requires a letter of Medical Necessity. |
| Eye and Ocular | | |
| • Blepharoplasty | 15820-15823 | • A letter of Medical Necessity, photographs and results of a visual field exam. |
| • Canthopexy | 21280, 21282 | |
| • Repair of Blepharoptosis | 67901-67911 | |
| • Repair Ectropion/Entropion | 67914-67924 | |
| • Excision, Repair, Reconstruction of Eyelids | 67950-67975 | |
| • Plastic Repair Canaliculi | 68700 | |
| Integumentary (Skin) | | |
| • Tissue Expander Insertion, Replacement, or Removal | 11960-11971 | • A letter of Medical Necessity, the patient's history, and photographs. |
| • Scar Revision | 15786, 15787 | • A photograph of the lesion, along with measurements, and a description of the impairment involved. |
| • Tracheostomy Scar Revision | 31830 | |
| Respiratory (Nose) | | |
| • Rhinoplasty | 30460-30462 | • Limited to cleft lip/palate or reconstruction due to accident or illness. Requires a letter of Medical Necessity and photographs from a surgeon. |
| • Submucous Resection | 30130-30140 | |
| • Septoplasty | 30520, 30620-30630 | |

The specialist must obtain a referral from the PCP if the member's plan requires a PCP referral.

Ambulatory Surgical Procedures that Are *Not* Covered



If the member's network is a provider system, then surgeries generally must be performed at facilities within that provider system. Non-covered Ambulatory Surgical Procedures include, but are not limited to, the following:

| Non-Covered Procedures: | | |
|---------------------------------------|---|--|
| Auditory (Ear) | | |
| • Ear Piercing | | |
| Breast | | |
| • Breast Augmentation | • Removal/Replacement of Breast Implants – <i>except when required for post-mastectomy reconstruction.</i> | • Correction of Inverted Nipple |
| Eye and Ocular | | |
| • Radial Keratotomy | | |
| Integumentary (Skin) | | |
| • Cervicoplasty | • Excessive Fat Removal (lipectomy) | • Salabrasion |
| • Chemical Peel | • Hair Transplant | • Subcutaneous Injections of Filling Material |
| • Dermabrasion | • Injection of Sclerosing Solutions | • Keloid Removal |
| • Electrolysis | • Rhytidectomy | |
| Reproduction | | |
| • Reversal of Voluntary Sterilization | • Intersex Surgery | |
| Respiratory (Nose) | | |
| • Excision for Rhynophyma | | |

Note:

VIVA HEALTH follows Medicare guidelines for VIVA MEDICARE members.



What Constitutes an Emergency?

An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or their unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. Emergency care must be available in and out of the service area and shall include appropriate ambulance services for emergency care dispatched by 911, if available, or by the local government authority. Emergency care shall be available 24 hours a day, seven days a week.

What Should a Patient Do in an Emergency?

- If time or the patient's condition does not permit them to call the PCP first, the patient should call 911 or go directly to the nearest emergency room and notify the PCP as soon as possible. Ambulance transportation is covered when medically necessary in an emergency. Ambulance transportation is by ground unless air transport is dispatched by 911, if available, or by the local government authority. In case of an emergency outside the service area, ambulance transportation shall be to the closest provider available to stabilize the patient or to the facility directed to by 911 or by the local government authority.
- If the patient is unsure if the situation is an emergency, the patient may call the PCP for advice. The PCP may authorize treatment in the emergency room, elect to treat the patient in the ER or in the office, or the PCP may refer the patient to a specialist.
- For urgent situations that are not emergencies but cannot wait to be treated during the PCP's normal office hours, Viva HEALTH contracts with several urgent-care centers.

Will the Emergency Room Treatment Be Covered by VIVA HEALTH?

Emergency medical care, including hospital emergency room services and emergency ambulance services will be covered twenty-four (24) hours per day, seven (7) days per week, if provided by an appropriate health professional whether in or out of the service area if the following conditions exist: (a) the patient has an emergency medical condition; and (b) treatment is medically necessary; and (c) treatment is sought immediately after the onset of symptoms (within twenty-four (24) hours of occurrence) or referral to a hospital emergency room is made by member's Primary Care Provider.

No prior authorization of emergency services from VIVA HEALTH is required. VIVA HEALTH may retrospectively review claims for emergency services to determine if each of the above criteria is met. In determining whether an emergency medical condition existed, VIVA HEALTH will consider whether a prudent layperson with an average knowledge of health and medicine would reasonably have considered the condition to be an emergency medical condition.

Most members have a Copayment for each emergency room visit. The copayment will be waived and the inpatient hospital copay applied if the patient is admitted to the hospital as an inpatient for the same condition within twenty-four (24) hours from the time of initial treatment by emergency room staff.

If a patient is admitted through the ER, the ER visit becomes part of the hospital admission.



The Medical Management Department is comprised of specially trained individuals including nurses, social workers, and referral coordinators. The plan's Chief Medical Officer oversees the staff to ensure that appropriate utilization, quality control, and departmental procedures are followed.

The Chief Medical Officer is supported by the UM/QI Committee, comprised of participating Primary Care Providers and specialists, which meets quarterly. At each meeting the committee reviews utilization information. This information includes specialty referrals, inpatient stays, and utilization statistics (referrals/1000, hospital days/1000, ER visits/1000, HEDIS measures, etc.). The Committee reviews the information and identifies areas of over and under utilization and changes in utilization trends. Once identified, the Committee recommends and helps implement ways to improve utilization, such as referral protocols, provider education and /or consultation, and necessary internal policy changes.

The Medical Management Department's goal is to assure that each VIVA HEALTH member receives the quantity and quality of medical care necessary at the appropriate time and in an appropriate setting. VIVA HEALTH accomplishes this goal through the successful implementation of these elements of the VIVA HEALTH Medical Management Program:

Inpatient Hospitalization Review

Inpatient Hospitalization Review is used to establish the medical necessity of an inpatient hospital medical service. All inpatient admissions are reviewed by a licensed clinician, after obtaining all pertinent clinical information from the provider's chart and staff, using established medical criteria. Criteria are reviewed by the UM/QI Committee and are updated as needed using practice standard guidelines that are founded in reasonable scientific evidence. If inpatient criteria are met, an authorization for the stay will be provided. If inpatient criteria are not met, the case will be referred to the Chief Medical Officer or provider designee for review.

Case Management

Case Management is the systematic process of assessing, planning, implementing, and evaluating services and resources required to respond to an individual's health care needs. Case Management establishes an organized process of coordinating care for patients with catastrophic illness or special needs. Case Management facilitates the coordination of available health care options and resources; it promotes quality, cost-effective health care. Case Management is an ongoing process working hand in hand with the inpatient review, discharge planning and other VIVA HEALTH processes; cases with high utilization or catastrophic diagnosis automatically trigger a Case Management review. Otherwise, Case Management is implemented as needed.

Discharge Planning

All hospitalized members are evaluated by the licensed clinician to determine if their illness or surgical procedure might require special discharge arrangements. During some hospitalizations, there is a point at which medically necessary quality health care services can be provided in an equally appropriate, yet less costly, setting. The Medical Management licensed clinician acts as a liaison among the patient, various providers, vendors, and family members to facilitate the implementation of a discharge or transfer to an alternative care setting, i.e., home, skilled nursing facility, relative's home, etc.



Appeals

Members using VIVA HEALTH's complaint procedure as outlined in the member's Certificate of Coverage have the right to appeal any decision made by VIVA HEALTH in accordance with such procedures. Providers may appeal decisions by following the procedures in this Provider Manual.

Provider Sanctioning

When a participating provider repeatedly fails to comply with medical management requirements, provider sanctioning provides a remedy. Medical Management compiles reports for the Chief Medical Officer and the Utilization Management/Quality Improvement Committee, as needed, to review and apply sanctions if appropriate. If the applied sanctions are based on the professional competence or conduct of the participating provider and adversely affect or limit the provider's participation in the VIVA HEALTH network, the provider will have a right to an appeal in accordance with the Provider Hearings Section of this Provider Manual. Further, if the provider's agreement with VIVA HEALTH or the Medicare Advantage rules, regulations, or policies, if applicable, entitle the provider to a hearing when sanctions are applied, the provider will have a right to an appeal in accordance with the Provider Hearings Section of this Provider Manual.

Medical Claims Review

Submitted claims lacking reasonable proof as to medical necessity are pended for requesting of medical records, review, and payment determination. Medical Management is responsible for expediting such requests and ensuring receipt of medical records needed to determine claims payment status. Medical records must be received within 60 days of request in order for the claim to be eligible for payment. If medical records are not received within 60 days, the claim will be denied and neither VIVA HEALTH nor the member will be responsible for payment. Upon receipt of the records, Medical Management confers with the Chief Medical Officer or provider designee, as needed, to determine medical necessity. The Chief Medical Officer or provider designee is responsible for deciding claims issues related to medical necessity with input from other providers, as needed/required.

Benefit Verification

Prior to all approvals/authorizations, group benefits outlined in the member's Certificate of Coverage and Schedule A are reviewed to determine if the requested services are covered. These documents may be viewed by contracted providers with VIVA HEALTH Provider Portal access.

Updating and Establishing Medical Policy

As needed, the Medical Management Department under the direction of the Chief Medical Officer will update or establish new policies based on medical indications, changes in technology, regulatory requirements, or other factors. All internal policies will be posted to the VIVA HEALTH website for providers to access.

VIVA HEALTH's Quality Improvement Program



VIVA HEALTH maintains an active Quality Improvement (QI) Program to ensure that members receive appropriate quality health care across all health care settings. The QI Program is designed to continuously monitor, evaluate and improve the clinical care and service provided to enrolled members. VIVA HEALTH provides feedback to our providers that can be utilized to promote appropriate changes and thereby improve or maintain quality of care. VIVA HEALTH's providers are considered integral partners in quality improvement efforts and are contractually required to participate in the Quality Improvement Program.

VIVA's QI Program activities encompass all aspects of VIVA HEALTH administration that contribute to quality care, such as care availability, care accessibility, care effectiveness and safety, care coordination and continuity, care documentation and care grievances or complaints. Additionally, the QI Program ensures services are provided by qualified individuals and organizations, and that all services are provided in a culturally competent manner. QI activities include all demographic groups, health care places of service and types of service.

Participating providers provide input into the QI Program via several mechanisms. The Utilization Management/Quality Improvement (UM/QI) Committee serves as a formal mechanism for the health plan to consult with providers who have agreed to provide services regarding VIVA's medical policy, quality improvement programs, and medical management procedures. The UM/QI Committee also provides guidance related to performance standards and objectives for the practitioner network. The Committee is chaired by VIVA HEALTH's Chief Medical Officer or their delegate, and includes a majority of members who are practicing physicians. These physicians include: at least one practicing physician who is independent and free of conflict relative to VIVA HEALTH; at least one practicing physician who is an expert regarding care of elderly or disabled individuals; and various clinical specialties (for example, primary care, behavioral health) to ensure that a wide range conditions are adequately considered in the development of the VIVA HEALTH's utilization management policies. The committee further includes leadership from clinical and operational departments of Viva Health who are involved in quality and utilization management related functions. Board certified specialists and other disciplines may be invited to participate on the committee and/or attend meetings when appropriate to meet committee objectives or provide expert input to resolve problems. The Committee meets a minimum of quarterly and reports subsequently to the Board of Directors.

VIVA HEALTH also maintains a Pharmacy and Therapeutics (P and T) Committee that includes provider and pharmacist representation. This committee reviews trends in pharmacy products and utilization, and receives information and provides input on VIVA HEALTH's efforts towards medication adherence and other quality improvement activities.

VIVA HEALTH also involves participating providers in specific projects or activities related to quality as the need arises. Examples include peer review activities, development of quality improvement projects specific to topical area of medical practice, development and sharing of best practices within the medical community, and promotion of member quality enhancing activities.

VIVA HEALTH complies with various CMS or other mandates and other activities related to specific QI Program activities. Examples are discussed below.

- Participation in the Healthcare Effectiveness Data and Information Set (HEDIS): HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS includes more than 90 measures across 6 domains of care. For more information regarding HEDIS and how the measures are developed visit The National Committee for Quality Assurance national website at www.ncqa.org.

VIVA HEALTH's Quality Improvement Program



VIVA HEALTH collects administrative data, such as medical/pharmacy claims and laboratory data, to report on the majority of HEDIS measures. Some measures require medical records review in order to supplement data not captured by claims. As a VIVA HEALTH provider, it is your obligation to provide electronic access to medical records or respond to requests for medical records in support of HEDIS data collection, and/or allow VIVA HEALTH associates on-site to collect necessary supplemental information. HEDIS data collection is time-sensitive, therefore, electronic health records are preferred; otherwise, provider responsiveness to requests is critical. The Health Insurance Portability and Accountability Act (HIPAA) does permit providers to release records to a VIVA HEALTH representative or designated vendor for HEDIS data collection.

- **Conducting Quality Improvement Projects:** Quality Improvement Projects include clinical and non-clinical initiatives to improve health outcomes and services for our members. VIVA HEALTH providers may be asked to participate in improvement project initiatives as part of the broader Quality Improvement program. VIVA HEALTH projects may include focused improvement in difficult HEDIS measures or Pharmacy quality measures. Many improvement projects are facilitated by the C4Q and QI nurses. Examples include improving statin use in members with diabetes or cardiovascular disease, increasing medication adherence in members with chronic disease, assisting members obtain recommended health screenings and services, or initiatives to reduce the risk of readmission following discharge.
- **Conducting a multi-year Chronic Care Improvement Program (CCIP):** VIVA HEALTH is required to conduct CCIP initiatives. CCIPs must promote effective management of chronic disease, improve care and health outcomes for our members with chronic conditions. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for VIVA and our members. The current VIVA CCIP targets improving transitions of care involving skilled nursing facility stays for members with chronic disease. VIVA contacts these members, facilitates making appropriate MD appointments after discharge, and/ or refers members for additional care management. The goal is to reduce the risk of readmission following a skilled nursing facility stay.
- **Conducting a Medicare Member Experience Survey annually:** VIVA HEALTH participates in an annual CMS Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey to assess member experiences with our Medicare Advantage and Part D plans. Many of the questions asked are a reflection of the service level provided by their provider. These include ease of getting needed care and seeing specialists, getting appointments and care quickly, providers who communicate well, coordination of members' health care services, and ease of getting prescriptions filled. The survey results are publicly reported by CMS for each contract in the Medicare & You Handbook published each fall and on the Medicare Plan Finder website (www.medicare.gov). The survey results are used by beneficiaries to assist in their selection of an MA or PDP plan. Several measures taken from CAHPS survey responses are included in the CMS Star Ratings for MA Quality Bonus Payments. VIVA HEALTH evaluates the survey results annually and provides survey results to our provider organizations as information is available. These results help inform our Quality Improvement Program initiatives.
- **Formally evaluating and adapting the QI Program annually:** The QI Department assesses the QI Program work plan against established goals to determine to what extent the program is achieving desired results and to lend assistance to the ongoing decision making and planning processes.
- **Promoting health equity and reducing health disparities:** Recently, CMS and NCQA have provided health plans select quality measure performance stratifications based on race, disability and those on low income subsidy and dual eligibility for Medicaid and Medicare. VIVA HEALTH is studying this information and sharing it with our providers to

VIVA HEALTH's Quality Improvement Program



increase awareness and assist in improvement strategies. We are also encouraging providers to collect and act on information from patients regarding their social environment, which may impact their health or provision of health care services. We ask that our providers code diagnosis codes that indicate potential social determinants of health (SDOH). These “Z” series SDOH-related diagnosis codes range from Z55–Z65. Submission of these codes on claims will assist VIVA HEALTH in knowing how many of our members are experiencing SDOH indicators and facilitate access to potential community resources through our care managers. For more information on SDOH diagnosis codes, you may access a CMS resource at <https://www.cms.gov/files/document/zcodes-infographic.pdf>.

Quality of Care Oversight:

VIVA HEALTH monitors reports to determine potential over utilization, under utilization, provider performance and member needs or gaps in care.

VIVA HEALTH maintains mechanisms for our members and providers to report potential quality of care and quality of service issues through our customer service or provider services areas. All potential problems with clinical care and services identified are reported to the QI department. The QI department then reviews pertinent medical records, prepares a summary of the care issue, and reports to the Medical Director and QoC committee for review and follow up recommendations. If the Medical Director determines that a significant quality of care issue exists, the issue is referred to the UM/QI Committee for review. All information concerning quality improvement and actions taken by the committee are treated as confidential information in accordance with Code of Alabama, 1975, 27-21A and 25.

VIVA HEALTH assists members with getting necessary screening or other health services. In addition to providing member benefits for services, VIVA HEALTH holds member health promotion events and assists in arranging member access to screening services. VIVA HEALTH also has the ability to provide the following health screening services either directly or through special provider partnerships:

- Hemoglobin A1C testing
- Osteoporosis screening
- Fecal immunochemical test (FIT) kits for colon cancer screening
- Retinal scans
- Seasonal Flu vaccination events

VIVA HEALTH assists in arranging necessary appointments for members to improve access and coordination of care and can provide case/care management services to members in need of more intensive care coordination and outreach. Please contact VIVA HEALTH if you have patients you would like to refer to VIVA HEALTH for any of these services.

Maintenance of Clinical Practice Guidelines:

VIVA HEALTH endorses clinical practice guidelines to assist participating providers in making decisions about appropriate advice and treatment for patients with specific medical conditions. Guidelines are typically adopted as recommendations by the VIVA HEALTH UM/QI committee from a nationally recognized public source. Guidelines are adopted based on the identified needs of our member population.



DISCLAIMER

Guidelines are only intended for your consideration. Guidelines are not:

1. Fixed protocols that must be followed. Patients' needs should be considered on an individual basis and in some cases appropriate treatment may differ from the guideline.
2. A substitute for provider assessment and advice. Guidelines do not take into account the unique needs and resources of the particular patient and community.
3. Designed to limit communication. VIVA HEALTH providers are encouraged to discuss all available treatment options with our members and to consult with other provider and information sources as necessary to provide high quality care.
4. Static. With medical advances and new technologies, guidelines can quickly become outdated. Rely on your professional judgment and the most currently available information when making treatment decisions.

All care shall be rendered in accordance with, and never less than, generally accepted medical and surgical practices and standards prevailing in the medical community at the time of treatment, and shall be within the scope of your license. VIVA HEALTH shall have no control over patient care. You remain solely responsible for the quality of health care services rendered to members.

VIVA HEALTH has adopted the following Practice Guidelines:

Diabetes Management

Standards of Medical Care in Diabetes

Source: American Diabetes Association

Cardiovascular Disease Prevention and Management

American Heart Association and American College of Cardiology

Attention Deficit/Hyperactivity Disorder Child and Adolescent

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Source: American Academy of Pediatrics

Adult Major Depression Guideline for Initial Outpatient Treatment of Adults

Major Depression Guideline for Initial Outpatient Treatment of Adults

Source: American Psychiatric Association

Pediatric Care

Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents

Source: American Academy of Pediatrics

Women's Preventive Services Guidelines

Source: U.S. Health Resources and Services Administration

Advisory Committee on Immunization Practices (ACIP)

- This standard can be reviewed by visiting <https://www.cdc.gov/vaccines>

Women's Prevention Services Initiative (WPSI)

- This standard can be reviewed by visiting <https://www.womenspreventivehealth.org/recommendations>

VIVA HEALTH's Quality Improvement Program



American Academy of Pediatrics Recommended Immunization Schedule U.S.

- This standard can be reviewed by visiting: <http://www.aap.org>

Guidelines for Adult Preventive Care Recommendations 2014

- This standard can be reviewed by visiting: <http://www.ahrq.gov>

U.S. Preventive Services Task Force; recommendations with an “A” or “B” rating

- This standard can be reviewed by visiting: <http://www.uspreventiveservicestaskforce.org>

Medicare Benefit Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Services

- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c02.pdf>

Member Educational Information

VIVA HEALTH has endorsed the *Choosing Wisely*® campaign, an initiative of the American Board of Internal Medicine Foundation, to help providers and patients engage in conversations to reduce overuse of tests and procedures, and support patients in their efforts to make smart and effective care choices. Information on various topics and patient-friendly educational materials are available at <https://www.ChoosingWisely.org>. VIVA HEALTH recommends using these available resources as a means of patient education. Additionally, VIVA HEALTH produces member educational materials. Materials are posted to <https://www.VivaHealth.com> under Member Resources. These materials are open and viewable to providers as well.

Information Needed to Assure Timely Claims Payment



In order to assure timely claims payment from VIVA HEALTH, the following fields must be completed on the standard UB-04 or CMS-1500 form:

- Covered person's name and relationship to the subscriber
- Covered person's 10-digit ID number (8-digit family ID# and 2-digit ID suffix)
- Subscriber's name and address
- Subscriber's employer group and contract number (if listed on ID card)
- Provider's name, address, signature and telephone number
- ICD-10 diagnostic codes
- CPT-4 procedure codes with modifiers, where appropriate
- CPT Category II codes for blood pressure and HBA1C, where appropriate
- Tax ID and NPI number of the provider performing the service (questions regarding your provider number should be directed to Provider Services at (205) 558-7474 or 800-294-7780)
- The HCPCS or other approved codes with modifiers, where appropriate
- Referring provider's name (if applicable)
- Dates of service(s)
- Place of service(s)
- Authorization number (if applicable)

All claims must be submitted within 180 days of date of service. A request to reprocess or adjust a claim must be received within 180 days of the original check/explanation or payment date.

Claims should be submitted to:

- Submit EDI claims to Change Healthcare payer ID 63114
- **For Employer Group Plan Members:**
 - VIVA HEALTH Claims
P.O. Box 55926
Birmingham, AL 35255-5926
- **For Medicare Advantage Plan Members:**
 - VIVA MEDICARE Claims
P.O. Box 55209
Birmingham, AL 35255-5209

Secondary professional claims can be filed electronically for all Commercial, Medicare, and Drummond lines of business. If VIVA HEALTH identifies another primary insurance carrier after paying a claim as the primary carrier, VIVA HEALTH may reverse its payment and request that the claim be filed with the primary carrier.

Filing Claims When Capitated

Some VIVA HEALTH providers are paid on a partially capitated (pre-paid) basis. This payment is furnished prospectively for future services. **Capitated providers must continue to file claims for all services rendered.** Claims are required for appropriate utilization review and reporting. For VIVA Medicare members, Medicare payment is determined by the diagnoses filed. The claims will be processed as usual and an Explanation of Payment (EOP) will be issued for each claim filed.

Electronic Claim Filing



VIVA HEALTH has selected Change Healthcare as its electronic claims clearinghouse. Providers can submit the 837 Professional and Vision claims, 837 Institutional hospital or facilities, and 837 Dental claims using Change Healthcare payer ID 63114.

VIVA HEALTH also accepts electronically submitted COB, Corrected Claims and Void Claims.

Corrected Claims – Claims with claim frequency code of ‘7’ and a Ref- F8 Payer Claim Controller Number

Void Claims – Claims with claim frequency code of ‘8’ and a Ref- F8 Payer Claim Controller Number

Front-End Rejections – When billing electronically, it is critical that both the member’s ID* and the rendering provider’s NPI ** (or billing provider if rendering provider is not submitted) is submitted correctly. If the member’s ID submitted is incorrect or it does not match a member ID in our system then the provider will receive the following error message on the 277.

A7/164 – Acknowledgement/Rejected for Invalid Information – the claim/encounter has invalid information as specified in the status details and has been rejected – Entity’s Contract/Member/Subscriber ID. To correct this issue, verify that the member ID is a combination of the family ID and the individual member ID suffix.

**Member numbers can be located on back of card.*

For Commercial members – 10 digit member ID is on the back of the member’s card (8-digit Family ID Number and 2-digit ID Suffix).

For Medicare members – 10 digit member ID is on the back of the member’s card (8-digit Family ID Number and 2-digit ID Suffix).

For Drummond members – 11 char member ID is on the back of the member’s card (9-character Family ID Number and 2-digit ID suffix).

For Cooper Green – 3-7 characters per member ID (no card)

If the provider’s NPI submitted is incorrect or it does not match a NPI in our system the provider will receive the following error message on the 277:

A7/562 – Acknowledgement/Rejected for invalid information –the claim/encounter has invalid information as specified in the status details and has been rejected- Entity’s National Provider Identifier (NPI) Rendering Provider.

****VIVA HEALTH will reject claims submitted electronically from providers who have not yet registered individual and/or group NPI with VIVA HEALTH. To correct this issue, contact:**

- Susan Mitchell: shmitchell@uabmc.edu or 205-266-2289
- Jennifer Brookshaw: jbrookshaw@uabmc.edu or 205-558-7447
- Modestie Bush: modestiebush@uabmc.edu or 205-558-3297

Electronic Funds Transfer (EFT) and 835 Electronic Remittances



VIVA HEALTH has selected Change Healthcare as its electronic payment and remittance reporting vendor. There is no cost to you to use Change Healthcare ePayment and enrollment is free.

Your VIVA HEALTH 'Provider ID' is your TAX ID and/or TAX ID + suffix (Vendor ID). The vendor ID can be found on the EOP remittances which accompany payments.

If you need assistance obtaining your VIVA HEALTH Vendor IDs, please contact VIVA HEALTH Customer Service at 800-294-7780 (or locally at 205-558-7474).

For Change Healthcare Enrollment/Assistance ERA/835, contact Change Healthcare at 1-866-506-2830

EFT/835: <https://support.changehealthcare.com/customer-resources/enrollment-services/medical-hospital-ef-enrollment-forms>.

Payment Portal: <https://cda.changehealthcare.com/Portal/>

EOB/ERA's can be viewed by logging into the Payment Manager Portal at Change Healthcare.

Claims Information for Dental Providers



Every VIVA MEDICARE plan offers a dental allowance that VIVA MEDICARE members can use for any preventive, diagnostic, or comprehensive dental service. These services include:

- Routine cleanings
- Fillings
- Tooth removals
- Bridges
- Dentures

VIVA MEDICARE members can use their dental allowance to receive covered services from a dentist. However, purely cosmetic services are excluded. VIVA MEDICARE members do not need a prior authorization to use their dental allowance and there are no copays or coinsurance.

Our network dentists offer discounted pricing on services which makes a members' dental allowance go further. You can find network dentist on our website at www.VivaHealth.com/Medicare.

Dental providers who have opted out of Medicare or are listed on Medicare's preclusion, exclusion, or debarment list may not provide these services to VIVA MEDICARE members.

For questions concerning this benefit or to determine the member's yearly dental allowance, please contact our Provider Customer Service department:

- **Telephone:** (205) 558-7474 or (800) 294-7780
- **Fax:** (205) 449-7849
- **Website:** www.VivaHealth.com/Provider

To submit a claim for services rendered to a VIVA MEDICARE member, please send claims to:

VIVA MEDICARE
P.O. Box 55209
Birmingham, AL 35255-5209

Unique Billing Situations



| | |
|--|--|
| <p>Provider Reimbursement Methodologies</p> | <p>Unique billing situations and provider reimbursement methodologies may exist or develop. VIVA HEALTH will calculate covered expenses following evaluation and validation of all provider billings in accordance with the methodologies in the most recent edition of CPT or as reported by generally recognized professional organizations or publications. Expenses not covered due to provider reimbursement methodologies are indicated in the “Provider Adjustment/Provider Discount” fields in the EOB. These are not to be balance billed to the VIVA HEALTH member. Please refer billing questions to Customer Service at 1-800-294-7780. Some of the more common provider reimbursement methodologies are described below and on the following pages. Please note that this is not a complete listing. Provider must use the appropriate modifiers.</p> |
| <p>Office Visits on the Same Day as Surgery</p> | <p>Bill for office visits on the same day as surgery in the following instances only:</p> <ul style="list-style-type: none"> • for a new patient • an initial consultation or emergency • if the visit is determined to be in connection with a condition unrelated to the surgery/ diagnostic procedure |
| <p>Multiple Procedures</p> | <p>When a claim is received for multiple procedures performed on the same day, then the procedures are reimbursed according to the following:</p> <ul style="list-style-type: none"> • 100% of the fee schedule for procedure with the highest RVU (relative value units) • 50% of the fee schedule for the remaining medically appropriate procedures <p>When a claim is received for multiple surgical procedures performed on the same day through the same operative field, then only the highest value procedure is reimbursed.</p> <p><i>**The above reimbursement does not apply when a facility is contracted to receive a specific contracted or case rate.</i></p> |
| <p>Assistant Surgeons</p> | <p>Assistant surgeons must be participating VIVA HEALTH providers unless specific prior authorization is received from VIVA HEALTH. Charges for assistant surgeons, for procedures where an assistant surgeon is not considered medically necessary, will not be covered. The VIVA HEALTH member cannot be balance billed for those charges.</p> |
| <p>Telephonic Care</p> | <p>Charges for telephonic care are not reimbursable. This includes services provided online. VIVA HEALTH members should not be charged a fee for using their providers’ on-call or after-hours service outside normal office hours or for return calls by the provider, office staff, or answering service.</p> |
| <p>Rebundled Charges</p> | <p>All billed charges are subject to rebundling and other automated logic during the adjudication process. Any services or amounts not covered due to rebundling or other reimbursement logic are not billable to the VIVA HEALTH member. Routine services and supplies are included by the provider in the general cost of the room where services are being rendered or the reimbursement for the associated surgery or other procedures or services. A separate payment is never made for routine bundled services and supplies and therefore is ineligible for separate reimbursement and should not be billed separately. VIVA may utilize a third party vendor to review claims pertaining to these routinely bundled services and supplies.</p> |

Unique Billing Situations



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| Photocopy Charges | <p>Photocopy charges are generally not reimbursable by VIVA HEALTH. Please refer to your Provider Agreement for additional information.</p> |
| Administrative Fees | <p>VIVA HEALTH does not consider administrative fees associated with admissions of patients, authorizations, medical records, or other similar fees to be separately covered expenses. These are not directly related to the treatment of an illness or injury. These fees are not billable to VIVA HEALTH or the VIVA HEALTH member.</p> |
| Facility Fees for Professional Office Visit Services | <p>These fees frequently billed under revenue codes 510 through 519 are not considered covered expenses. The portion of these fees that are for facility overhead should be recovered from the professionals billing for the services. These fees are not billable to VIVA HEALTH or the VIVA HEALTH member.</p> |
| Anesthesia Codes | <p>Every anesthesia code should be submitted with a payment modifier. Anesthesia codes 00100-01999 will be rejected if a modifier is not included. The accepted payment modifiers include:</p> <ul style="list-style-type: none"> AA Anesthesia service performed personally by anesthesiologist AD Medically supervised by a provider for more than four concurrent procedures QK Medical direction of 2-4 concurrent anesthesia procedures involving qualified individuals QX Anesthetist service with medical direction of a provider (currently payable only for VIVA MEDICARE) QY Medical direction of one CRNA by an anesthesiologist QZ Anesthetist service without medical direction of a provider (currently payable only for VIVA MEDICARE) |
| Maternity Care | <p>Maternity care is included under the global maternity code (CPT Code 59400 or 59510). A copay will be charged at the first office visit. You may not bill for each office visit for routine maternity care; these visits will be included in the payment for your global maternity bill. If global maternity services include VBAC (vaginal birth after C-section) or complicated delivery, please add the modifier 22 to CPT code 59400. Include supporting documentation for complications, such as Operative Summary or Discharge Summary. If you are not responsible for the entire maternity care, please contact Medical Management at 1-800-294-7780.</p> |

Unique Billing Situations



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|---------------------------------|---|
| Coordination of Benefits | <p>If VIVA HEALTH or VIVA MEDICARE is secondary to a member's other insurance, VIVA HEALTH will pay the amount (i.e., copays, coinsurance) for covered services that is the member's responsibility under the primary insurance.</p> <p>Where the allowed amount of the primary insurance is less than the allowed amount for VIVA HEALTH/VIVA MEDICARE, total payment to the provider shall not exceed the amount allowed by the primary insurance. In instances where primary insurance has denied covered services for failure to follow their plan guidelines, VIVA HEALTH/VIVA MEDICARE may, at its discretion, deny payment as secondary coverage.</p> <p>Effective March 1st, 2018, Coordination of Benefits claims for all lines of business (i.e., Commercial, Medicare) must be filed within 18 months from the date of service in order to be considered for secondary payment.</p> |
| Subrogation | <p>Subrogation occurs in health insurance when the health plan pays one of its member's claims for an accident or injury, then makes its own claim against others who may have insured the loss. The health care provider should submit the bill/claim to the liability insurer and also to VIVA HEALTH within the usual timely filing deadline. If known, include any information regarding the third party carrier (i.e., auto insurance name, lawyer's name, etc.). The plan will pay the claim for covered services less the member's copayment or coinsurance (if any) required by their VIVA HEALTH plan. All claims will be processed per the usual claims procedures. VIVA HEALTH uses a contracted vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the patient, provider, and attorney and assists with settlements.</p> |
| Unlisted Codes | <p>Unlisted codes provide the means for reporting procedures, services, or items that do not have a descriptive CPT or HCPCS code. Because unlisted codes do not describe a specific procedure, service, or item, it is necessary to submit supporting documentation. Supporting clinical documentation is required for all unlisted codes submitted. Documentation is to include, but is not limited to:</p> <ul style="list-style-type: none">• Thorough description of the nature, extent, and need for the procedure or service• Invoice for all unlisted DME and supply codes• NDC#, dosage units, and method of administration for unlisted drug codes• Comparable procedure code <p>Please note: unlisted codes submitted without supporting documentation will be denied. All documentation will be reviewed for appropriate coding, coverage reimbursement, and prior authorization, if needed.</p> |

Fee Schedule Changes



VIVA HEALTH periodically makes changes or adjustments to the Fee-for-Service Reimbursement Schedule. If you would like a copy of your current fee schedule, please contact Provider Customer Service at (205) 558-7474 or 1-800-294-7780.

VIVA HEALTH provides covered behavioral health services through Uprise Health, formerly American Behavioral Benefit Managers, Inc. (American Behavioral), the University of Alabama at Birmingham (UAB) Department of Psychiatry, and North Alabama Managed Care Inc. (NAMCI). If you have questions about the participating mental health providers or what mental health benefits a VIVA HEALTH member may have, please contact VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. Note that some employers have contracted mental health/ substance abuse benefits out to a separate vendor.

Appealing Denied Claims

Claims Issues

Providers should first inquire about claim denials or other concerns regarding payment by calling our Customer Service Department at (205) 558-7474 in Birmingham or toll free at 1-800-294-7780.

If the issue is not resolved after speaking with our Customer Service Department, the provider may submit a written appeal to request review of denied claims, to request additional payments, or otherwise to reprocess claims. A written appeal must be submitted within 180 days of the date of the initial Explanation of Payment or, if a payment was sent, the date of the check. The appeal should include information and documentation that the provider wants to be considered. Appeals for untimely claim filing should include proof of timely filing. Appeals for claims denied for no authorization should explain why the authorization wasn't obtained. Unless the claim was denied for medical necessity, please do not send medical records. The plan does not retrospectively review medical records when a provider fails to get a timely authorization. If medical records are submitted, please send them on a CD (with password) rather than paper. Appeals will generally be reviewed within 45 days of receipt and a written decision will be issued to the provider. An appeal decision is not subject to further internal review by VIVA HEALTH. A provider's having submitted an appeal is a condition precedent to filing litigation or initiating arbitration. Any litigation or arbitration shall be limited to the information made available to VIVA HEALTH during the appeal.

Appeals of hospital or post-acute admission claims denied due to criteria not being met may be eligible for a second level, external review appeal. For dates of service starting January 1, 2024 and after, participating providers may ask VIVA HEALTH to forward such denied appeals to the outside reviewer contracted with VIVA HEALTH after VIVA HEALTH upholds the denial upon appeal due to the member's stay not meeting medical necessity criteria. 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, including but not limited to denials for no authorization, untimely claims filing or member ineligible for coverage, are not eligible for external review. 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. Please be advised that external reviews are billed by the hour and hourly fees vary based on the type of review required. New information not

Appealing Denied Claims



provided to VIVA HEALTH upon the initial appeal will not be included for the external review. A request for an external review of an eligible claim must be initiated within 60 days of the date of the upheld denial notification by VIVA HEALTH from the first level provider appeal.

Appeals should be sent to:

- VIVA HEALTH
ATTENTION: PROVIDER APPEALS
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

Appeals may also be faxed to the attention of Provider Appeals at (205) 449-7542 if there are 20 pages or less.

VIVA HEALTH's Provider Credentialing/ Recredentialing & Provider Sanctioning



Initial Credentialing

VIVA HEALTH will utilize CAQH Proview to obtain your initial and recredentialing applications and other necessary documentation. VIVA HEALTH shall have access to all data used for credentialing, including but not limited to any database or credentialing sources utilized by VIVA HEALTH or its designated entity during the credentialing process. An updated attestation is required for VIVA HEALTH to use your CAQH information for initial credentialing and recredentialing.

Once credentialing data has been collected and verified, it is presented to the VIVA HEALTH Credentialing Committee for review and determination. This Committee makes determinations based on the qualifications, training, and experience of the provider, as well as the welfare and needs of VIVA HEALTH and its members. Sex, race, religion, creed, national origin, or any other criteria lacking professional justification are not considered in determining qualification for participation with VIVA HEALTH. If the determination is favorable, a welcome letter will be mailed to the provider, along with information as to where the Compliance Plan Training can be found on our company website. If the determination is unfavorable, the notice will include the reason(s) for the unfavorable decision.

If the initial credentialing determination is unfavorable and entitles the provider to a hearing under the Provider Hearings Section of this Provider Manual, then the notice will generally adhere to the requirements of the Health Care Quality Improvement Act of 1986, and its implementing regulations, as may be amended from time to time ("HCQIA") and the provider may appeal the decision in accordance with the provisions contained in this Provider Manual.

If the initial credentialing determination is unfavorable and does not entitle the provider to a hearing under the Provider Hearings Section of this Provider Manual, the provider will be given an opportunity to request a meeting with VIVA HEALTH to discuss the decision. The provider must request such meeting within thirty (30) calendar days following the provider's receipt of the notice of the unfavorable decision. The meeting will be with representatives of VIVA HEALTH and can be held at the election of the provider either in person at VIVA HEALTH's office located in Birmingham, Alabama, or by telephone conference. The purpose of the meeting will be to allow the provider the opportunity to discuss the decision and to provide information deemed relevant by the provider. Following such meeting, VIVA HEALTH will notify the provider in writing of the final determination.



CONVENIENT PROVIDER SUPPORT SERVICES

We are located right here in Alabama, and we are willing to go the extra mile to meet your needs.

Recredentialing

VIVA HEALTH providers must be recredentialed every three (3) years at a minimum. At VIVA HEALTH's sole discretion, the recredentialing process may be initiated at any time. The provider's information will be taken before the Credentialing Committee who will make a determination regarding the recredentialing of the provider. In accordance with the applicable

VIVA HEALTH's Provider Credentialing/ Recredentialing & Provider Sanctioning



provider agreement, a provider is responsible for notifying VIVA HEALTH of loss, restriction, or recommended adverse action against their hospital privileges, DEA permit, State Controlled Substances Certificate, or physician license, the loss of or a change in malpractice coverage, or Medicare sanction.

If the recredentialing determination is unfavorable and entitles the provider to a hearing under the Provider Hearings Section of this Provider Manual, then the notice will generally adhere to the requirements of the Health Care Quality Improvement Act of 1986, and its implementing regulations, as may be amended from time to time ("HCQIA") and the provider may appeal the decision in accordance with the provisions contained in this Provider Manual. If the recredentialing decision is unfavorable and does not entitle the provider to a hearing under the Provider Hearings Section of this Provider Manual, the provider will be given an opportunity to request a meeting with VIVA HEALTH to discuss the decision.

The provider must request such meeting within thirty (30) calendar days following the provider's receipt of the notice of the unfavorable decision. The meeting will be with representatives of VIVA HEALTH and can be held at the election of the provider, either in person at VIVA HEALTH's office located in Birmingham, Alabama, or by telephone conference. The purpose of the meeting will be to allow the provider the opportunity to discuss the decision and to provide information deemed relevant by the provider. Following such meeting, VIVA HEALTH will notify the provider in writing of the final determination.

Provider Sanctioning

If the VIVA HEALTH Medical Director at any time determines that there are reasonable concerns about the quality of care or level of service being provided to VIVA HEALTH's members by a provider, corrective action may be taken against the provider. Corrective action includes, but is not limited to, the following:

- Individual discussion with a provider, including issuance of a verbal warning;
- Formal letter of reprimand;
- Development of an improvement or corrective action plan;
- Reduction, suspension, or restriction of the privilege to provide specified services to VIVA HEALTH members;
- Suspension from participation with VIVA HEALTH; or
- Termination of the provider's agreement with VIVA HEALTH .

If the corrective action results in a suspension, the facts and circumstances of the suspension shall be reviewed by an appointed committee or the Utilization Management/Quality Improvement Committee within seven (7) days and the reviewing committee shall determine the corrective action, if any, to be taken in the matter.

VIVA HEALTH's Provider Credentialing/ Recredentialing & Provider Sanctioning



Provider Hearings

The following actions and/or recommendations shall entitle a provider to a hearing in accordance with the terms of this section:

- Initial credentialing denial;
- An action has been taken or a recommendation has been made against a credentialed provider based on their professional competence or conduct and such action or recommendation will adversely affect or limit the provider's participation in the VIVA HEALTH network; or
- A hearing is otherwise afforded a credentialed provider under their provider agreement with VIVA HEALTH or under the Medicare Advantage rules, regulations, or policies, if applicable.

Except as set forth directly before, a provider shall not be entitled to a hearing under this Section. Without limiting the foregoing, a provider shall not be entitled to a hearing to address corrective action based on a provider's failure to comply with VIVA HEALTH contract requirements, administrative policies or procedures, or business or billing practices. If a provider is entitled to a hearing under the terms of this section, the notice and hearing will generally adhere to the procedures set forth in HCQIA.

Within sixty (60) days after the conclusion of the hearing, a written recommendation, which shall include the reasons supporting the recommendation, will be issued. The recommendation shall be submitted to the VIVA HEALTH Board of Directors for final review, with a copy being sent to the provider.

The VIVA HEALTH Board of Directors shall issue a final decision, which shall be in writing and shall include the reason(s) for the decision. A copy of the final decision will be sent to the provider.

VIVA HEALTH will notify other parties of the final decision as required by state or federal law.

The provider shall not be entitled to more than one (1) hearing on any matter which shall have been the subject of an adverse action or recommendation. A provider must exhaust all available hearing rights as a condition precedent to filing litigation or initiating arbitration.



BACKED BY THE WORLD RENOWNED UAB HEALTH SYSTEM

We have been locally owned and operated right here in Birmingham since 1995.

Provider Information Updates



BetterDoctor

The Consolidated Appropriations Act of 2021 was signed into law on December 27, 2020. Included in this law is the No Surprises Act, part of which protects patients by aiming to improve the accuracy of provider directory information. This law enacted a new mandate for self-insured group health plans and health insurance issuers that offer group or individual health insurance coverage to establish: 1) a provider data verification process to ensure accurate provider directories; 2) a response protocol for individuals inquiring about the network status of a provider; and 3) a database that is publicly accessible and contains accurate information about their in-network providers and facilities.



VIVA HEALTH, Inc. has enlisted Quest Analytics' BetterDoctor services to implement a robust process to assist with meeting these requirements. As a participating provider, you will be prompted to attest to your information every 90 days through BetterDoctor. Notices may come to you via email, fax, direct mail, and/or phone calls to ensure that your practice providers and service locations are listed correctly in VIVA HEALTH, Inc. provider directories.

BetterDoctor notices will direct you to the BetterDoctor online portal for attestation to information on file with VIVA HEALTH, Inc. Please note that providers with more than one service location may be prompted to attest for each location. Once details are received by BetterDoctor and verified, VIVA HEALTH, Inc. directories will be updated with any new information within two business days of receiving the provider updates. Failure to attest to your demographics could lead to the suppression of your practice from our provider directories. **PROMPT RESPONSE IS KEY.** You will continue to receive prompts throughout the 90-day outreach period until your attestation is completed.

For questions regarding the verification process, please contact BetterDoctor directly at support@betterdoctor.com or call (844) 668-2543, 8:00 AM – 5:00 PM CST.

You may also contact VIVA HEALTH Provider Services at 1-800-294-7780, 8:00 AM – 5:00 PM CST, Monday – Friday.

Groups With 10+ Practitioners

Organizations with more than ten (10) practitioners and/or service locations are invited to participate in BetterDoctor's streamlined roster solution to complete their quarterly provider data attestations. The roster template includes the minimum provider directory data that must be verified for each of your practice providers every 90 days. For more information on participating in the streamlined roster solution, please contact your VIVA HEALTH, Inc. provider representative or email rosters@questanalytics.com to work directly with the roster solutions team at BetterDoctor.

Accessing Mental Health/Substance Abuse Services



VIVA HEALTH provides covered mental health services either through an agreement with Uprise Health, formerly ABH (American Behavioral), or through providers in the University of Alabama at Birmingham (UAB) Department of Psychiatry. If you have questions about the participating mental health providers or what mental health benefits a VIVA HEALTH member may have, please contact VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. Note that some employers have contracted mental health/ substance abuse benefits out to a separate vendor.

- **Members who should use UAB Department of Psychiatry providers for mental health services.** VIVA UAB adult members (18 and older) and the VIVA MEDICARE members selecting a UAB PCP receive mental health services from providers in the UAB Department of Psychiatry. The UAB Department of Psychiatry can be reached by calling (205) 934-7008 or 1-800-782-1133.
- **Members who should use Uprise Health participating providers for mental health services.** All members with behavioral health benefits through VIVA HEALTH, except VIVA UAB Adults (age 18 and older) and VIVA MEDICARE members with a UAB PCP, receive mental health services from Uprise Health participating providers.

VIVA HEALTH Commercial Pharmacy Information

VIVA HEALTH currently works with Express Scripts, a pharmacy benefit management company, to administer the prescription drug program for its employer group plans that include drug benefits. Note that some employers have carved prescription drug benefits out to another vendor.

The information below pertains to employer groups. For Medicare, see *page 101* of this manual.

1. Pharmacy RX Benefit Information

VIVA HEALTH employer groups typically have a four tiered copay structure for employer group members. The lower copayment is for generics, the middle copayment is for preferred brand drugs on the Commercial Formulary, the higher copayment is for other covered brand drugs and the last tier is for specialty drugs. Here are a few tips to help our employer group members use their RX benefit appropriately.

To help the members save money on copayments:

- Prescribe generics whenever possible. In most cases, if a patient uses a brand when a generic is available, the patient will pay the difference between generic and brand price, plus the higher brand copayment.
- If a generic isn't available, see if a drug listed on the Commercial Formulary will meet the patient's needs.

To help the members save on out-of-pocket costs:

- If referring patients to pharmacies, remember they must use a participating pharmacy. This applies to all prescriptions; even compounded drugs. Prescriptions filled at non-participating pharmacies will generally not be covered by VIVA HEALTH.

VIVA HEALTH Commercial Pharmacy Information

To save time and effort:

- Review the VIVA HEALTH Commercial Formulary. If applicable, make sure your office has obtained the necessary authorizations from VIVA HEALTH before the patient gets to the pharmacy.
- Keep a copy of the most current VIVA HEALTH Commercial Formulary in your office for reference.

2. VIVA HEALTH Commercial Formulary

The VIVA HEALTH Commercial Formulary changes periodically. When a drug becomes available in the generic form or over the counter, it may be removed from the Commercial Formulary. Throughout the year, other changes can occur. Many pharmacy and patient complaints are due to patients not having prior authorizations in place. A few minutes spent on getting the drugs authorized can eliminate unnecessary work and aggravation at the pharmacy. You can contact VIVA HEALTH's Provider Customer Service Department at (205) 558-7474 or 1-800-294-7780 to get a current Commercial Formulary mailed to you.

3. Biological, Biotechnical, and Injectable Drugs

VIVA HEALTH works with Accredo for employer group members to distribute covered self-administered injectable biological and biotechnical drugs to our members. Accredo provides services to individuals with various chronic or genetic disorders such as Crohn's Disease, Cystic Fibrosis, Hemophilia, Hepatitis C, Immune Disorder, Multiple Sclerosis, Rheumatoid Arthritis, and to members who require growth hormones or drugs for RSV Prevention. The VIVA HEALTH Commercial Formulary indicates which products are considered specialty.

If you have a patient that needs to be enrolled, please call:

- Accredo at 1-844-516-3320 for employer group members.

Specialty medications can also be obtained at the following locations:

- UAB Kirklin Clinic Pharmacy: 205-801-8730
- UAB Highlands Pharmacy: 205-930-7585
- University Medical Center Pharmacy (1917 Clinic): 205-975-5656
- UAB Home Infusion: Pharmacy: 205-934-2661
- Baptist Tower Pharmacy: 334-286-6200
- MCC Apothecary: 334-273-2281

4. RX Rider

Members through employer groups who have purchased an RX Rider through VIVA HEALTH have pharmacy benefits. The pharmacy information can be found on the member's VIVA HEALTH identification card.

Commercial Pharmacy Coverage Determination Form

| Patient Information: | Prescriber Information: |
|---|---|
| Patient Name: | Prescriber: |
| Member ID #: | Office Phone #: |
| Date of Birth: | Office Fax #: |
| Phone #: | NPI #: |
| Address: | Office Contact: |
| Medication and Diagnosis Information: | |
| Medication: _____ | Strength: _____ |
| Dispensed from: <input type="checkbox"/> Provider's Stock (Buy & Bill) | <input type="checkbox"/> Pharmacy's Stock |
| Must check one: <input type="checkbox"/> Brand <input type="checkbox"/> Generic | Route: _____ |
| Frequency: _____ | Quantity: _____ |
| Diagnosis: _____ | |
| If expedited review is needed, please provide rationale: _____ | |
| | |
| Alternate Drug(s) Previously Tried or Contraindicated: | |
| Drug: _____ | Date(s) Used: _____ Outcome: _____ |
| Drug: _____ | Date(s) Used: _____ Outcome: _____ |
| Drug: _____ | Date(s) Used: _____ Outcome: _____ |
| <input type="checkbox"/> Indicate if request is due to drug supply shortage. | |
| Rationale for Request: (Please attach relevant labs and clinic notes) | |
| | |
| Prescriber or Authorized Representative Signature: | |
| Signature: _____ | Date: _____ |
| Prescriber Specialty: _____ | |

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Revised: 08/16/2023

Member's Rights & Responsibilities



VIVA HEALTH members have the right to:

- Timely and effective redress of complaints through a complaint procedure.
- Obtain current information concerning a diagnosis, treatment, and prognosis from a provider in terms the member can reasonably be expected to understand. When it is not advisable to give such information to the member, the information shall be made available to an appropriate person on the member's behalf.
- Be given information about VIVA HEALTH and its services and the name, professional status, and function of any personnel providing health services to them.
- Give their informed consent before the start of any surgical procedure or treatment.
- Refuse any drugs, treatment, or other procedure offered to them by the health maintenance organization or its providers to the extent provided by law and to be informed by a provider of the medical consequences of the member's refusal of drugs, treatment, or procedure.
- Obtain emergency services without unnecessary delay when such services are medically necessary.
- See all records pertaining to their medical care, unless access is specifically restricted by the attending provider for medical reasons.
- Be advised if a health care facility or any of the providers participating in their care propose to engage in or perform human experimentation or research affecting their care or treatment. A member or legally responsible party on their behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which they have previously given informed consent.
- Obtain the names, qualifications, and titles of participating providers by contacting VIVA HEALTH's Customer Service Department.
- Be informed of the rights listed in this subsection.

- Participate in decision-making regarding their health care.
- Be treated with dignity. We recognize the member's right to privacy. Identifiable, protected health information shall not be released except where proper authorization to release medical records is obtained or when release is permitted by law.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

VIVA HEALTH members have the responsibility to:

- Provide, to the extent possible, information needed by professional staff to care for the member and to follow instructions and guidelines given by those providing health care services.
- To obtain all medical care, except emergency services and urgently needed care when outside of the service area, through a participating provider.
- Only use emergency room services for emergency medical conditions (see section on Emergency Services).
- To always carry their membership ID card, show it to the provider each time health services are received, and never permit its use by another person.
- To notify the plan of any changes in address, eligible family members, and marital status or if secondary health insurance coverage is acquired.
- To pay all applicable coinsurance, copayments, and/or deductible directly to the participating provider who renders care at the time of service.
- To cooperate in the administration of the double coverage, coordination of benefits or subrogation provisions set forth in plan documents. Failure to do so may result in VIVA HEALTH denying payment for affected claims.

NO HEALTH MAINTENANCE ORGANIZATION MAY, IN ANY EVENT, CANCEL OR REFUSE TO RENEW A MEMBER SOLELY ON THE BASIS OF THE HEALTH OF A MEMBER.

VIVA HEALTH's Complaint Procedure



FOR EMPLOYER GROUP MEMBERS

(See VIVA MEDICARE section for Medicare Complaint Procedure)

It is VIVA HEALTH's intention to provide prompt and equitable solutions to any complaints that VIVA HEALTH members may have. In addition, the Member Complaint Procedure provides a mechanism for feedback from our customers to the VIVA HEALTH staff, in order to improve the on-going operations of VIVA HEALTH.

If a member has a question about the services provided, the member should call Customer Service at the number indicated in their Certificate of Coverage or on the back of the member identification card.

Any problem or dispute between a member and VIVA HEALTH must be dealt with through VIVA HEALTH's Complaint Procedure. Complaints may concern non-medical or medical aspects of care, as well as the terms of the Certificate of Coverage, including its breach or termination. Complaints are processed according to the Complaint Procedure set forth in the Certificate of Coverage. The Complaint Procedure may be revised by VIVA HEALTH from time to time. The member must initiate the Complaint Procedure no later than twelve (12) months after the incident or matter in question occurred. Some employer groups require Complaints to be initiated within 180 days.

VIVA HEALTH must receive a written authorization from the member appointing the member's provider as their representative in order for VIVA HEALTH to process a complaint initiated by the provider. The only exceptions are 1) Expedited Formal Complaints, which may be filed for preservice denials or reductions when the standard response time could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or 2) Formal Complaints if the provider certifies in writing to VIVA HEALTH that the member is unable to act on their own behalf due to illness or disability.

Please be advised that members only get one level of appeal within VIVA HEALTH for Expedited Formal Complaints whereas they get two opportunities to appeal within VIVA HEALTH if they go through the standard complaint process (the informal level and formal level). Expedited complaints should only be requested when the member's health is such that the standard process jeopardizes the life or health of the member.

The Complaint Procedure consists of the following levels for review:

A. Inquiries. Most problems can be handled simply by discussing the situation with a representative of VIVA HEALTH's Customer Service Department. This can be done by phone or in person and will often avoid the need for written complaints and formal meetings. VIVA HEALTH asks members to try this process first to resolve any problems. Members with Inquiries, which are not resolved to their satisfaction, will be informed of the Informal Complaint Procedure available to them or their authorized representative.

B. Informal Complaint. If the member's problem cannot be resolved to the member's satisfaction by the Customer Service Representative at the inquiry level or the member requires a written response, the member may file an informal complaint. Informal complaints may be made verbally or in writing. A decision regarding an informal complaint and the mailing of a written notice to the member is completed from the receipt date within 15 days for pre-service appeals, within 30 days for post-service appeals and within 45 days for other complaints. The written notice includes the outcome of VIVA HEALTH's review of the informal complaint. In the case of an adverse outcome (in whole or in part), the member has a right to a second review by filing a formal complaint.

VIVA HEALTH's Complaint Procedure



C. Formal complaint. A formal complaint is the subsequent written expression of dissatisfaction by or on behalf of a member regarding the resolution of an informal complaint. A formal complaint must be filed within 12 months of VIVA HEALTH's receipt of the original informal complaint. VIVA HEALTH may allow an extension of the 12-month limit due to extenuating circumstances. Formal complaints may be submitted by written letter or using a Formal Complaint Form available from VIVA HEALTH. The formal complaint should be sent to:

VIVA HEALTH
ATTENTION: COMPLAINT COORDINATOR
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

A provider may act on behalf of the member in the formal complaint process if the provider certifies in writing to VIVA HEALTH that the member is unable to act on their own behalf due to illness or disability. A family member, friend, provider, or any other person may act on behalf of the member after written notification of authorization is received by VIVA HEALTH from the member. Members also have the right to request that a VIVA HEALTH staff member assist them with the formal complaint.

The Formal Complaint Committee reviews all formal complaints. The member or any other party of interest may provide pertinent data to the Formal Complaint Committee in person or in writing. The Formal Complaint Committee issues its decision within 30 days of the receipt date of the formal complaint (for a member employed by an employer subject to ERISA, this timeframe is shortened to 15 days on pre-service claims only). The member is given written notification regarding the Formal Complaint Committee's decision within 5 working days of the decision being made. In the case of an adverse outcome (in whole or in part), members of plans offered under VIVA HEALTH, Inc.'s HMO license have a right to a third level review by the State Health Officer or the Alabama Insurance Commissioner. Also, members in non-grandfathered health plans have a right to an external review by an independent review organization to appeal certain adverse benefit determinations. Please see Section F. below for more information.

D. Expedited Formal Complaints. Any complaint related to an adverse medical necessity decision may be considered for expedited review. This includes complaints related to service denials or reductions. Expedited review allows the member to bypass the informal and formal complaint steps of the complaint procedure. The member or provider may request an expedited review. Both the decision to grant an expedited review and the expedited review itself are conducted by the Expedited Formal Complaint Committee. An expedited review is granted if the standard response time could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If the Expedited Formal Complaint Committee determines the complaint justifies an expedited review, the Expedited Formal Complaint Committee will review the complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than 72 hours after the time the request was received. The Expedited Formal Complaint Committee notifies the provider of its decision by phone or fax the day the decision is made, or the next business day if the provider's office is closed. Written notification of the decision is mailed to both the provider and the Member within three days after the day the decision is made.

If the Expedited Formal Complaint Committee determines the complaint does not justify an expedited review, the member will receive written notification of the decision, postmarked within three working days after receipt of the member's request. The notification will verify that the request will be automatically transferred to the informal level of the complaint procedure as described above.

VIVA HEALTH's Complaint Procedure



E. Third Level Review. If the member believes the complaint procedure has not been carried out in accordance with the Certificate of Coverage, members of plans offered under VIVA HEALTH, Inc.'s HMO license may register a complaint with the Alabama Department of Insurance. Members of plans administered by VIVA HEALTH for an employer may contact the employer's human resource department. Also, Members in non-grandfathered health plans have a right to an external review by an independent review organization to appeal certain adverse benefit determinations. Please see Section F. below for more information.

F. External Review. For non-grandfathered health plans, VIVA HEALTH has available an independent external review process for certain denied claims for benefits. Non-grandfathered health plans are those that were not in existence when the Affordable Care Act was enacted in March 2010 or plans that have had substantial changes since that time. Members in grandfathered health plans have a limited right to external review. The external review process is handled by an Independent Review Organization (IRO). An IRO's external review decision is binding on VIVA HEALTH, as well as the member, except to the extent other remedies are available under state or Federal law.

The member, or the member's appointed representative, must initiate the external review process unless the appeal qualifies for an expedited external review. The member or provider may request an expedited external review, as described below. The external review process applies to an adverse benefit determination or final internal adverse benefit determination on appeal that involves medical judgment or compliance with the Cost Sharing and surprise billing protections in the No Surprises Act and its implementing regulations or a rescission of coverage. The decision to be reviewed usually will be the denial of an appeal as part of the formal complaint process described above. A determination that a person is not a member under the terms of the plan's Certificate, however, is not eligible for the external review process unless it involves a rescission. Members in grandfathered health plans have a right to an external review only for adverse benefit determinations involving surprise medical bills as defined by the federal No Surprises Act.

An expedited external review process is available for (i) an adverse benefit determination, if the adverse benefit determination involves a medical condition of the member for which the timeframe for completion of an expedited formal complaint would seriously jeopardize the life or health of the member, or would jeopardize the member's ability to regain maximum function and the member has filed a request for an expedited formal complaint; or (ii) a final internal adverse benefit determination, if the member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the member received emergency services, but has not been discharged from a facility.

The member must file a request for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If eligible for external review, the member's Certificate of Coverage describes in detail how to access the external review process.

VIVA HEALTH's Complaint Procedure



APPOINTMENT OF REPRESENTATIVE STATEMENT

Member's Name: _____

Member's I.D. #: _____

Appointed Representative: _____

Appointed Representative's Address: _____

Appointed Representative's Telephone #: _____

I hereby appoint and authorize the above referenced person to act on my behalf in the VIVA HEALTH, Inc. complaint procedure. I understand I may revoke this authorization at any time by providing prior written notice to VIVA HEALTH, Inc. at the following address:

VIVA HEALTH, Inc.
Attention: Complaint Coordinator
417 20th Street North, Suite 1100
Birmingham, AL 35203

Member's Signature

Date

VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-633-1542 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-633-1542 (TTY: 711)。

VIVA MEDICARE Information

(Medicare Members)



If you are not a VIVA MEDICARE participating provider, this section does not apply to you.

Introduction to VIVA MEDICARE



Since 1998, VIVA HEALTH, Inc. has contracted with the Centers for Medicare & Medicaid Services (CMS), the federal government agency that administers Medicare, to provide the VIVA MEDICARE product to Medicare beneficiaries. This contract authorizes VIVA MEDICARE to provide comprehensive health services to people entitled to Medicare benefits and who choose to enroll. VIVA MEDICARE covers all services and supplies offered by Medicare Parts A and B, plus additional benefits not covered by Medicare. Most VIVA MEDICARE plans also include Medicare Part D prescription drug benefits.

Medicare Advantage plans, like VIVA MEDICARE, allow members to get all their Medicare benefits from one company. Otherwise they would have to get Part A and B benefits from Medicare, Part D benefits from a stand-alone Part D plan, and for many, a Medicare supplement from yet another company. Medicare Advantage plans also give Medicare beneficiaries more options by offering a range of plan designs from plans with low or no premium and higher out-of-pocket costs to plans with a monthly premium but lower out-of-pocket costs. Plans such as VIVA MEDICARE *Extra Value* and VIVA MEDICARE *Extra Care* are designed specifically for Medicare beneficiaries who qualify for Medicaid. The simplicity, choice, and service offered by Medicare Advantage plans have made them extremely popular in Alabama with patients on Medicare.

CMS regulations are different in many aspects from the state regulations governing VIVA HEALTH's employer group products. We have created this supplemental section to the provider manual specifically for the VIVA MEDICARE products. For VIVA MEDICARE members, the information provided in this section supersedes the information found elsewhere in the provider manual. If an item is not addressed in this section, you may assume the information in other parts of the provider manual holds true for VIVA MEDICARE members. If you have any questions about the VIVA MEDICARE products, please call Customer Service at (205) 558-7474 in Birmingham or 1-800-294-7780. Office hours are 8am to 5pm, Monday-Friday.

Some product highlights are described below, many of which are discussed in more detail in the sections that follow:

Member Identification Card

A VIVA MEDICARE identification card is issued to each member to present at provider appointments and any other time health services are received. Sample VIVA MEDICARE identification cards are shown in a following section. VIVA MEDICARE members are instructed to carry their membership identification cards with them at all times. The card should be presented whenever services are received, whether from the member's PCP, a specialist, hospital, or other health care provider. Each ID card includes the member's name and member number, card issue date, some of the most common plan copayments, the selected Primary Care Provider, and the selected provider system. For VIVA MEDICARE members with prescription coverage, the card also includes information about the Part D drug benefit and should be presented to the pharmacist.

Eligibility Verification

VIVA HEALTH strongly encourages providers to verify eligibility (whether the patient states that they are on traditional Medicare or a Medicare Advantage plan such as VIVA MEDICARE) at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee member eligibility or coverage.

Introduction to VIVA MEDICARE



It is the responsibility of the provider to verify the eligibility of the cardholder. Please contact the VIVA MEDICARE Customer Service Department at (205) 558-7474 or 1-800-294-7780 for any questions about a VIVA MEDICARE member's eligibility or, for registered VIVA HEALTH Provider Portal users, visit www.VivaHealth.com/Provider and click on the VIVA HEALTH Provider Portal Login link.

Premiums and Copays

VIVA MEDICARE members are responsible for payment of the Medicare Part B premium (and Part A premium if applicable), typically deducted automatically from their Social Security checks. VIVA MEDICARE has \$0-premium plans, where members pay no additional plan premium, and plans with additional monthly premiums which offer lower out-of-pocket costs and/or richer benefits. Some services require copayments; some of the copayment amounts are listed on the member's identification card. Copayments must be paid directly to the provider at the time services are received. Note that under a special agreement with the Alabama Medicaid Agency, copays are not required from VIVA MEDICARE members who are eligible for full Medicaid benefits. Identification cards for these Medicare/Medicaid dual eligibles will show \$0.00 in the copayment fields.

Coinsurance

Some plans have a 20% coinsurance on certain benefits such as DME, prosthetics, renal dialysis, and Part B drugs. Again, coinsurance is not required from those VIVA MEDICARE members who are eligible for full Medicaid benefits. Coinsurance is paid to the provider by the patient based on the Explanation of Payment the provider receives from VIVA HEALTH.

Out-of-Pocket Maximums

There is an out-of-pocket maximum per calendar year on the amount the patient pays on the plan overall. After this limit is reached, VIVA MEDICARE will pay 100% of the cost of the benefit for the rest of the calendar year. The out-of-pocket maximum does not apply to Part D prescription drug benefits.

Member Complaints/Grievances and Appeals

There are three processes available for members to voice their concerns:

- The Medicare Appeals process is for concerns involving the denial of a claim, referral, or service that the member feels should have been covered and for disputes related to the discontinuation or reduction of services. An expedited appeal should be requested when a member's life, health, or ability to regain maximum function could be jeopardized by a delay. There is a separate Medicare appeals process for Medicare Part D prescription drug coverage.
- If a member disputes a hospital inpatient, SNF, HHA or CORF discharge decision, they may request a review of the decision by the local Quality Improvement Organization (QIO). If a member fails to exercise QIO review rights, they may still utilize the Medicare appeals process.
- The VIVA MEDICARE Grievance Process is for all other complaints including complaints about the quality of care or service received.

Introduction to VIVA MEDICARE



Claims

VIVA MEDICARE members pay any applicable copayments to the provider at the time of service and the provider files the claim directly to VIVA MEDICARE. Contracted providers agree to accept VIVA HEALTH's payment as payment in full for covered services and not to bill the patient for any remaining balance, other than the member's copayment or coinsurance, if due. Clean claims are processed within 30 days of receipt. Fee schedule changes/updates made by the Centers for Medicare & Medicaid Services will generally be implemented within 30 days after the changes are publicly available. Claims paid prior to implementation of Medicare fee changes will not be reprocessed. Special Medicare payment reductions, such as sequestration, will also be applied.

Hospital Readmission Review

To ensure that the care delivered to our members is of the highest possible quality, VIVA HEALTH will perform readmission reviews on all admissions to an acute, general, or short-term hospital occurring less than 31 calendar days from the date of discharge from the same 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:

- If the readmission was medically unnecessary;
- If the readmission resulted from a premature discharge from the same hospital; or
- If the patient was readmitted for care that could have been provided during the first admission.

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.

VIVA HEALTH has adopted a 30-day review policy that is consistent with CMS guidance and the QIO Manual. As such, the following factors related to clinical instability and discharge planning may be considered in determining whether a discharge was premature or a readmission preventable.

- **Premature Discharge of Patient That Results in Subsequent Readmission of Patient to Same Hospital** – This prohibited action occurs when a patient is discharged even though they should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in your judgment, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital.

Introduction to VIVA MEDICARE



- **Readmission of Patient to Hospital for Care That Could Have Been Provided During First Admission** – This prohibited action occurs when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission. [QIO Manual Chapter 4; Section 4255]

Additionally, in accordance with CMS guidance, and per §482.43 CMS State Operations Manual, thorough and appropriate discharge planning is the expectation of VIVA HEALTH. The discharge plan should consider the individual needs of the patient and caregiver, and consider the availability of services. A readmission review will consider the index admission, and whether the following basic elements were present:

- A follow-up appointment with the PCP or specialist within 30 days of discharge, clearly documented in the record to include the provider, date, and time of the appointment.
- A thorough medication reconciliation, including clearly indicated changes to the pre-admission medications, documented in the medical record.
- The signs and symptoms to watch out for post-discharge, and the action plan in the event of their occurrence, clearly documented in the record.

Upon identification of a readmission, the facility will be notified of the denial and given three (3) business days to provide documentation from the index admission to demonstrate that the patient was not prematurely discharged at that time, as well as the documentation of an appropriate discharge plan, as described above.

If documentation is not provided within three business days, the readmission will be denied, and the opportunity to provide such documentation will be afforded during the appeals process. Appeals may be submitted to:

VIVA HEALTH

ATTENTION: PROVIDER APPEALS
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

Appeals may also be faxed to the attention of Provider Appeals at (205) 449-7542. However, it is recommended that appeals with large amounts of documentation, such as medical records, NOT be faxed.

Emergency and Urgently Needed Services

VIVA MEDICARE covers medical emergencies 24 hours a day, 7 days a week, anywhere in the world from any provider, contracted or non-contracted. A medical emergency is when a patient reasonably believes that their health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse. Prior authorization is not required for emergency services to be covered. Urgently needed services are covered from non-contracted providers without prior authorization when members are traveling away from the service area and have an unforeseen illness or injury. Urgently needed services from a non-contracted provider are covered within the service area only in the extraordinary circumstance that no contracted provider is available. For both emergency and urgently needed care, the patient or hospital must contact VIVA HEALTH within 24 hours of receiving services. If a participating hospital fails to contact VIVA HEALTH within 24 hours or the next business day, the emergency admission will not be covered and the patient cannot be billed.

VIVA HEALTH Medicare Advantage Plans



VIVA HEALTH offers several Medicare Advantage plans to suit the needs and budgets of Medicare-eligible recipients. Each plan offers all the services and supplies offered by traditional Medicare, plus some services and supplies not covered by Medicare. Plan benefits, member cost sharing and premiums change from year to year. Visit www.VivaHealth.com/Medicare/Member-Resources/ for current plan information.

Part D Late Enrollment Penalty

If a patient does not have other drug coverage that is as good as or better than Medicare prescription drug insurance (called “creditable” coverage) after they were first eligible or had a continuous period of 63 days or more when they didn’t have creditable prescription drug coverage, the patient will pay a late enrollment penalty if they join a Medicare prescription drug plan. Even if patients are not taking many prescription drugs now, they may in the future and would be penalized for joining a Medicare prescription drug plan late.

Which Plan Is Best for My VIVA MEDICARE Patients?

Patients should compare monthly plan premiums, benefits, and out-of-pocket costs to determine which VIVA MEDICARE plan best meet their needs.

How Can My Patients Enroll in a VIVA MEDICARE Plan?

If you have a patient interested in learning more about VIVA MEDICARE or ready to enroll in a plan, they have several options:

- **Call VIVA MEDICARE toll-free** at 1-888-830-VIVA (8482) (TTY users, dial 711). Monday - Friday, 8am - 8pm CT (October 1 - December 31: 7 days a week, 8am - 8pm CT)
- **Enroll online** by visiting www.VivaHealth.com/Medicare.
- **Or enroll online** through www.medicare.gov or by calling Medicare at 1-800-MEDICARE 24 hours a day, 7 days a week.

Things to Know About VIVA MEDICARE Provider Systems



All VIVA MEDICARE identification cards will indicate the member's plan, chosen Primary Care Provider (PCP), and provider system in which the member's PCP is affiliated. Below is a description of each VIVA MEDICARE provider system:

VIVA MEDICARE Open Provider System: VIVA MEDICARE members who have selected a PCP in an open provider system have open access to our VIVA MEDICARE provider network. The member's identification card, next to provider system will read, "Any VIVA MEDICARE Hosp/Specialist." Members in an open provider system do not require referrals to see any participating VIVA MEDICARE specialist and can receive care at any participating hospital.

VIVA MEDICARE Closed Provider Systems - VIVA MEDICARE UAB and Infirmiry Health: VIVA MEDICARE members who have selected a PCP in the UAB Hospital System must receive all their care within the UAB closed provider system. This means the member can visit any specialist or facility within the UAB system as well as any specialist or facility within the Medical West or Ascension St. Vincent's systems. This will be indicated on the member's identification card on the provider system line and with a green stripe at the top of the card. The member does not require referrals to specialists within this provider system.

In partnership with Infirmiry Health, VIVA MEDICARE offers the *Infirmiry Health Advantage* (HMO) plan in the Mobile market. This plan is only offered in the following counties: Baldwin and Mobile. Members in this plan must receive their care within the VIVA MEDICARE *Infirmiry Health Advantage* closed provider system. As with the VIVA MEDICARE UAB closed provider system, the member does not require referrals to see specialists within this provider system.

Some specialties, even in a closed or limited network, are still considered open, meaning the VIVA MEDICARE member has open access to see a participating specialist for these specialties. Please see the provider matrix on the following page.

All VIVA MEDICARE provider systems require authorization for non-emergent hospital admissions, and certain procedures do require authorization. Please see the prior authorization list found in the provider manual. Possession of an ID card does not guarantee coverage. We encourage providers to verify member's eligibility by contacting the Customer Service Department or using the VIVA HEALTH Provider Portal, VIVA HEALTH's internet access for providers.

Open/Closed Provider System Matrix



VIVA MEDICARE members in an open provider system have open access to our VIVA MEDICARE network.

Members who select a plan or PCP in a closed network are limited to the providers in their chosen provider system. However, the following specialties are open in the closed or limited network provider systems:



| VIVA MEDICARE Provider System | General Network | Podiatrist | Optometry | Ophthalmology | Pain Management | Dermatology | Rheumatology | Allergy & Immunology | Endocrinology | Chiropractor | Mental Health |
|-------------------------------|-----------------|----------------|-----------|---------------|-----------------|-------------|----------------|----------------------|----------------|--------------|---------------|
| *UAB | Closed | Open | Open | Open | Open | Open | Open | Open | Open | Open | ABBM |
| Infirmiry Health | Limited | Limited | Open | Open | Limited | Open | Limited | Limited | Limited | Open | ABBM |
| Huntsville (NAMCI) | Limited | Open | Open | Open | Open | Open | Open | Open | Open | Open | NAMCI |

*VIVA Medicare members who have selected a PCP in the UAB provider system will be able to see specialists affiliated with any Medical West and St. Vincent's hospital systems. The member's ID cards will reflect this network change and will have a green stripe. The member does not require a referral to see a specialist within these provider systems. The members may also access hospital care at any of these hospitals systems with prior authorization.

| VIVA Medicare Provider System | Oral Maxillofacial Surgery | Dermatopathology | Physical Medicine and Rehabilitation |
|-------------------------------|----------------------------|------------------|--------------------------------------|
| *UAB | Open | Open | Open |
| Infirmiry Health | Open | Open | Limited |
| Huntsville (NAMCI) | Open | Open | Open |

Last Updated 12/14/2023

Plans Offered by VIVA MEDICARE in 2024



Below is a brief overview of the 8 Medicare Advantage plans offered by VIVA MEDICARE in 2024. To be eligible for VIVA MEDICARE, members must still pay their part B premium to Medicare.

VIVA MEDICARE *Plus* (HMO)*

- Includes both medical and Part D prescription drug coverage for a \$0 monthly premium.

VIVA MEDICARE *Plus* (HMO)

A Medicare Advantage Plan - Medicare limiting charges apply

| | |
|--|--|
| <p>Member: Jane H. Doe Member ID: Plan (80840): Provider System: PCP: PCP Phone: PCP: Specialist: ER:</p> | <p>Issue Date: 00/00/0000 Group: RxBIN: 004336 RxPCN: MEDADV RxGRP: RX7816 RxID:</p> |
|--|--|

MedicareRx
Prescription Drug Coverage
 CMS H0154 000

VIVA MEDICARE *Plus* (HMO)

A Medicare Advantage Plan - Medicare limiting charges apply

| | |
|--|--|
| <p>Member: Jane H. Doe Member ID: Plan (80840): Provider System: PCP: PCP Phone: PCP: Specialist: ER:</p> | <p>Issue Date: 00/00/0000 Group: RxBIN: 004336 RxPCN: MEDADV RxGRP: RX7816 RxID:</p> |
|--|--|

MedicareRx
Prescription Drug Coverage
 CMS H0154 000

VIVA MEDICARE *Premier* (HMO)*

- For an additional monthly premium of \$96, the plan includes both medical and Part D prescription drug coverage along with lower out-of-pocket costs and more benefits than the VIVA MEDICARE *Plus* plan.

VIVA MEDICARE *Premier* (HMO)

A Medicare Advantage Plan - Medicare limiting charges apply

| | |
|--|--|
| <p>Member: Jane H. Doe Member ID: Plan (80840): Provider System: PCP: PCP Phone: PCP: Specialist: ER:</p> | <p>Issue Date: 00/00/0000 Group: RxBIN: 004336 RxPCN: MEDADV RxGRP: RX7816 RxID:</p> |
|--|--|

MedicareRx
Prescription Drug Coverage
 CMS H0154 000

VIVA MEDICARE *Premier* (HMO)

A Medicare Advantage Plan - Medicare limiting charges apply

| | |
|--|--|
| <p>Member: Jane H. Doe Member ID: Plan (80840): Provider System: PCP: PCP Phone: PCP: Specialist: ER:</p> | <p>Issue Date: 00/00/0000 Group: RxBIN: 004336 RxPCN: MEDADV RxGRP: RX7816 RxID:</p> |
|--|--|

MedicareRx
Prescription Drug Coverage
 CMS H0154 000

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:

Green: UAB Hospital System / Medical West / Ascension St. Vincent's
Grey: VIVA MEDICARE *Infirmiry Health Advantage*


If a member is in the **open panel** provider system, there is no stripe and the member may use any VIVA MEDICARE specialist or hospital.

Plans Offered by VIVA MEDICARE in 2024




VIVA MEDICARE *Prime* (HMO)*

- For an additional monthly premium of \$46, the plan includes both medical and Part D prescription drug coverage along with lower out-of-pocket costs and more benefits than the VIVA MEDICARE *Plus* plan.


 "A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: |
| PCP Phone: | RxPCN: |
| PCP: | RxGRP: |
| Specialist: | RxID: |
| ER: | |

MedicareRx
 Prescription Drug Coverage
 CMS H0154 000



 "A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: 004336 |
| PCP Phone: | RxPCN: MEDADV |
| PCP: | RxGRP: RX7816 |
| Specialist: | RxID: |
| ER: | |

MedicareRx
 Prescription Drug Coverage
 CMS H0154 000


VIVA MEDICARE *Select* (HMO)*

- A Medicare Advantage plan with only medical coverage and no monthly premium. Designed for individuals who have prescription drug coverage through another source.


 "A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: |
| PCP Phone: | RxPCN: |
| PCP: | RxGRP: |
| Specialist: | RxID: |
| ER: | |

MedicareRx
 Prescription Drug Coverage
 CMS H0154 000


 "A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: 004336 |
| PCP Phone: | RxPCN: MEDADV |
| PCP: | RxGRP: RX7816 |
| Specialist: | RxID: |
| ER: | |

MedicareRx
 Prescription Drug Coverage
 CMS H0154 000

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:

Green: UAB Hospital System / Medical West / Ascension St. Vincent's
Grey: VIVA MEDICARE *Infirmiry Health Advantage*


If a member is in the **open panel** provider system, there is no stripe and the member may use any VIVA MEDICARE specialist or hospital.

Plans Offered by VIVA MEDICARE in 2024



VIVA MEDICARE *Extra Value* (HMO SNP)*

- A Medicare Advantage plan for individuals that have both Medicare and Medicaid (dual eligibles). Includes Part D prescription drug coverage for no additional monthly premium. Copays depend on the level of aid received with full duals having no out-of-pocket costs for their health care expenses.

 **VIVA MEDICARE** *Extra Value* (HMO SNP)


"A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: 004336 |
| PCP Phone: | RxPCN: MEDADV |
| PCP: | RxGRP: RX7816 |
| Specialist: | RxID: |
| ER: | |

MedicareRx
Prescription Drug Coverage
CMS H0154 000

VIVA MEDICARE *Infirmiry Health Advantage* (HMO)*

- This plan is offered in partnership with Infirmiry Health and is available only in Mobile and Baldwin Counties. Members in this plan must receive their care within the VIVA MEDICARE *Infirmiry Health Advantage* closed provider system. This plan has a limited network.

 **VIVA MEDICARE**
INFIRMIRY HEALTH ADVANTAGE(HMO)

"A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|--|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: Infirmiry Health | |
| PCP: | RxBIN: |
| PCP Phone: | RxPCN: |
| PCP: | RxGRP: |
| Specialist: | RxID: |
| ER: | |

MedicareRx
Prescription Drug Coverage
CMS H0154 000

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:

Green: UAB Hospital System / Medical West / Ascension St. Vincent's
Grey: VIVA MEDICARE *Infirmiry Health Advantage*

If a member is in the **open panel** provider system, there is no stripe and the member may use any VIVA MEDICARE specialist or hospital.


Plans Offered by VIVA MEDICARE in 2024



In partnership with the Huntsville Hospital Health System, VIVA MEDICARE offers two plans in the Huntsville market. These plans are only offered in the following counties: Jackson, Limestone, Madison, Marshall, and Morgan. Although members in these plans have access to the full network of VIVA MEDICARE providers, they must choose a PCP in Blount, Calhoun, Colbert, Cullman, Etowah, Franklin, Jackson, Lauderdale, Limestone, Madison, Marshall, or Morgan County.

VIVA MEDICARE *Classic* (HMO)

- Includes both medical and Part D prescription drug coverage and has no monthly premium.




"A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: 004336 |
| PCP Phone: | RxPCN: MEDADV |
| PCP: | RxGRP: Rx7816 |
| Specialist: | RxID: |
| ER: | |

MedicareRx
Prescription Drug Coverage
CMS H0154 000

VIVA MEDICARE *Extra Care* (HMO SNP)

- A Medicare Advantage plan for individuals that have both Medicare and Medicaid (dual eligibles). Includes Part D prescription drug coverage for no additional monthly premium. Copays depend on the level of aid received with full duals having no out-of-pocket costs for their health care expenses.



"A Medicare Advantage Plan - Medicare limiting charges apply"

| | |
|----------------------------|-------------------------------|
| Member: Jane H. Doe | Issue Date: 00/00/0000 |
| Member ID: | Group: |
| Plan (80840): | |
| Provider System: | |
| PCP: | RxBIN: 004336 |
| PCP Phone: | RxPCN: MEDADV |
| PCP: | RxGRP: Rx7816 |
| Specialist: | RxID: |
| ER: | |

MedicareRx
Prescription Drug Coverage
CMS H0154 000

2024 Plan Consolidation

Effective January 1, 2024, the VIVA MEDICARE *Me* (HMO) plan is merging with the VIVA MEDICARE *Plus* (HMO) plan. Additionally, the VIVA MEDICARE *Preferred* (HMO) plan is merging with the VIVA MEDICARE *Premier* (HMO) plan.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:

Green: UAB Hospital System / Medical West / Ascension St. Vincent's
Grey: VIVA MEDICARE *Infirmiry Health Advantage*

If a member is in the **open panel** provider system, there is no stripe and the member may use any VIVA MEDICARE specialist or hospital.

Provider Responsibilities



It is the responsibility of the Primary Care Provider to provide primary care and coordinate other medical care for VIVA MEDICARE members who have selected them as their PCP. This includes evaluating each member's medical needs and facilitating communication and information exchanged, among the different providers treating the member. To ensure that each VIVA MEDICARE member receives medically necessary care in the most appropriate setting, the Primary Care Provider manages the overall care of the member, directing them to other contracted providers, as needed.

The PCP should direct the care to the appropriate specialist within the PCP's provider system. If a service is not available in the VIVA MEDICARE member's provider system, the PCP should contact VIVA HEALTH's medical management department for assistance in identifying an alternate contracted provider for the particular service.

The only medical services a member may receive from non-contracted providers are:

- Emergency care anywhere (if you are made aware of an emergency admission to a non-contracted hospital, please contact VIVA HEALTH as soon as possible so the member's care can be followed and a transfer to a contracted hospital can be arranged, if appropriate).
- Urgently needed care when the member is outside the service area or in the service area in the rare circumstance that no contracted provider is available.
- Dialysis services when the member is away from the service area.
- Services prior authorized by VIVA HEALTH.

Patient Communication:

In today's fast-paced world, consumers often feel hurried and may not always receive the information necessary to make informed choices. Unfortunately, the health care industry is no exception. This is why the role of the PCP has become so critical. As a PCP, you are the provider your patients look to first for medical guidance and to coordinate care and services. VIVA HEALTH encourages PCPs to communicate openly with our members, to allow them the right to participate in decision-making regarding health care, and to provide information on available treatment options or alternative courses of care. We urge you to discuss medical conditions and treatment plans with the member in layman's terms and to take the time to explain potential complications and side effects and what the patient should do if they arise. Patients should be made aware of when follow-up services need to be scheduled.

Treatment Plans:

The PCP identifies patients that have complex or serious medical conditions. To assist in this effort, VIVA HEALTH conducts a health risk assessment of new VIVA MEDICARE enrollees and notifies the PCP if the patient falls into the high-risk classification. The PCP should consider all aspects of the patient's care in formulating the patient's treatment plan including the seriousness, progression, and expected duration of the patient's diagnosis.

- The nature and level of complexity of treatment. Generally, the more complicated and/or difficult the treatment, the more useful a detailed treatment plan will be.
- The existence of co-morbidity. Diagnoses that taken individually may not be as serious, when combined for the same patient often make a detailed treatment plan necessary.

Provider Responsibilities



- The patient's level of compliance. Patients who have difficulty complying with prescribed treatment may benefit from a written treatment plan.
- Whether the patient scored as high risk on the health risk assessment. Generally, members who score as high risk require a more detailed treatment plan.

Once the PCP identifies a patient with a complex or serious condition, the PCP is responsible for addressing and/or monitoring the patient's conditions and developing an appropriate treatment plan. To be most effective, the treatment plan should include:

- The timeframe covered.
- Individual goals for the patient.
- Resources, including seeing one or more specialists for an adequate number of visits to accommodate implementation of the treatment plan.
- A mechanism for periodic evaluation. The treatment plan should be updated periodically with input from any specialist or other providers involved in the patient's care. If further intervention is necessary, the treatment plan should be modified appropriately.
- Input from the patient or the patient's authorized representative. The treatment plan should be reviewed with and mutually agreed to by the patient or the patient's authorized representative. The involvement of the patient or patient representative is important for all VIVA MEDICARE members, and especially for those with mental health or substance abuse problems, with chronic diseases, or at the end of life.
- Any recommendations regarding self-care, medication management, exercise, use of medical equipment, and other measures the patient may take to promote their own health.

Complete and Accurate Coding and Documentation:

Providers should submit claims timely following complete and accurate coding guidelines appropriately capturing the acuity and complexity of a member's condition while maintaining the proper documentation in the medical records to support codes submitted along with a treatment plan and care coordination actions. Notify VIVA HEALTH for any codes that are determined to have been submitted in error.

Coding guidelines require that a provider document to the highest level of known specificity which includes the following:

- All conditions that exist at the time of the encounter.
- Condition documentation should be specific, clear, and concise.
- Documentation must include the condition was monitored, evaluated, assessed and addressed, or treated.
- Member's name, date of birth, and date of service must present on every page.
- Provider's signature and credentials must be legible and present on the medical record.
- Documentation should be signed within two days of the encounter, but no more than 180 days.
- Telemedicine encounters should be clearly documented if the encounter is an audio and visual or audio only.
- A diagnostic statement is required along with a treatment plan for each condition. ICD-10-CM codes are not sufficient for diagnosing a member's health, the codes are a statistical classification used for reporting purposes only.
- Ensure there are no conflicting discrepancies, for example if the documentation under the Exam states the left leg has normal reflexes, normal pedal pulses and under the Assessment the documentation states s/p left leg amputation 2002.

Provider Responsibilities



*Refer to the Medicare Advantage Risk Validation Audit Section on page 82 for additional information

**VIVA HEALTH follows the ICD-10-CM Official Guidelines for Coding and Reporting. “A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.”

ICD-10-CM Official Guidelines for Coding and Reporting FY 2024 -- UPDATED October 1, 2023 (October 1, 2023 - September 30, 2024)

<https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm>

Advance Directives:

PCPs are expected to engage each VIVA MEDICARE member regarding their future health care needs and available options for treating those needs. PCPs should discuss with members the importance of having an advance directive in place. Advanced care planning and the use of advance directives provide a tool for ensuring individual autonomy at end of life. There are two ways members can make a formal advance directive:

- Living Will
- Power of Attorney for Health Care Document

An advance directive form is provided in this manual at the end of this section and can also be found on our website at www.VivaHealth.com/Medicare/Member-Resources (select the member’s VIVA MEDICARE plan name, then click the link titled “Advanced Directive for Healthcare”). Documentation of the PCPs discussion of advance directives with members must be maintained in the medical record as well as documentation indicating if the member currently has an advanced directive in place.

Hospice Benefits:

If a member becomes hospice eligible (terminally ill), the member’s PCP is responsible for supplying information regarding Medicare hospice benefits. *See pages 94-97* for additional information.

If a VIVA MEDICARE member joins the Medicare hospice program, their coverage through VIVA Health is limited to those services not covered by original Medicare. *See page 94* for more information regarding hospice.

Your Role in Care Transitions:

When a VIVA MEDICARE member moves from one care setting to another, we need your help to be sure the transition is safe and well coordinated. As a patient’s health status changes, the appropriate care setting may also change. It is vital that the sending setting provider (the provider responsible for the patient’s care before the transition) and the receiving setting provider (the provider who will care for the patient after the transition) communicate effectively with one another. It is equally as important that the patient and the patient’s caregiver(s) understand the transition and what it means for the patient’s care plan and treatment. Examples of transitions include but are not limited to:

Provider Responsibilities



- A member moving from a hospital to a skilled nursing facility (SNF) or rehab facility
- A member moving from a hospital or SNF to home with home health care
- A member moving from a SNF to a custodial care facility

PCP

- The Primary Care Provider (PCP) is responsible for developing and communicating the member's Plan of Care (treatment plan).
- Changes in the member's health status and resulting changes in the Plan of Care should be made and communicated to the member by the member's PCP.
- Communication with the member or responsible party can be written, face-to-face, or telephonic.
- Changes to the Plan of Care and health status along with documentation of the communication to the member or responsible party should be placed in the member's medical record within 5 business days.

Facility (Inpatient, Rehabilitation, Skilled Nursing Facility)

- The discharging facility is responsible for communicating with the member or responsible party about the care transition process and changes in the member's health status and in the Plan of Care.
- The discharging facility is responsible for ensuring the receiving facility obtains a copy of treatment orders, including medication record. This can be done verbally, by written copy, via facsimile or telephone, but must be documented in the medical record at both the sending and the receiving facility.
- The discharging facility must communicate the Plan of Care to the receiving facility within 24 hours prior to discharge. VIVA MEDICARE verifies the Plan of Care communication between both entities within 24 hours of the transition. This verification is done during the authorization process. In accordance with state requirements, the receiving facility must have the Plan of Care prior to admission.

Home Health

- The Home Health agency receives treatment orders from the provider.
- The Home Health agency is responsible for communicating the Plan of Care to the member at the time of the initial visit. Changes in the Plan of Care should also be communicated, as needed, at subsequent visits and be documented in the medical record within 5 business days.

Change of Member's PCP:

Whenever a member changes PCPs, we ask that you cooperate in the transfer of medical records to the new provider in a timely manner that ensures continuity of care.

Provider Treatment or Service Decisions for VIVA MEDICARE Members

If a participating provider declines to give an item or service that a VIVA MEDICARE member has requested, or offers an alternative item or service with which the member disagrees, the member (or provider) should contact VIVA MEDICARE in advance to request an organization determination for the item or service in question. VIVA MEDICARE will review the request to determine if the item or service is covered by the plan and will notify the member (and/or provider) in writing of its organization determination.

Provider Responsibilities



If VIVA MEDICARE determines the item or service is not covered by the plan, a denial letter with the member's appeal rights will be sent to the member. If the member disputes the unfavorable organization determination, the case will be handled through the plan's appeal process.

Providers cannot hold a Medicare Advantage (MA) plan member financially responsible for the requested item or service unless VIVA MEDICARE issues a denial letter to the member in advance, or the item or service is clearly excluded in the VIVA MEDICARE Evidence of Coverage (EOC).

The Centers for Medicare & Medicaid Services (CMS) considers participating providers to be agents of the plan (as stated in 42 CFR Parts 417 and 422). This means that CMS considers items or services furnished to MA plan members by plan providers to be "approved" unless providers can demonstrate that the member received prior notice of non-coverage for the requested item or service (e.g., via a clear exclusion in the EOC or by a denial letter issued by the plan). Providers cannot bill a member more than the normal member cost-sharing owed as a member of VIVA MEDICARE unless the provider confirms the plan has denied the requested item or service, or the item or service is clearly excluded in the member's EOC.

If a member has been notified in advance of the non-covered item or service (as described above) and chooses to receive the item or service regardless, providers may have the member complete the Patient Liability Form on *page 80* and may hold the member financially responsible for the charges. It is important to give the member a copy of this form and retain a copy in the patient's chart for your records. VIVA MEDICARE or CMS may require a copy of this form if the item or service is later disputed.

IMPORTANT NOTE: *Providers cannot issue an Advance Beneficiary Notice (ABN) to MA plan members as documentation of the member's liability for non-covered items or services. CMS regulations indicate the ABN is only to be used for beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program, not for MA plan members.*

ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. Living Will

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

If I become terminally ill or injured:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either “yes” or “no”:

I want to have life sustaining treatment if I am terminally ill or injured. Yes No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either “yes” or “no”:

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

Yes No

If I Become Permanently Unconscious:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either “yes” or “no”:

I want to have life-sustaining treatment if I am permanently unconscious. Yes No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either “yes” or “no”:

I want to have food and water provided through a tube or an IV if I am permanently unconscious.
 Yes No

Other Directions: Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

If you do not have other directions, place your initials here:

No, I do not have any other directions.

Section 2. If I need someone to speak for me.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

_____ I **do not** want to name a health care proxy. *(If you check this answer, go to Section 3)*

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

Instructions for Proxy

Place your initials by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. _____ Yes _____ No

Place your initials **by only one** of the following:

_____ I want my health care proxy to follow **only** the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form **and** to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.
- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

Section 4. My signature

Your name: _____

The month, day, and year of your birth: _____

Your signature: _____

Date signed: _____

Section 5. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

Section 6. Signature of Proxy

I, _____, am willing to serve as the health care proxy.

Signature: _____ Date: _____

Signature of Second Choice for Proxy:

I, _____, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: _____ Date: _____

Provider Responsibilities



Patient Liability Form

(To be used only when a member requests a service that has been denied by the plan or is excluded in the member's Evidence of Coverage)

Medicare Advantage Plan Patient Liability Form for Items/Services Requested and Denied by the Plan (or excluded in the member Evidence of Coverage)

*** Please provide patient with a completed copy and retain original. ***

I. Provider Information (to be completed by the provider)

Provider's Name: _____

Patient's Name: _____

Patient's Member Number: _____

Requested Item(s)/Service(s): _____

The date items/services will be provided to you: _____

The total cost for the items/services will be: \$ _____

II. Patient/Member Consent (to be completed by the patient/member)

___ Yes, I have been notified by my health plan that the item(s)/service(s) will not be covered. I want to receive the item(s)/service(s) listed above and I understand that I will be fully responsible for paying for the item(s)/service(s) above.

___ No, I have decided not to receive the item(s)/service(s) listed above.

Patient's Signature

Date

Medicare Advantage Risk Adjustment Validation Audit



Source: CMS Instructions for Medicare Advantage Risk Adjustment Data Validation Audit

The Centers for Medicare & Medicaid Services (CMS) conducts data validation after risk adjustment data is collected and submitted, and payments are made to VIVA HEALTH. The purpose of the risk adjustment data validation is to ensure risk adjusted payment integrity and accuracy. Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by VIVA HEALTH are supported by medical record documentation for a member (according to coding guidelines).

Overview of CMS Risk Adjustment Data Validation Audit

The Medicare Advantage Risk Adjustment Data Validation Audit (RADV Audit) is accomplished through medical record review. VIVA HEALTH Risk Adjustment Department initiates the process with a letter to each provider selected for review; this letter will include a listing of Medicare Advantage members identified for audit. In addition to the request, a letter from CMS is provided, asking for this information. VIVA HEALTH requires that a copy of the medical record be provided to substantiate the results of the audit by CMS.

The medical record documentation is required to record findings and observations about a member's health status, including past and present illnesses, examinations, tests, treatments, and outcomes. The guiding principle for validation states the risk adjustment diagnosis must be:

- Based on clinical medical record documentation from a face-to-face encounter
- Coded according to the ICD-CM Guidelines for Coding and Reporting
- Assigned based on dates of service within the data collection period; and
- Submitted to VIVA HEALTH from an appropriate:
 - Risk adjustment (RA) provider type (inpatient, outpatient, and provider)
 - Provider data source (refer to RA provider specialty list)

Technical Medical Record Requirements

A medical record represents one face-to-face encounter on one date of service (for outpatient and provider records) or a date range (for inpatient records). Per CMS, medical records must meet the following requirements:

- The patient name must be listed on every page of the medical record. The date of service must be listed on every page of the medical record and should also be within the data collection period.
- The medical record should list an acceptable risk adjustment provider type and provider specialty.

All medical records must include a valid signature and credentials. If this is missing, a CMS-generated attestation will be required.

The primary goals of risk adjustment data validation are to:

- **Identify** – Continued risk adjustment discrepancies
– Organizations in need of technical assistance to improve quality of risk adjustment data
- **Measure** – Accuracy of risk adjustment data
– Impact of discrepancies on payment
- **Improve/Inform** – Quality of risk adjustment data
– The CMS risk adjustment models

**Note: All Claims/Encounters submitted to VIVA HEALTH are subject to State, Federal and/or internal health plan auditing at any time. Providers are required to submit medical records to validate data previously submitted to VIVA HEALTH within an appropriate amount of time.*



Provider Promotional Activities:

VIVA MEDICARE contracted providers may assist VIVA HEALTH in promoting the VIVA MEDICARE product in accordance with CMS standards. Below is an excerpt from the Code of Federal Regulations (CFR) related to provider-based activities. The full document is available on the Internet at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422>. If your office would like to work with us to distribute VIVA MEDICARE product information to your Medicare patients, please contact our Marketing Department at (205) 558-7474.

From Code of Federal Regulations (CFR):

§ 422.2266 Activities with healthcare providers or in the healthcare setting.

(a.) *Where marketing is prohibited.* The requirements in paragraphs (c) through (e) of this section apply to activities in the health care setting. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:

- (1.) Exam rooms.
- (2.) Hospital patient rooms.
- (3.) Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).
- (4.) Pharmacy counter areas.

(b.) *Where marketing is permitted.* Marketing activities and materials are permitted in common areas within the health care setting, including the following:

- (1.) Common entryways.
- (2.) Vestibules.
- (3.) Waiting rooms.
- (4.) Hospital or nursing home cafeterias.
- (5.) Community, recreational, or conference rooms.

(c.) *Provider-initiated activities.* Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Provider-initiated activities that meet the definition in this paragraph (c) fall outside of the definition of marketing in § 422.2260. Permissible provider-initiated activities include:

- (1.) Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>), including in areas where care is delivered.
- (2.) Providing the names of MA organizations with which they contract or participate or both.
- (3.) Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.

Marketing Guidelines



(4.) Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at <https://www.medicare.gov>, or 1–800–MEDICARE.

(5.) Referring patients to MA plan marketing materials available in common areas;

(6.) Providing information and assistance in applying for the LIS.

(7.) Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

(d.) *Plan-initiated provider activities.* Plan-initiated provider activities are those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements.

(1.) During plan-initiated provider activities, MA organizations must ensure that the provider does not:

(i) Accept or collect Scope of Appointment forms.

(ii) Accept Medicare enrollment applications.

(iii) Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.

(iv) Mail marketing materials on behalf of the MA organization.

(v) Offer inducements to persuade patients to enroll in a particular MA plan or organization.

(vi) Conduct health screenings as a marketing activity.

(vii) Distribute marketing materials or enrollment forms in areas where care is being delivered.

(viii) Offer anything of value to induce enrollees to select the provider.

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2.) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e.) *MA organization activities in the health care setting.* MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in paragraphs (a) and (b) of this section. However, during MA organization activities, the following is permitted:

(1.) Accepting and collect Scope of Appointment forms.

(2.) Accepting enrollment forms.

(3.) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

VIVA MEDICARE's Connect for Quality Program (C4Q)



The Connect for Quality (C4Q) program is based on improving the quality of care and health status for VIVA MEDICARE members through disease prevention and management activities. C4Q is an incentive program for VIVA MEDICARE participating PCPs, when their membership is within the required guidelines. VIVA MEDICARE provides a nurse clinician as a resource to C4Q PCPs to promote provider engagement and member satisfaction by proactively supporting the PCP/patient relationship.

PCPs can realize generous bonus incentives by working collaboratively with their C4Q nurse. C4Q encourages the completion of annual wellness visits, preventive screenings and comprehensive management of chronic diseases such as diabetes and hypertension, to promote optimal outcomes. C4Q nurses work with different disciplines within the community such as VIVA's Care Management team.

C4Q activities are calendar-year based and reflect STARS and HEDIS measures that are best achieved through provider engagement, including:

- Sharing meaningful and actionable reporting with the PCP, including the identification and targeting of at-risk members and measure gaps;
- Ensuring members receive their annual wellness visit, with completion of the Comprehensive Review Form (CRF);
- Facilitating provider orders and the scheduling of preventive screenings and standard of care testing for STARS/HEDIS measures;
- Monitoring and impacting outcomes for control of blood pressure and blood sugar;
- Monitoring medication adherence, post discharge medication reconciliation and transition of care.

For more information about the Connect for Quality program, please contact your VIVA HEALTH Provider Services representative.

Compliance



Compliance is a very important component of daily operations and core values at VIVA HEALTH. We define Compliance as meeting and/or exceeding all Federal and state regulatory requirements, as well as being vigilant against Fraud, Waste and Abuse (FWA).

Why We Conduct Compliance Training

Compliance Training is one of the primary tools in the VIVA HEALTH Compliance Plan. Compliance training is required for all VIVA HEALTH employees, board members, committee members, and contractors.

In addition to meeting regulatory requirements, Compliance Training allows us to:

- Improve service for our members
- Define expected conduct
- Provide guidance on decision making
- Quickly identify and resolve compliance concerns
- Avoid legal and financial penalties

VIVA HEALTH's Compliance Mission

VIVA HEALTH's mission is to direct our business in an ethical manner and in accordance with all existing state and Federal laws and regulations. Our Compliance Plan is designed to effectively and promptly implement any new regulatory requirements while fostering open, honest, and timely communication and cooperation between VIVA HEALTH and our partners. We focus on integrating Compliance as an essential part of our daily operations.

Code of Conduct

VIVA HEALTH adopted the following Code of Conduct as a cornerstone of our Compliance Plan:

- Be honest
- Know the rules
- Ask questions
- Don't be afraid to ask for help
- Admit mistakes
- Report Concerns

What Are My Responsibilities as a Partner?

As a partner, contracted provider, you are responsible for following the guidelines outlined in this Provider Manual and any separate VIVA HEALTH Provider Compliance Training materials (available on <https://www.VivaHealth.com/Provider/Download.aspx?ID=1007&Type=doc>). All partners are expected to:

- Comply with all licensing requirements mandated by Federal and state regulatory agencies.
- Report any suspected violations of laws, regulations, or the VIVA HEALTH Code of Conduct.
- Assist in prevention, detection, and elimination of FWA.
- Cooperate with any investigation of suspected violations.



Fraud, Waste and Abuse (FWA)

FWA is a national problem that affects all of us, directly or indirectly. Billions of dollars are lost each year to FWA, driving up healthcare costs and premiums. In addition to the responsibilities discussed in the section above, Medicare Sponsors and providers have an obligation to prevent, detect and eliminate FWA. Abbreviated definitions and examples of FWA are provided below:

Fraud:

Fraud is knowingly misrepresenting information that can benefit you or another person. Submitting false claims for health care services not provided or filing claims for more complicated services than the ones provided (upcoding) are two, of many, examples of Fraud.

Waste:

Waste is using more resources than are necessary to complete a task. Examples of Waste include using or billing for more supplies, technology, or hours than are required.

Abuse:

Abuse is providing products or services that are inconsistent with accepted practices or that are clearly not reasonable or necessary. Billing for services/products that are not medically necessary is an example of Abuse.

Anti-Kickback Laws

The Anti-Kickback Statute and Stark Laws are Federal laws that prohibit knowingly or willfully offering, paying or receiving anything of value for a referral. Examples of prohibited activities include, but are not limited to:

- Waiving or reducing a copay or deductible for reasons other than real financial hardship or other allowable exceptions
- Accepting payment different from fair market value as a means to obtain more business
- Demanding or requesting a kickback (i.e., gifts, cash, write-offs, free supplies) for referring patients to specific providers
- Failure to comply with these laws can result in fines, jail, and/or exclusion from Medicare, Medicaid, or other Federal and state health programs.

False Claims Act (FCA)

The FCA is another Federal law that applies to Federal and state programs. The FCA prohibits knowingly submitting false, fictitious, or fraudulent claims to obtain payment from Federal or state programs. Knowingly and/or willfully making a false claim is a Federal felony. Penalties for FCA violations can result in significant fines, jail time, and/or exclusion from participation in Federal and state programs.



Criminal Activity

Any felony convictions or other criminal activity (not including minor traffic violations) must be disclosed to VIVA HEALTH. This includes anything that occurred prior to contracting with VIVA HEALTH or that occurs during the contract period. Evidence of criminal activity will be reviewed during the initial credentialing and subsequent recredentialing processes.

Debarment or Exclusion

The Office of Inspector General (OIG) and the General Services Administration (GSA) maintain lists of individuals and entities that have been debarred or excluded from working with Federal health programs. Debarment and exclusion is based on participation or engagement in certain impermissible, inappropriate or illegal conduct. VIVA HEALTH cannot employ or contract with anyone or any entity on the OIG and GSA Debarred and Excluded lists.

The OIG and GSA lists are reviewed during the initial and subsequent recredentialing processes and on a monthly basis. With criminal activities, VIVA HEALTH requires self-disclosure of any information related to debarment, exclusion, or any other activity that prevents you from working directly or indirectly with Federal or state health programs.

Preclusion List

CMS provides a preclusion list to Medicare Advantage (MA) plans on the 1st of each month. The preclusion list is a list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. The list was created to ensure patient protections and safety and to protect the Trust Funds from prescribers and providers identified as bad actors.

The list contains individuals or entities who meet the following criteria:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

OR

- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

The monthly preclusion list is reviewed by the plan, and members are notified by letter if they have received services or Part D drugs that were furnished or prescribed in the past 12 months by a provider on the list. The provider is copied on all member letters. The letter indicates the date (no earlier than 60 days from the date of the letter) by which claims for health care items or services must be denied, pharmacy claims must be rejected, or member requests for reimbursement must be denied. After the expiration of the 60-day period specified in 42 CFR §422.222, the provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per 42 CFR §422.504(g)(1)(iv). The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider will have already received notification of the preclusion. [422.504(g)(1)(v)]. Any provider/prescriber on the preclusion list will have been notified by CMS and given an opportunity to appeal before being precluded. As a VIVA MEDICARE provider, you must ensure payments are not made to individuals and entities included on the preclusion list, defined in §422.2.



[42 CFR 422.504.(i)(2)(v)]. For more information about the preclusion list, visit CMS's website at <https://www.cms.gov/Medicare/Provider-Enrollment-And-Certification/MedicareProviderSupEnroll/PreclusionList.html>.

Confidential Information

Compliance with the Health Insurance Portability and Accountability Act (HIPAA) is mandatory and the confidentiality of records, documents, and business practices must be maintained. Protected health information (PHI) and other member information must be safeguarded. This includes paper records, electronic records, and oral communication. PHI should only be shared if the disclosure is specifically allowed by HIPAA.

Monitoring and Auditing

Everyone is obligated to monitor compliance and FWA through normal daily operations. Any suspicion of non-compliance or FWA should be reported immediately. VIVA HEALTH reviews claims and other data submitted by each provider as an internal monitoring and auditing control.

Records

CMS regulations and the VIVA HEALTH Compliance Plan require records related to Medicare members and Medicare claims be retained for a minimum of 10 years. This retention time period can be extended in the event of an open investigation or audit. The records may be kept in any accessible format including paper and electronic. Records must never be falsified. At a minimum, falsification of records is FWA and/or a FCA violation.



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Get Assistance or Report a Potential Violation

To ask a question about Compliance and/or FWA or report a suspected violation, use any one or all of the following methods:

- VIVA HEALTH
(205) 558-7474 or 800-294-7780
- VIVA HEALTH
ATTN: Compliance Officer
417 20th Street North, Suite 1100
Birmingham, Alabama 35203
- Complete the online reporting tool located at the following address:
<https://www.VivaHealth.com/Medicare/FraudComplaint/>
Reports can be made anonymously.
- Officer of Inspector General (OIG)
Hotline: 800-447-8477
E-mail: HHSTips@oig.hhs.gov
Mail: HHS Tips Hotline:
PO Box 23489
Washington DC
20026-3489

Medicare Part D issues can also be reported through the Medicare Drug Integrity Contractors (MEDICs). Currently FWA issues and Compliance issues are handled by two separate MEDICs:

FWA Issues

Health Integrity
ATTN: MEDIC
877-7SafeRx (877-772-3379)

Compliance Issues

SafeGuard Services (SGS)
717-975-4442 (fax)

Compliance Investigations

VIVA HEALTH investigates every report. Unless disclosure is required by law, the reporter's identity will be anonymous if requested. When an investigation confirms a violation, Corrective Action will be taken. The Corrective Action may include, but is not limited to:

- Retraining
- Contract suspension or contract termination
- Regulatory agency reporting

There will be no retribution for any reports made in good faith or to any whistleblowers.

Compliance Summary

The material and policies in this Provider Manual and associated training materials are mandatory. Ethical behavior can never be sacrificed in the pursuit of other objectives. VIVA HEALTH is committed to the highest standards of ethics and compliance. Everyone is responsible for their own conduct and behavior. If you are not sure about a potential compliance or FWA issue, please ask.

2024 Special Needs Plan Model of Care



Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage Plan (like an HMO or PPO). SNPs were created by Congress in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan that focuses on certain vulnerable groups of Medicare beneficiaries. Medicare SNPs limit membership to people with specific diseases or characteristics and tailor benefits, provider choices, and drug formularies to best meet the specific needs of the groups served. VIVA HEALTH's Special Needs Plans serve approximately 20,000 enrollees through two Dual Eligible SNP (D-SNP) plans called VIVA MEDICARE *Extra Value*, and VIVA MEDICARE *Extra Care* in North Alabama. The plans consist of dual-eligible individuals who qualify for both Medicare and Medicaid.

VIVA MEDICARE *Extra Value* became effective January 1, 2010, and VIVA MEDICARE *Extra Care* became effective January 1, 2021. Individuals eligible for D-SNP membership must live in VIVA MEDICARE *Extra Value* or *Extra Care*'s geographic service area and be enrolled in Medicare Part A and Medicare Part B. D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility. If you have any questions about a specific category of eligibility, please feel free to contact our Sales or Enrollment teams at (205) 939-1718.

The Model of Care (MOC) is a document that is required for all Special Needs Plans and is the basic framework and description of how the plan will meet the needs of this vulnerable population. The MOC is a vital quality improvement tool and provides the foundation for the following:

- Detailed description of the population served and the unique needs of that population, including further describing and identifying characteristics of the most vulnerable SNP enrollees served;
- Care Coordination Processes and the clinical teams responsible for those processes;
- The Provider Network – how the plan ensures network adequacy and robust specialized expertise to address the identified needs of the SNP population;
- Description of how the plan monitors, evaluates, and reports quality performance of the SNP Plan to its enrollees, Provider Network, and stakeholders.

The goal of the SNP Program is to improve the quality of health of our enrollees through improved access, coordination of care, and evidenced based prevention strategies. Outlined below are organizational goals for the population in 2024.

Providing and Maintaining Improved Access and Affordability of Care to SNP Members

VIVA HEALTH's goal is to ensure provider network adequacy for our SNP members by meeting CMS compliance expectations regarding access to Primary Care Providers and specialists for members across our Medicare service area. VIVA HEALTH has maintained compliance with CMS expectation in providing network adequacy with county designations and specialists. We will continue using the CMS benchmark to ensure robust access. VIVA HEALTH maintained 100% network adequacy in 2022 and 2023 for all service areas.

VIVA MEDICARE *Extra Value* and *Extra Care* have also maintained the affordability of services by removing cost as a barrier to care for our SNP members by eliminating cost sharing for PCP and specialist office visits, as well as enhancing the pharmacy benefit through \$0 copay for all covered Part D drugs in all drug phases.

The Plan also strives to improve monitoring of enrollee experience and satisfaction with benefits through annual survey. Topics covered in the survey include usefulness of tools provided by the plan for managing health conditions, satisfaction with Care Management services, ease of use of benefits, and topics they would like to see covered in newsletters.

2024 Special Needs Plan Model of Care



Feedback from these surveys are compiled and disseminated throughout the organization, and utilized to develop process and customer experience improvements. We strive to collect feedback from 5% of our SNP members.

Improved Coordination of Care

VIVA HEALTH delivers and demonstrates Care Coordination to our SNP enrollees through:

- **Health Risk Assessment (HRA)** – At least once annually, we will attempt to engage members in an HRA in which we will assess the medical, cognitive, functional, psychosocial, and mental health needs of the enrollee.
- **Individualized Care Plan** – In conjunction with the enrollee or caregiver, an Individualized Care Plan is developed based on health goals identified via the HRA and member input. Care Plan goals are designed to be specific, measurable, achievable, relevant, and time-bound.
- **Interdisciplinary Care Team (ICT)** – It is the expectation of CMS that member goals be communicated with all members of the Care Team – that includes you, our Providers! Care plans may be provided for your review, and we welcome your recommended revisions or feedback regarding care plan goals.
- **Transitional Care** – It is the goal of the program to provide all SNP members who experience a hospitalization with transitional support. We achieve this by ensuring the member receives the appropriate follow-ups after hospitalization, assist with medication reconciliation, provide education about any changes in their plan of care, and recognize when the member’s condition warrants a call to their provider.

It is the expectation of CMS we complete HRAs, Individualized Care Plans, and Care Team Reviews on 100% of our enrollees. It is also expected 100% of enrollees experiencing a transition receive transitional care and support.

Reduction of Readmission Rates for SNP Members

VIVA HEALTH’s goal is to reduce the number of 30-day SNP readmissions to 0%. Reporting is reviewed on a monthly basis, and this result is reported as a yearly average. Current data for calendar years (CY) 2022 and 2023 is currently 16%. VIVA HEALTH addresses this goal, in conjunction with the Transitions goal, by providing enrollees who experience a hospitalization individualized support with a Care Manager (licensed nurse or Social Worker) for medication reconciliation, appropriate follow-up care, and education regarding any changes in the plan of care or health status.

Ensuring Appropriate Utilization of Services for Preventive Health and Chronic Conditions

Recognizing an established relationship with a Primary Care Provider is the cornerstone of good preventive care, VIVA HEALTH encourages all members, and certainly our SNP members, to develop a relationship with their PCP and visit their provider at least annually. This metric is measured quarterly with claims data and captures the number of SNP members who have accessed care from their identified PCP at least once during that calendar year. The most recent annual measurement result of this metric was 81% of SNP members seeing the PCP at least once annually for CY 2022. Realizing the significant need for the Primary Care Provider to be the driver of the member’s health care plan, VIVA HEALTH will continue to monitor the goal of 90% of SNP members seeing their PCP at least annually.

2024 Special Needs Plan Model of Care



VIVA HEALTH employs and/or contracts with individuals to perform various clinical functions related to its SNP administration:

- **Contracted Providers** – includes a broad range of Primary Care Providers, specialists (including mental health providers), facilities, and pharmacies to meet the special needs of the target population fully.
- **Pharmacists** – provide clinical support for the care team and monitor prescription drug utilization and costs to identify and address quality, cost-effectiveness, and adherence.
- **Health Services** – includes Medical Management and Care Management staff. Medical Management consists of Utilization Review staff and Case Managers who serve in clinical roles and in acute and post-acute settings. Care Management staff includes RNs, LPNs, and Licensed Social Workers who support members with care coordination needs and assist members in maximizing their health status in the least restrictive environment.
- **Connect for Quality** – work directly with Primary Care Providers at the point of care to improve quality, utilization, and member health status. Prevention and screening are key components to this program.
- **Quality Improvement** – this team works in clinical roles and directly interact with SNP members at Health Fairs and during telephonic outreach.

Oversight of the Special Needs Plan

The SNP Administrator and Director of Health Services Programs provide primary oversight of the Special Needs Plan. Secondary oversight is by the Utilization Management/Quality Improvement (UM/QI) committee, which consists of board-certified physicians from appropriate disciplines and service areas, and are supported by Compliance, Health Services, Quality Improvement, and Network Development.

Interdisciplinary Care Team

It is expected that all SNP enrollees have an Individualized Care Team that is reflective of their identified and individualized needs. At a minimum, the ICT consists of the enrollee/caregiver, the PCP, and the VIVA Care Manager. As a provider of care to our enrollees, you are an integral part of the team, and may receive notification of enrollees Care Plans. If you wish to speak to a VIVA Care Manager, discuss revision of any enrollee Care Plan, or notify us of an enrollee need or change in health status, we can be reached at (855)698-2273. VIVA HEALTH also maintains a core clinical staff that may be included in any enrollee's ICT as needed. These include our Chief Medical Officer and Medical Directors, clinical pharmacists, licensed nurses, social workers, and mental health professionals.

Provider Network and Use of Clinical Practice Guidelines

The SNP provider network covers the full spectrum of primary and specialty care. Providers and facilities are screened through a strict credentialing and re-credentialing process. The plan develops or adopts evidenced-based practice guidelines using criteria from various medically recognized organizations, such as the American Heart Association. Selection of topics for the development of practice guidelines and clinical pathways is coordinated by the UM/QI Committee.

Model of Care Training and attestation is required for all VIVA HEALTH providers serving the Special Needs Program population. For providers, the mandatory annual Model of Care (MOC) training is included in the Provider Manual and on our provider website.

Any provider may request live presentation of the Model of Care Training by contacting your Provider Services representative or SNP Administrator.

2024 Special Needs Plan Model of Care



Communication for Plan Performance and Process Improvement

The SNP Administrator and Leadership regularly communicate the status and performance of the SNP Program. Program details reviewed may include:

- Policy and procedure updates
- Progress towards goals
- Regulatory changes
- Member satisfaction outcomes
- Utilization metrics and population trends
- Training activities
- SNP Specific Quality metrics such as Stars

Enrollee Communication occurs in a variety of ways: the [VivaHealth.com](https://www.vivahealth.com) website, Evidence of Coverage, Summary of Benefits, formularies, directories, contacts such as Case and Care Management, newsletters, and VIVA HEALTH Cafés.

Internal Communication occurs within the organization through the Medicare Operations Team, UM/QI Committee, Electronic Health Record, ICT Meetings, and the Board of Directors.

Provider Network Communication occurs through *The Viva Voice* Newsletter, the Provider Manual, and Provider Model of Care Training.

If you have any questions about the Special Needs Plan, the Model of Care, or wish to speak to the SNP Administrator or a member of the Care Management Team, our contact information is below:

Jen Klopstein, SNP Administrator: jklopstein@uabmc.edu

Care Management Team: 1-855-698-2273

SNP MOC Training Available Online

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage Organizations (MAO) provide Special Needs Plan (SNP) Model of Care (MOC) training to all participating Medicare providers that care for Medicare/Medicaid dual eligible members. For more information concerning the Special Needs Plan (SNP) Model of Care please refer to the section of this provider manual titled 2024 Special Needs Plan Model of Care. An attestation can be completed one time for all providers within a group by an individual given authority to sign on behalf of the practice. In efforts to simplify this process, we have created an online submission option through our website. You may view and submit the training online at vivahealth.com/provider/snp-provider-training/.

Hospice Care for the Terminally Ill



Definition of Hospice

Hospice is a special way of caring for a person whose disease cannot be cured and is considered terminal. It is available as a benefit under Medicare hospital insurance (Part A). A Medicare beneficiary who chooses hospice care receives non-curative medical and support services for their terminal illness. Home care is provided along with necessary inpatient care and a variety of services not otherwise covered by Medicare.

The focus of hospice is on care, not cure. Emphasis is on helping the person to make the most of each hour and each day of remaining life by providing comfort and relief from pain. Under Medicare, hospice is primarily a program of care delivered in the patient's home by a Medicare-approved hospice. Reasonable and necessary medical and support services for the management of a terminal illness are furnished under a plan-of-care established by the hospice and the patient's attending provider.

When all requirements are met, Medicare hospice benefits include:

- Provider services
- Nursing care
- Medical appliances and supplies
- Outpatient drugs for symptom management and pain relief
- Short-term inpatient care, including respite care
- Home health aid and homemaker services
- Physical therapy, occupational therapy and speech/language therapy services
- Medical social services
- Dietary, and other counseling

Medicare pays nearly the entire cost of these services. The only expense to the patient is limited cost-sharing for outpatient drugs and inpatient respite care. While on the hospice program, VIVA MEDICARE members continue to be covered by VIVA HEALTH for any additional benefits our plan offers, such as routine eye exams and by traditional Medicare for care unrelated to the hospice-qualifying condition.

Hospice Eligibility Criteria

Medical coverage for hospice care is available only if:

- The patient is eligible for Medicare Part A (a requirement to be a VIVA MEDICARE member);
- The patient's doctor and the hospice medical director certify that the patient is terminally ill with a life expectancy of six months or less;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness; and
- The patient receives care from a Medicare-approved hospice program.

Hospice Care for the Terminally Ill



Hospice Providers

Hospice care can be provided by a public agency or private organization that is primarily engaged in furnishing services to terminally ill individuals and their families. To receive Medicare payment, the agency or organization must be approved by Medicare to provide hospice services.

Coverage of Hospice Services

Special benefit periods apply to hospice care. A Medicare beneficiary may elect to receive hospice care for two 90-day benefit periods, followed by a 30-day period and, when necessary, an extension period of indefinite duration. The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be certified as terminally ill at the beginning of each period.

A patient has the right to cancel hospice care at any time and return to standard Medicare or Medicare Advantage coverage, then later re-elect the hospice benefit if another benefit period is available. If a patient cancels during one of the first three benefit periods, any days left in that period are lost. For example, if a patient cancels at the end of 60 days in the first 90-day period, the remaining 30 days are forfeited. The patient is, however, still eligible for the second 90-day period, the 30-day period, and the indefinite extension. If cancellation occurs during the final period, the patient returns to standard Medicare or VIVA MEDICARE benefits and cannot use the hospice benefit again.

Besides having the right to discontinue hospice care at any time, patients also may change hospice programs once each benefit period.

Payment for Hospice Services Provided to VIVA MEDICARE Members

For services related to the terminal illness, Medicare pays the hospice directly at specified rates, depending on the type of care given each day. The patient is only responsible for:

- **Drugs or biologicals:** The hospice can charge 5% of the reasonable cost, up to a maximum of \$5, for each prescription for outpatient drugs or biologicals for pain relief and symptom management.
- **Inpatient respite care:** The hospice may periodically arrange for inpatient care for the patient to give temporary relief to the person who regularly provides care in the home. Respite care is limited each time to a stay of no more than 5 days. The patient can be charged about \$5 per day for inpatient respite care. The charge, which is subject to change each year, varies slightly depending on the geographic area of the country.

Services not covered under hospice

All services required for treatment of the terminal illness must be provided by or through the hospice. When a Medicare beneficiary chooses hospice care, Medicare will not pay for:

- Treatment for the terminal illness which is not for symptom management and pain control;
- Care provided by another hospice that was not arranged by the patient's hospice; and
- Care from another provider that duplicates care the hospice is required to furnish.

Hospice Care for the Terminally Ill



When a Medicare beneficiary chooses hospice care, they give up the right to standard Medicare or Medicare Advantage benefits, only for treatment of the terminal illness. The patient can use all appropriate Medicare Part A and Part B or Medicare Advantage benefits for the treatment of health problems unrelated to the terminal illness.

CMS pays the hospice program through the original Medicare program and subject to the usual rules of payment for hospice care furnished to the Medicare enrollee. CMS pays the provider or supplier directly for other Medicare-covered services furnished to a VIVA MEDICARE member. Other services refer to non-hospice services that are not related to the terminal illness. For example, any services provided by an attending provider to a Medicare Advantage member who has elected hospice are non-hospice services if the provider is not employed or contracted by the enrollee's hospice program. In addition, CMS pays providers directly for all Medicare-covered services a VIVA MEDICARE member gets for the remainder of the month in which the member revokes their hospice election.

Since a Medicare Advantage organization cannot bill a Fiscal Intermediary (FI), nor can an FI make payments to Medicare Advantage organizations, a Medicare Advantage provider (e.g., hospital or provider) or supplier can bill the FI or carrier directly. See the following information taken from the Medicare Claims Processing Manual, Chapter 11 Processing Hospice Claims, Section 40.2.2 – Claims From Medicare Advantage Organizations:

40.2.2 - Claims from Medicare Advantage Organizations

(Rev. 1, 10-01-03)

B3-4175.3

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b).

A - Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider or a provider treating an illness not related to the terminal condition to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit, if billed by a Medicare hospice;
2. Services of the enrollee's attending provider if the provider is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the first day of the month after the beneficiary has revoked their hospice election.

Hospice Care for the Terminally Ill



B - Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X and 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so beneficiary's medical care and payment is not disrupted.

Medicare provider may bill such services directly to carriers, as long as all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were set forth in Transmittal 1728 CR 1910 in Pub. 14-4 (Medicare Carriers Manual) effective April 2002 and specifies use of modifiers –GV and –GW. When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

Claims processed by the Medicare carrier or FI may charge the member a 20% coinsurance under regular Medicare rules. After the carrier or FI pays, those claims may be filed with VIVA MEDICARE along with the Medicare EOB. VIVA MEDICARE will pay the remainder, less the VIVA MEDICARE copay or coinsurance amounts (if applicable).

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Medicare Advantage organization enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

50 - Billing and Payment for Services Unrelated to Terminal Illness

(Rev. 1, 10-01-03)

HSP-303.2, B3-4175.2, AB-02-015

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the FI or carrier for non-hospice Medicare payment. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition" when submitted to a carrier or with condition code 07 "Treatment of Non-terminal Condition for Hospice" when submitted to an FI. Contractors process services coded with the GW modifier and "07" condition code in the normal manner for coverage and payment determinations. If warranted, contractors may conduct prepayment development or post payment review to validate that services billed with the GW modifier or "07" condition code are not related to the patient's terminal condition. See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for provider type of services) for billing rules.

The entire Medicare Claims Processing Manual can be found on the CMS web site at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

Form Instructions for the NOMNC



Instructions for completing the Notice of Medicare Non-Coverage (NOMNC) and a model NOMNC are shown below. **It is the responsibility of the contracted HHA, SNF, or CORF to issue the NOMNC.**

Instructions for completing the NOMNC can be found at:

www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Instructions-for-Notice-of-Medicare-Non-Coverage-NOMNC.pdf

{Insert provider contact information here}
Notice of Medicare Non-Coverage

Patient name:

Patient number:

The Effective Date Coverage of Your Current **{insert type}**
Services Will End: **{insert effective date}**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current **{insert type}** services after the effective date indicated above.
 - You may have to pay for any services you receive after the above date.
-

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
 - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
 - Neither Medicare nor your plan will pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
-

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: **{insert QIO name and toll-free number of QIO}** to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: 1-800-633-1542
TTY: 1-800-548-2546

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

VIVA MEDICARE Part D Prescription Drug Benefit

VIVA HEALTH uses CVS/Caremark as the Pharmacy Benefit Manager for the VIVA MEDICARE business. VIVA MEDICARE members cannot enroll in stand-alone Medicare prescription plans.

Members of Medicare Advantage plans like VIVA MEDICARE must get their Part D Medicare drug insurance from that plan. If a VIVA MEDICARE member signs up with any stand-alone Medicare prescription drug plan, their membership in VIVA MEDICARE will automatically end and they will be put back on original Medicare, which may require a Medicare supplement. This is true even if the member enrolls in our VIVA MEDICARE SELECT plan that does not include Part D prescription coverage.

The Formulary and Coverage Determinations

- The formulary (list of covered drugs) is available on our website at www.VivaHealth.com/Provider/Resources/#Formulary_Information_List. You can find the drugs that are covered in the back index. Go to the page listed for each covered drug to see its tier and applicable clinical edits (e.g. PA, BvD, ST, QL).
- Some drugs on the Medicare Part D formulary may require a coverage determination review by VIVA MEDICARE. A coverage determination is a request for coverage of a drug under Part D benefits.
- Drugs may have clinical edit designations next to them including: PA, ST, B/D, or QL.
 - PA (Prior Authorization): Clinical criteria must be met for the drug to be covered.
 - B/D (Medicare Part B versus D) The drug may be covered under Part B or D benefits.
 - ST (Step Therapy): A trial/failure of an alternate drug before that drug will be covered.
 - QL (Quantity Limit): The drug has a total daily dose limit restriction.
- Drugs not listed on the formulary are considered non-formulary.
- Exception requests for non-formulary drugs, quantity limits, and tiers require a prescriber supporting statement.
- A prescriber supporting statement must include the following information below in order for VIVA MEDICARE to render a decision on an exception request:
 - A.** Member's diagnosis(es) for use of the requested drug AND
 - B.** Address the following information depending on the type of exception request:
 - Non-Formulary: All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested non-formulary drug, and/or would have adverse effects.
 - Quantity limit: The number of doses available under a dose restriction for the requested drug has been ineffective in the treatment of the enrollee's disease or medical condition; or
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - Tier: The drugs in the applicable lower cost-sharing tier(s) would not be as effective and/or would have adverse effects. Tier exceptions are not available for Tier 5 medications/specialty medications.

Please fax our Pharmacy Department at (205) 449-2465 or complete a request online at www.VivaHealth.com/Provider/Resources/#Forms to request authorization before going to the pharmacy.

The VIVA Pharmacy Department will notify you if the coverage determination is approved, denied, or requires additional

VIVA MEDICARE Part D Prescription Drug Benefit

information before a final coverage decision is rendered by VIVA MEDICARE.

- A listing of the prior authorization criteria can be found on our website at www.VivaHealth.com/ProviderResources/#Prior_Authorization_List.

Real-Time Benefits (RTB) and Electronic Prior Authorizations (ePAs) – ONLY FOR Viva Medicare MEMBERS

- RTB is an electronic prescription decision support tool provided by CVS Health that is integrated within the prescriber’s enabled electronic health record (EHR) and workflow.
- RTB provides the member’s prescription plan information with pricing transparency at the point-of-prescribing for up to five lower-cost therapeutic alternatives and whether a prior authorization (PA) is required or other restrictions (non-formulary or quantity limits).
- Electronic prior authorization (ePA) is the electronic transmission between the prescriber and a payer to determine whether or not a medication request is granted. This process is much faster in lieu of a phone or fax request. Currently, the ePA functionality only works for Medicare Part D at VIVA HEALTH.
- For more information on RTB and ePAs, please visit this link: <https://www.VivaHealth.com/Download.aspx?ID=35672>

VIVA MEDICARE plans have the following coverage steps:

(Unless members qualify for the low-income assistance described later.)

Step One: Deductible – For 2024, all VIVA MEDICARE plans offering Part D coverage have no drug deductible.

Step Two: Initial Coverage – Members pay copayments or coinsurance for their prescription drugs. Copayments are lowest for generic drugs, more for preferred brand drugs, and the most for non-preferred drugs. Specialty drugs have a coinsurance. Coinsurance is where the member pays for a percent of the drug cost. Please see the formulary at www.VivaHealth.com/Provider/Resources/#Formulary_Information_List to determine if the drug has a copay or a coinsurance.

Step Three: Coverage gap – After total drug costs for the year reach a certain level defined by Medicare, there is a coverage gap. At this point, the member pays a percent of the costs of covered drugs until their out-of-pocket drug spending for the year reaches a certain level, also defined by Medicare (25% for generics and 25% for brands in 2024).

Step Four: Catastrophic coverage – There is \$0 copay in the Catastrophic Phase for 2024.

Biological, Biotechnical, and Injectable Drugs

VIVA HEALTH offers several specialty pharmacies to distribute covered self-administered injectable biological and biotechnical drugs to our members. These specialty pharmacies provide services to individuals with various chronic or genetic disorders such as Crohn’s Disease, Cystic Fibrosis, Hemophilia, Hepatitis C, Immune Disorders, Multiple Sclerosis, Rheumatoid Arthritis, and to members who require growth hormones or drugs for RSV Prevention.

If you have a member that needs to be enrolled, please see our pharmacy directories available at: <https://www.VivaHealth.com/Medicare/Member-Resources/#Pharmacy>

VIVA MEDICARE Part D Prescription Drug Benefit

Turn-around timeframes – Medicare Part D coverage determination & appeal requests:

| UM Edit | Type | Time Frame for VIVA MEDICARE to review |
|--|---|---|
| Prior Authorization | Expedited | 24 hrs from time received |
| | Standard | 72 hrs from time received |
| B vs D | Expedited | 24 hrs from time received |
| | Standard | 72 hrs from time received |
| Step Therapy | Expedited | 24 hrs from time received |
| | Standard | 72 hrs from time received |
| Exceptions (Formulary/QL/Tier/PA/ST) | Expedited | 24 hrs from time the prescriber supporting statement received |
| | Standard | 72 hrs from time the prescriber supporting statement received |
| | VIVA MEDICARE may pend an initial exception request for 14 calendar days to allow the prescriber to provide a supporting statement. | |
| Re-determinations (Part D Appeals) ** must be same drug, strength and w/in 60 days of denial to classify as redeterm * | Expedited | 72 hrs from time received |
| | Standard | 7 calendar days from time received |
| Hospice - may be pended like exceptions | Expedited | 24 hrs from time the prescriber supporting statement received |
| | Standard | 72 hrs from time the prescriber supporting statement received |
| Hospice Drug Classes: analgesics, antiemetics, laxatives, anxiolytics | To be covered under Part D review, the enrollee has elected hospice, the drug must be for treatment of a condition that is unrelated to the terminal prognosis of the individual. Requirements: 1) the provider or hospice provider's supporting statement 2) provider or hospice provider's signature and stated hospice diagnosis 3) verification the drug requested is unrelated to the terminal illness and related conditions. | |

VIVA MEDICARE Tried/Failed Medication Review Guidelines for Formulary and Tier Exceptions

- If there are 1-2 formulary alternatives, then the patient must have tried/failed at least 1 of these.
- If there are 3-4 formulary alternatives, then the patient must have tried/failed at least 2 of these.
- If there are 5-6 formulary alternatives, then the patient must have tried/failed at least 3 of these.
- If there are 7-8 formulary alternatives, then the patient must have tried/failed at least 4 of these.
- If there are greater than 8 formulary alternatives, then the patient must have tried/failed at least 5 of these.

Diabetic Supplies

VIVA MEDICARE members should obtain needed diabetic testing supplies through an approved diabetic supply vendor. To confirm an approved diabetic supply vendor, please contact Provider Customer Service toll free 1-800-294-7780 or 205-558-7474 or visit the VIVA MEDICARE website <https://www.VivaHealth.com/download.aspx?ID=35233&Type=doc>. Members with Part D prescription drug benefits may get standard quantities of Accu-Chek test strips and monitors as well as any brand of lancets, lancet devices and glucose control solutions at any network pharmacy that has them.

MEDICARE PART D COVERAGE DETERMINATION FORM

*** Please note any incomplete information may result in a denial ***

| Patient Information: | | Prescriber Information: | |
|--|---|---|--|
| Patient Name: | | Prescriber: | |
| Member ID #: | | Office Phone #: | |
| Date of Birth: | | Office Fax #: | |
| Phone #: | | NPI #: | |
| Address: | | Office Contact: | |
| Medication and Diagnosis Information: | | | |
| Medication: _____ | | Strength: _____ | |
| Must check one: <input type="checkbox"/> Brand <input type="checkbox"/> Generic | | Route: _____ | |
| Frequency: _____ | | Quantity: _____ | |
| If Injectable or Nebulized: where is being administered? Must check one: | | | |
| <input type="checkbox"/> Home (Self-Administered) | <input type="checkbox"/> Long-Term Care | <input type="checkbox"/> Skilled Nursing Facility | |
| <input type="checkbox"/> Provider's Stock (Buy & Bill) | <input type="checkbox"/> Provider's Office (Patient Provides) | | |
| Diagnosis: (Please attach all office notes and labs supporting diagnosis) | | | |
| Please indicate here if the drug requested is for the member receiving hospice care <input type="checkbox"/> | | | |
| If indicated, is the drug requested unrelated to the terminal illness and related conditions? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |

Request for Expedited Review:

By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member's ability to regain maximum function.

Please provide an afterhours contact and direct number: _____

Confidentiality Notice: The information transmitted with this facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message in error, please notify us immediately and destroy the related message.

View Plan Formulary, Prior Authorization and Step Therapy Criteria at:

<https://www.vivahealth.com/medicare/MemberResources/>

Exception requests require the patient to have tried and failed the following:

- ✓ 1 formulary alternative if there are 1-2 formulary alternatives available
- ✓ 2 formulary alternatives if there are 3-4 formulary alternatives available
- ✓ 3 formulary alternatives if there are 5-6 formulary alternatives available
- ✓ 4 formulary alternatives if there are 7-8 formulary alternatives available
- ✓ 5 formulary alternatives if there are greater than 8 formulary alternatives available

***** Please provide a complete supporting statement under the applicable request *****

Formulary Exception: Request for a drug that is not on the plan’s list of covered drugs. The prescriber must provide information that, given the patient’s medical condition, all covered Part D drugs on any tier of the plan’s formulary would not be as effective and/or would have adverse side effects. _____

Quantity Limit Exception: Request for an exception to the plan’s limit on the number of pills available. The prescriber must provide documentation that the restricted dose has been found to be ineffective OR based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance. _____

Tier Exception: Request for an exception to the tier level for a covered drug. The prescriber must provide documentation that the drug in the lower-cost sharing tier for the treatment of the member’s condition would not be as effective as the requested drug in the higher cost-sharing tier and/or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or for drugs approved as a formulary exception. _____

Alternative drugs tried and failed:

| | |
|----------------|----------------|
| Drug #1 | Drug #5 |
| Drug #2 | Drug #6 |
| Drug #3 | Drug #7 |
| Drug #4 | Drug #8 |

Indicate if request is due to drug supply shortage.

Prescriber or Authorized Representative Signature:

Signature: _____

Date: _____

I attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., U.S.C. §§ 3729 – 3733.



Medicare Part D Opioid Policies: Information for Prescribers

The Centers for Medicare and Medicaid Services (CMS) Medicare drug (Part D) [opioid policies](#) include **safety alerts** when opioid prescriptions are dispensed at the pharmacy and **drug management programs** for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions. Beginning in 2020, patients with sickle cell disease should be excluded from the safety edits. These policies should not impact patient access to medication-assisted treatment (MAT), such as buprenorphine.

Opioid Safety Alerts

Part D plans are expected to implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. CMS encourages prescribers to respond to pharmacists' outreach in a timely manner and give appropriate information to on-call prescribers when necessary to resolve opioid safety edits expeditiously and avoid disruption of therapy.

| Opioid Safety Alert | Prescriber's Role |
|--|--|
| <p>Seven-day supply limit for opioid naïve patients (“hard edit”)</p> <p>Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days) will be limited to a supply of 7 days or less.</p> <p><u>Important Note:</u> <i>This alert should not impact patients who already take opioids. If a patient switches drug plans, the new plan may not know their current prescription information.</i></p> | <p>Patient may receive up to a 7 days supply or request a coverage determination for full days supply as written.</p> <p>The provider or other prescriber has the right to request a coverage determination on patient's behalf, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.</p> <p>Prescriber only needs to attest to plan that the days supply is the intended and medically necessary amount.</p> <p>Subsequent prescriptions filled within the plan's look back window are not subject to the 7 days supply limit, as the patient will no longer be considered opioid naïve.</p> |
| <p>Opioid care coordination alert at 90 morphine milligram equivalent (MME)</p> <p>This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative MME per day across all of their opioid prescription(s) reaches or exceeds 90 MME.</p> <p><i>Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.</i></p> <p>The prescriber will be contacted to resolve the alerts and to be informed of other opioid prescribers or increasing level (MME) of opioids.</p> | <p>Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater.</p> <p>The prescriber who writes the prescription whose daily dose prompts the alert will be contacted even if that prescription itself is below the 90 MME threshold.</p> <p>Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on every subsequent opioid prescription written for the same patient unless the plan implements further restrictions.</p> |

| | |
|--|---|
| <p><u>Important Note:</u> <i>This is not a prescribing limit.</i> Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.</p> | <p>On the patient’s behalf, the provider or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.</p> |
| <p>Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy (“soft edits”)</p> <p>The alerts will trigger when opioids and benzodiazepines are taken concurrently or if on multiple duplicate long-acting opioids.</p> | <p>The pharmacist will conduct additional safety reviews to determine if the patient’s opioid use is safe and clinically appropriate. The prescriber may be contacted.</p> |
| <p>Optional Safety Alert at 200 MME or more (“hard edit”)</p> <p>Some plans may implement a hard safety alert when a patient’s cumulative opioid daily dosage reaches 200 MME or more.</p> <p><i>Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.</i></p> <p><u>Important Note:</u> <i>This is not a prescribing limit.</i> Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber.</p> | <p>This alert stops the pharmacy from processing the prescription until an override is entered or authorized by the plan.</p> <p>On the patient’s behalf, the provider or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.</p> <p>In the absence of other approved utilization management requirements, once the prescriber(s) attests that the identified cumulative MME level is the intended and medically necessary amount, the medication will be dispensed to the patient.</p> |

Drug Management Programs (DMPs)

Medicare Part D plans have a DMP that limits access to opioids and benzodiazepines for patients who are considered to be at-risk by the plan for prescription drug abuse or misuse. The goal of a DMP is better care coordination for safer use. Patients are identified for the program by opioid use involving multiple doctors and pharmacies, and undergo case management conducted by the plan with the patients’ prescribers.

Coverage limitations under a DMP can include requiring the patient to obtain these medications from a specified prescriber and/or pharmacy, or implementing an individualized POS edit that limits the amount of these medications that will be covered for the patient. The coverage limitation tools may be put in place for 12 months and extended for an additional 12 months (total of 24 months).

After the plan conducts case management with prescribers, and before implementing a coverage limitation tool, the plan will notify the patient in writing. Plans are required to make reasonable efforts to send the prescriber a copy of the letter. After this 30 day time period, if the plan determines based on its review that the patient is at-risk and implements a limitation, it must send the patient a second written notice confirming the specific limitation and its duration.

If the plan decides to limit coverage under a DMP, the patient and their prescriber have the right to appeal the plan’s decision. The patient or prescriber should contact the plan for additional information on how to appeal.

The plan does not include the following in its DMP: Patients in long-term care facilities, those getting hospice, palliative, or end-of-life care, those with sickle cell disease, or those being treated for active cancer-related pain.

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Glucagon-like Peptide (GLP-1) Drugs

- **Medicare Part D allows coverage of GLP-1 drugs for a medically-accepted indication.** Type 2 Diabetes Mellitus is a medically accepted indication for the below listing of GLP-1 drugs. Fatty Liver Disease is included as a medically accepted indication for Victoza. Nonalcoholic steatohepatitis (NASH) is included as a medically accepted indication for Ozempic.
 - Metabolic syndrome, obesity, pre-diabetes, and weight loss are **not** coverable conditions under Medicare Part D.
- GLP-1 drugs:
 - Bydureon BCise
 - Rybelsus
 - Ozempic
 - Adylinx
 - Byetta
 - Trulicity
 - Victoza

Inflation Reduction Act changes for 2024

- Insulin coverage
 - Maximum of \$35 copay for 1 month supply of Insulins covered under Part B or Part D.
 - If the member receives a low-income subsidy and pays the LICs copay, the member would still pay that amount when less than \$35.
 - Members with SNP (JEF212 and JEF219) benefits will pay a zero copay for Part D covered insulins.
- Vaccine coverage
 - Most Part D covered vaccines will have a zero dollar member cost. The listing of covered vaccines will be reviewed periodically and updated based on recommendations from the Advisory Committee on Immunization Practices (ACIP).
 - Vaccines for COVID-19, Pneumonia, or Flu will have a zero dollar member cost under Part B.
 - Part D vaccines include:
 - Hepatitis A
 - Hepatitis A and Hepatitis B
 - Hepatitis B*
 - Human papillomavirus (HPV)[†]
 - Measles, mumps, and rubella (MMR)
 - Meningococcal
 - Respiratory Syncytial Virus (RSV) (only age 60 and older)
 - Tetanus and diphtheria toxoids*
 - Tetanus and diphtheria toxoids and acellular pertussis
 - Varicella (chickenpox)
 - Zoster (shingles)

* May require a Part B vs Part D coverage determination. For Hepatitis B or Tetanus/diphtheria toxoid vaccines covered under Part B, the member will have a zero copay or 20% co-insurance based on their VIVA benefit plan package.

[†] Zero cost share is applicable for adults aged 19 through 45

2024 VIVA MEDICARE Pharmacy Reference Guide

CMS Opioid Safety Alert Guidelines

The following are some of the Medicare Opioid Safety Alerts that might cause a delay in your patients filling their opioid or benzodiazepine medications at the pharmacy:

- **7-day supply limit for opioid naïve patients**
 - This alert may occur at the pharmacy for patients who have enrolled in a new plan that does not have the patient's opioid prescription history.
 - Once a patient fills an initial opioid prescription, subsequent prescriptions filled within a 90-day lookback window are not subject to the 7-day limit.
 - If there is a gap greater than 90 days between opioid prescription fills, this restarts the 7-day opioid naïve supply limit alert.
- **Opioid care coordination alert at 90 morphine milligram equivalent (MME)**
 - This alert may occur when a patient's cumulative MME per day for all of their opioid prescriptions reaches or exceeds 90 MME.
- **Concurrent Use of Opioids and Benzodiazepines**
 - This alert may occur when a patient fills opioids and benzodiazepines concurrently.
- **Concurrent Use of Duplicate Long-Acting Opioids**
 - This alert may occur when a patient fills multiple long-acting opioids.

Prior Authorization and Quantity Limitation restrictions may also apply to an opioid or benzodiazepine. You may request a coverage determination from VIVA for any of the above safety alerts that apply to your patients.

The VIVA MEDICARE formulary can be accessed online at:

<https://www.vivahealth.com/Medicare/Member-Resources/#Formularies>

Website References:

<https://www.cms.gov/files/document/mln2886155-prescribers-guide-medicare-prescription-drug-part-d-opioid-policies.pdf>

<https://opioidremseducation.com/>

alabamaoti.org

Member's Rights & Responsibilities



VIVA HEALTH recognizes certain member rights and responsibilities related to the health care they receive through our organization. Please take a minute to review the rights and responsibilities listed in the member's VIVA MEDICARE Evidence of Coverage. We ask that you keep these in mind when treating our members.

Section 1 - Our plan must honor our members' rights and their cultural sensitivities as members of the plan

Section 1.1 - We must provide information in a way that works for our members and that is consistent with their cultural sensitivities (in languages other than English, in audio or large print, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give information in large print, or other alternate formats at no cost if needed. We are required to give members information about the plan's benefits in a format that is accessible and appropriate. Members can call Member Services to get information from us in a way that works best for them.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide the necessary care. In this case, members will only pay in-network cost sharing. If members find themselves in a situation where there are no specialists in the plan's network that cover a needed service, they should call the plan for information on where to go to obtain this service at in-network cost sharing.

If members have any trouble getting information from our plan in a format that is accessible and appropriate, seeing women's health specialists, or finding a network specialist, they should call to file a grievance with Member Services (phone numbers are printed on the back cover of this document). Members may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 - We must ensure that members get timely access to covered services and drugs

Members have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and help arrange for covered services. We do not require referrals from a PCP before members see network specialists in their selected Provider System.

Members have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when needed. Members also have the right to get prescriptions filled or refilled at any of our network pharmacies without long delays.

If members think they are not getting medical care or Part D drugs within a reasonable amount of time, they should call Member Services.

Member's Rights & Responsibilities



Section 1.3 - We must protect the privacy of personal health information

Federal and state laws protect the privacy of medical records and personal health information. We protect personal health information as required by these laws.

- Personal health information includes the personal information provided to us by members when they enrolled in this plan as well as medical records and other medical and health information.
- Members have rights related to information and controlling how their health information is used. We provide a written notice to our members, called a “Notice of Health Information Practices,” that tells about these rights and explains how we protect the privacy of health information.

How do we protect the privacy of health information?

- We make sure that unauthorized people don't see or change records.
- Except for the circumstances noted below, if we intend to give health information to anyone who is not providing the member's care, or paying for the care, *we are required to first get written permission from the member or someone legally authorized to make decisions on behalf of the member.*
- There are certain exceptions that do not require us to get a member's written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - We are required to give Medicare our Medicare Advantage members' health information including information about Part D prescription drugs. If Medicare releases the information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies a member is not shared.

Members can see the information in their records and know how it has been shared with others.

Members have the right to look at their medical records held by the plan, and to get a copy of the records. We are allowed to charge a fee for making the copies. Members also have the right to ask us to make additions or corrections to their medical records. If members ask us to do this, we will work with appropriate healthcare providers to decide whether the changes should be made.

Members have the right to know how their health information has been shared with others for any purposes that are not routine.

Members should call Member Services if they have questions or concerns about the privacy of their personal health information.

Section 1.4 - We must give members information about the plan, our network of providers, and covered services

As a member of VIVA MEDICARE, members have the right to get several kinds of information from us. If members want any of the following kinds of information, they can call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

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- **Information about our network providers and pharmacies.** Members have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about plan coverage and the rules members must follow when using the coverage.** Chapters 3 and 4 of the plan's *Evidence of Coverage* provide information regarding medical services. Chapters 5 and 6 of the *Evidence of Coverage* provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what members can do about it.** Chapter 9 of the *Evidence of Coverage* provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 - We must support members' rights to make decisions about their care

Members have the right to know their treatment options and participate in decisions about their health care.

Members have the right to get full information from their doctors and other health care providers. Plan providers must explain a member's medical condition and treatment choices *in a way that the member can understand*.

Members also have the right to participate fully in decisions about their health care. To help members make decisions with doctors about what treatment is best, members' rights include the following:

- **To know about all of their choices.** Members have the right to be informed about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our plan. It also includes being informed about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** Members have the right to be informed about any risks involved in their care. Members must be informed in advance if any proposed medical care or treatment is part of a research experiment. Members always have the choice to refuse any experimental treatments.
- **The right to say "no."** Members have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. Members also have the right to stop taking their medication. Of course, if members refuse treatment or stop taking medication, they accept full responsibility for what happens to their body as a result.

Members have the right to give instructions about what is to be done if they are not able to make medical decisions for themselves

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. Members have the right to say what they want to happen if they are in this situation. This means that, *if they want to*, they can:

- Fill out a written form to give **someone the legal authority to make medical decisions for them** if they ever become unable to make decisions for themselves.
- **Give their doctors written instructions** about how they want medical care handled if they become unable to make decisions for themselves.

The legal documents that members can use to give directions in advance of these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**"

Member's Rights & Responsibilities



and “**power of attorney for health care**” are examples of advance directives.

If members want to use an “advance directive” to give instructions, here is what they should do:

- **Get the form.** They can get an advance directive form from a lawyer, from a social worker, or from some office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare. Members can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where the form is obtained, it is considered a legal document. Members should consider having a lawyer help prepare it.
- **Give copies to appropriate people.** Members should give a copy of the form to their doctor and to the person they name on the form who can make decisions for them if they no longer can do so. They may want to give copies to close friends or family members and they should keep a copy at home.

If members know ahead of time that they are going to be hospitalized, and they have signed an advance directive, they should **take a copy with them to the hospital.**

- The hospital will ask whether members have signed an advance directive form and whether they have it with them.
- If they have not signed an advance directive form, the hospital has forms available and will ask if they want to sign one.

Remember, it is a member's choice whether or not to fill out an advance directive (including whether a member wants to sign one if the member is in the hospital). According to law, no one can deny care or discriminate against someone based on whether or not the person has signed an advance directive.

What if the member's instructions are not followed?

If a member has signed an advance directive, and a doctor or hospital did not follow the instructions in it, the member may file a complaint with the Alabama Board of Medical Examiners at 1-800-227-2606.

Section 1.6 – Members have the right to make complaints and to ask us to reconsider decisions we have made

If members have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of the *Evidence of Coverage* tells what actions members can take. Whatever members do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat them fairly.**

Section 1.7 - What can members do if they believe they are being treated unfairly or their rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If members believe they have been treated unfairly or their rights have not been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, they should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users should call 1-800-537-7697). They can also call their local Office for Civil Rights.

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Is it about something else?

If members believe they have been treated unfairly or their rights have not been respected, *and* it is *not* about discrimination, they can get help dealing with the problem they are having:

- They can call **Member Services**.
- They can call **the SHIP**. For details, go to Chapter 2, Section 3 of the plan's *Evidence of Coverage*.
- Or, they can call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 - How to get more information about their rights

There are several places where members can get more information about their rights:

- They can call **Member Services**.
- They can call **the SHIP**. For details, go to Chapter 2, Section 3 of the plan's *Evidence of Coverage*.
- They can **contact Medicare**.
 - They can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, they can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 – Members have some responsibilities as a member of the plan

Things members need to do as a member of the plan are listed below. If members have any questions, they should call Member Services.

- **Get familiar with their covered services and the rules they must follow to get these covered services.** Use the plan's *Evidence of Coverage* to learn what is covered and the rules that must be followed to get covered services.
 - Chapters 3 and 4 of the *Evidence of Coverage* give the details about medical services.
 - Chapters 5 and 6 of the *Evidence of Coverage* give the details about Part D prescription drug coverage.
- **If members have any other health insurance coverage or prescription drug coverage in addition to our plan, they are required to tell us.**
- **Members should tell their doctor and other health care providers that they are enrolled in our plan.** They should show their plan membership card whenever getting medical care or Part D prescription drugs.
- **Help their doctors and other providers help them by giving them information, asking questions, and following through on their care.**
 - To help get the best care, they should tell doctors and other health providers about their health problems and follow the treatment plans and instructions agreed upon with their doctors.
 - Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements.
 - If they have any questions, be sure to ask and get answers they can understand.

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- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what they owe.** As a plan member, they are responsible for these payments:
 - They must pay their plan premiums, if applicable.
 - They must continue to pay a premium for their Medicare Part B to remain a member of the plan.
 - For most of their medical services or drugs covered by the plan, they must pay their share of the cost when getting the service or drug.
 - If they are required to pay a late enrollment penalty, they must pay the penalty to keep prescription drug coverage.
 - If they are required to pay the extra amount for Part D because of their yearly income, they must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If they move *within* our plan service area, we need to know** so we can keep their membership record up-to-date and know how to contact them.
- **If they move *outside* of our plan service area, they cannot remain a member of our plan.**
- If they move, it is also important to tell Social Security (or the Railroad Retirement Board).



TRUSTED AND PROVEN

We're located right here in Alabama. When your office calls VIVA HEALTH, you will talk to a plan representative located here at home, not in another state or overseas.

Complaints, Grievances, Appeals & QIO Review



It is VIVA HEALTH's intention to provide prompt and equitable solutions to any concerns that VIVA MEDICARE members may have. VIVA HEALTH is responsible for examining the concern from a VIVA MEDICARE member and determining which procedure is appropriate for processing. There are two types of procedures for addressing member concerns: the grievance process and the Medicare appeals process. There is also a special review process available from the local Quality Improvement Organization (QIO) for hospital inpatient, Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Comprehensive Outpatient Rehabilitation Facility (CORF) discharge decisions.

Grievance Process For VIVA MEDICARE Members:

The Grievance Process is utilized for all concerns that do not qualify as appeals under the Medicare appeals process. Examples may include, but are not limited to the following:

- Quality of care or services
- Wait times for appointments and in the provider's office
- Provider or office staff demeanor and behavior
- A decision by VIVA HEALTH not to expedite a member's appeal

For concerns that do not qualify as appeals, the grievance process for VIVA MEDICARE members is much the same as the complaint process for VIVA HEALTH employer-group members:

Grievance

A member may file a grievance either verbally to the Member Services Department or in writing to the Appeals and Grievances Department within 60 days of the event in question. VIVA HEALTH will respond no later than 30 days from receipt of the grievance. VIVA HEALTH may extend the 30-day time frame by up to 14 days if 1) the member requests the extension or 2) VIVA HEALTH justifies a need for additional information that could benefit the member. If an extension is made, the member is notified in writing.

If a member disputes VIVA HEALTH's refusal to do an expedited review of a coverage determination or appeal, or the decision to take a 14-day extension, VIVA HEALTH will respond within 24 hours from receipt of the member's dispute.

The member is notified of the response in writing.

Medicare Appeals Process:

When a member's concern is classified as an appeal and filed by an appropriate party, VIVA HEALTH will process the appeal in accordance with CMS regulations. The Medicare appeals procedure addresses the concerns of a member who is dissatisfied with a decision of VIVA HEALTH not to pay for or arrange for services or supplies that a member feels should be covered under their benefit contract. This includes denied emergency services, post-stabilization care, urgently needed services, services denied or refused due to failure to secure a referral or prior authorization from a non-contracted provider, payments denied because services were rendered by a non-contracted provider, and reductions in or discontinuation of services. This policy applies to coverage concerns whether the service has already been received or is yet to be received. **This policy DOES NOT apply to Medicare Part D prescription drug benefit.** Please see the section of this manual that addresses the Part D Appeals Procedure.

Complaints, Grievances, Appeals & QIO Review



Depending on the nature of the situation, an appeal may be classified as either a standard appeal or an expedited appeal. The difference between the two types of appeals is described below.

1. **Standard Appeal.** An appeal of a coverage decision for services the member has already received or services the member has not yet received but the timing of which is not significant to the life or health of the member or the member's ability to regain maximum function.
2. **Expedited Appeal.** An appeal of a coverage decision for services the member has not yet received and the timing of which is deemed by VIVA HEALTH or a provider acting on behalf of the member to be significant to the life or health of the member or the member's ability to regain maximum function. Because of the time sensitive nature of expedited appeals, the time frames for processing expedited appeals are shorter and some of the notices normally required in writing may be made verbally. The party filing the appeal must request an "expedited" or "fast" appeal.

Procedure:

The steps for processing a standard appeal are listed below. Below each step in italics are any differences required for an expedited appeal.

- I. VIVA HEALTH will provide the member a written notice of its adverse organization determination within sixty (60) calendar days of an initial request for payment of a claim and within fourteen (14) calendar days of an initial request for provision of services or as quickly as the member's health requires. The member notice will state VIVA HEALTH's denial decision and specific reasons for the determination. This notice will also include the member's right to appeal.
- II. The member must file a written appeal within sixty (60) days (unless there is good cause for an extension) from the date the member receives notice of VIVA HEALTH's adverse organization determination.

For expedited appeals, the member's reconsideration request may be made verbally.

- III. Someone not involved in making the initial organization determination will review the reconsideration request and issue the member a written notice. If the appeal involves a request for payment, the notice will be issued within sixty (60) calendar days. If the appeal involves a request for services, the notice will be issued as quickly as the member's health condition requires and within thirty (30) calendar days, unless up to a fourteen (14) day extension is requested by the member or is needed by VIVA HEALTH to gather additional information that may benefit the member. VIVA HEALTH must include written justification of any extension in the case file. The member will be given reasonable opportunity to submit evidence and other relevant information regarding the appeal in person or in writing. VIVA HEALTH's decision notice will state the decision and specific reasons for the reconsideration determination. VIVA HEALTH may decide to grant the request and pay for or provide the services in question. If, however, VIVA HEALTH upholds its adverse organization determination in whole or in part, then the member's case will be forwarded to a CMS designated contractor for review. In this case, VIVA HEALTH will concurrently notify the member of its action.

For expedited appeals, VIVA HEALTH will issue its determination as quickly as the member's health condition requires and within seventy-two (72) hours unless an extension of up to fourteen (14) days is requested by the member or if VIVA HEALTH finds that additional information is needed and the delay is in the interest of the member. VIVA HEALTH must include written justification of any extension in the case file. If VIVA HEALTH upholds its adverse decision, in whole or in part, it will forward the case to the CMS contractor within 24 hours.

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- IV. The CMS designated contractor will re-review the case and will issue a written notice of its determination directly to the member and VIVA HEALTH. If the CMS contractor overturns VIVA HEALTH's decision, VIVA HEALTH will authorize a standard service within 72 hours from the date the plan receives notice or makes plans to provide the service within 14 days, will make a claim payment within 30 days from the date of the notice, or will authorize expedited service within 72 hours or earlier if the member's health requires. If the CMS contractor upholds VIVA HEALTH's decision, the member may appeal further as described below.

For Expedited Appeals the CMS contractor will re-review the case within seventy-two (72) hours under an expedited process for time-sensitive situations. If the CMS contractor overturns VIVA HEALTH's decision, VIVA HEALTH will authorize the services under dispute immediately.

- V. If the member is dissatisfied with the CMS contractor's decision and the amount in controversy is over the minimum requirements set by CMS, the member or their representative may ask the CMS contractor to forward the appeal for a review by an administrative law judge. An administrative law judge of the Social Security Administration will conduct a hearing.
- VI. The member, the member's representative, or VIVA HEALTH may appeal the administrative law judge's decision to the Departmental Appeals Board.
- VII. If the amount in controversy is over the minimum requirements set by CMS, any of the parties may request judicial review by the Federal District Court.

Quality Improvement Organization (QIO) Review Of Inpatient Discharge Decisions:

VIVA MEDICARE members who feel they are being asked to leave the hospital too soon have the right to request that KEPRO, the Quality Improvement Organization (QIO) contracted by CMS, conduct an immediate review. Hospitals are required to issue the "Important Message from Medicare" at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.

Hospitals may deliver the initial copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission. If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior. Members that dispute their discharge date have until midnight the day of discharge to contact the QIO. The notice instructs the member on how to contact the QIO for a review.

If the member requests a QIO review, VIVA HEALTH continues to pay for the member's inpatient stay while the QIO review is conducted. If the QIO authorizes additional inpatient days, VIVA HEALTH is financially responsible for covering the additional days authorized by the QIO. If the QIO agrees with VIVA HEALTH's discharge decision, the member becomes financially liable for the cost of the continued inpatient services at noon of the day following the member's receipt of the QIO's decision. For example, the hospital issues the "Important Message from Medicare" on a Monday and the member's discharge date is Wednesday. The member has until midnight Wednesday to contact the QIO. The QIO reviews the case and issues its decision on Thursday. If the QIO agrees with VIVA HEALTH, VIVA HEALTH must continue to pay for the inpatient services from Monday through noon on Friday. If the QIO disagrees with VIVA HEALTH and finds that one (1) additional inpatient day is medically necessary, VIVA HEALTH must pay for the inpatient services from Monday through

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noon on Friday plus the additional day authorized by the QIO.

If the QIO agrees with VIVA HEALTH's discharge decision, the member may request a reconsideration of the QIO's initial decision. However, the member is financially liable for the cost of inpatient care during the QIO's reconsideration review unless the QIO reverses its initial decision. If the member exercises the right to QIO review, the QIO's decision is binding and the member may not file an appeal with VIVA HEALTH. If the member does not exercise the right to QIO review the member may file an expedited appeal with VIVA HEALTH which will be processed according to the Medicare appeals process described previously.

Quality Improvement Organization (QIO) Review Of Skilled Nursing Facility (SNF), Home Health Agency (HHA) Or Comprehensive Outpatient Rehabilitation Facility (CORF) Discharge Decisions:

VIVA MEDICARE members who feel their SNF, HHA or CORF services are ending too soon have the right to request that KEPRO conduct an immediate review.

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities are responsible for delivering a "Notice of Medicare Non-Coverage" (NOMNC) to VIVA MEDICARE members no later than 2 days before the termination of services. This notice fulfills the CMS requirement at 42 CFR 422.624(b) (2) of the Federal Register. See pages 95-97 for instructions for the "Notice of Medicare Non-Coverage" (NOMNC) as well as a copy of the CMS-approved form that must be used.

If KEPRO reviews the case, it will first look at the member's medical information. Then it will give an opinion about whether it is medically appropriate for the member's services to be terminated on the date that has been set. KEPRO will make this decision within one full day after it receives the information it needs to make a decision.

If KEPRO decides that the decision to terminate, services coverage was medically appropriate, the member will be responsible for paying the SNF, home health, or CORF charges after the termination date on the advance notice.

If KEPRO agrees with the member, then VIVA MEDICARE will continue to cover the SNF, home health or CORF services for as long as medically necessary.

If the member doesn't ask KEPRO for a review by the deadline, the member may still ask VIVA MEDICARE for a "fast appeal."



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