2026 Provider Manual

VIVA HEALTH® VIVA MEDICARE

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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Disclaimer: As a VIVA HEALTH Provider and/or a VIVA MEDICARE Provider you are legally required to comply with the content of this Provider Manual in accordance with your provider contract.

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

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

Faxing authorization requests will be decommissioned effective 3/31/2026. Authorization requests may be entered online by using the VIVA HEALTH Provider Portal as described on page 27 of this Provider Manual.

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) 558-7445 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.

Credentialing and Contracting

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

(205) 558-7474

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

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.

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 or address on the right.

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

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
- Medicare Part D Redeterminations (appeals)

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

Electronic Prior Authorization (ePA) submission now available for both Commercial and Medicare. Prescribers can access ePA via the Cover-My-Meds portal or Surescripts, which are integrated with many electronic health records (EHR) vendors and our new ePA databases.

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

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

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

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

Introduction to VIVA HEALTH

Who We Are:

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.

Extensive Provider Network:

VIVA HEALTH's extensive network includes many of the finest providers and health care facilities throughout the state. In addition to 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 offer a complete continuum of care.

Our Primary Care Providers (PCPs) 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 our network providers the opportunity to voice how VIVA HEALTH is managed through various committees including the Utilization Management/Quality Improvement Committee, Credentialing Committee, and Pharmacy and Therapeutic Committee. Valuable suggestions and feedback are always welcomed. Provider feedback helps ensure that we never waiver from our commitment to provide high-quality health care for our members.

Core Values:

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

Commercial 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 27.

All VIVA HEALTH products require members to utilize participating providers for services to be covered except in emergency situations and/or for urgently needed care when traveling. Some products limit members to sub-networks called Provider Systems within the VIVA HEALTH network of participating providers. All VIVA HEALTH 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

Small Group Plans

VIVA HEALTH's open access plans for small businesses allow members to seek care from any participating specialist in the network without first obtaining a Primary Care Provider (PCP) referral. Members are not required to select a PCP. However, certain services may require prior authorization by VIVA HEALTH. This is a simple copayment or coinsurance system for members when visiting a VIVA HEALTH participating provider. As a managed care product, our plans are designed to involve members in controlling health care costs through the use of financial incentives to encourage members to make cost-effective choices. This product is available through six different plan benefit offerings: Platinum, Gold, Silver Plus, Silver, Silver Lite, and Bronze HSA.

Large 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.

Even on plans where the employee has the ability to visit any physician within the network without a referral, certain services require prior authorization by VIVA HEALTH. The VIVA HEALTH participating provider should request prior authorization from VIVA HEALTH prior to delivering the service or supply.

Commercial PY 2026 Provider Access Matrix

VIVA HEALTH®

PY 2026 Provider Access Matrix *(Updated 10/23/2025)*

Commercial Group	General Network	Podiatry	Optometry	Opthamology	Pain Mgmt	Dermatology	Rheumatology	Allergy & Immunology	Endocrinology	Chiro	Mental Health	OB/GYN	Peds
Med West[1] (UAMW & MWHD)	Closed	Open	Open	Open	Open	UAB Only	UAB Only	Open	UAB Only	Open	Open	Open	Open
Montgomery Baptist[2] (MONT & MON3)	Closed	Open	Open	Open	Open	Closed	Closed	Open	UAB Only	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	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 and UAB Medicine Enterprise	Open (but tiered)	This Plan's tiered provider network includes the physicians associated with the UAB network on Tier 1 and the remainder of the entire VIVA HEALTH (VIVA) network on Tier 2. The UAB network includes all pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA network or the UAB network. The VIVA 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 Kirklin Clinic of UAB Hospital, UAB Spain Rehabilitation Center, UAB Callahan Eye Hospital, UAB St Vincent's, Medical West, and all UAB satellite clinics.											
HCAA-RMC	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 Kirklin 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.											
Triton Health (TRI2)	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 Kirklin Clinic of UAB Hospital, Medical West, UAB Callahan Eye Hospital, UAB St. Vincent's, UAB Spain Rehabilitation Center, all UAB satellite clinics, and Children's Hospital.											
UAB St. Vincent's	Open (but tiered)	This Plan's tiered provider network includes the physicians associated with the UAB/UAB St. Vincent's network on Tier 1 and the remainder of the entire VIVA HEALTH (VIVA) network on Tier 2. "UAB/UAB St. Vincent's Network" means University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, UAB St. Vincent's, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, and all UAB and UAB St. Vincent's satellite clinics. The UAB and UAB St. Vincent's network includes all pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA network or the UAB and UAB St. Vincent's network. The VIVA network includes hospitals and health centers contracted with VIVA HEALTH but outside of UAB and UAB St. Vincent's.											
UAB Post-Doctoral	Open	Needs referral for specialists for subscribers and dependents, except for vision and OB/GYN.											

[1] **Med West:** All providers who admit to Med West & UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, UAB St. Vincent's, and all UAB satellite clinics.

[2] **Montgomery 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 Kirklin 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.

[3] **VIVA 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.

To view the Commerical PY2026 Provider Access Matrix in landscape orientation, please visit:
https://www.vivahealth.com/provider/manual/ and click "Provider Access Matrix."

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 no premium and higher out-of-pocket costs to a plan with a monthly premium but lower out-of-pocket costs. Plans such as VIVA MEDICARE *Extra Value* (HMO SNP) and VIVA MEDICARE *Extra Care* (HMO SNP) 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. For VIVA MEDICARE members, the information provided regarding VIVA MEDICARE supersedes the information found elsewhere in the provider manual. If an item is not addressed specifically for VIVA MEDICARE members, 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.

VIVA MEDICARE 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 meets 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.

VIVA MEDICARE Product Highlights

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 on pages 15-18. 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.

It is the responsibility of the provider to verify the eligibility of the cardholder. Please contact the VIVA HEALTH 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.vivaproviders.com.

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 a plan with an additional monthly premium which offer lower out-of-pocket costs and 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 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.

VIVA MEDICARE Product Highlights

Member Complaints/Grievances and Appeals

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

1. 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.
2. 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.
3. The VIVA MEDICARE Grievance Process is for all other complaints including complaints about the quality of care or service received.

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.
- ***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 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 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 *Infirmary Health Advantage* Closed Provider System: In partnership with Infirmary Health, VIVA MEDICARE offers the *Infirmary 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 *Infirmary Health Advantage* closed provider system. Members do 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	*UAB	Infirmary Health	Huntsville (NAMCI)
General Network	**Open**	Limited	Limited
Podiatrist	**Open**	Limited	**Open**
Optometry	**Open**	**Open**	**Open**
Ophthalmology	**Open**	**Open**	**Open**
Pain Management	**Open**	Limited	**Open**
Dermatology	**Open**	**Open**	**Open**
Rheumatology	**Open**	Limited	**Open**
Allergy & Immunology	**Open**	**Open**	**Open**
Endocrinology	**Open**	Limited	**Open**
Chiropractor	**Open**	**Open**	**Open**
Mental Health	**Open**	**Open**	NAMCI
Oral Maxillofacial Surgery	**Open**	**Open**	**Open**
Dermatopathology	**Open**	**Open**	**Open**
Physical Medicine & Rehabilitation	**Open**	Limited	**Open**

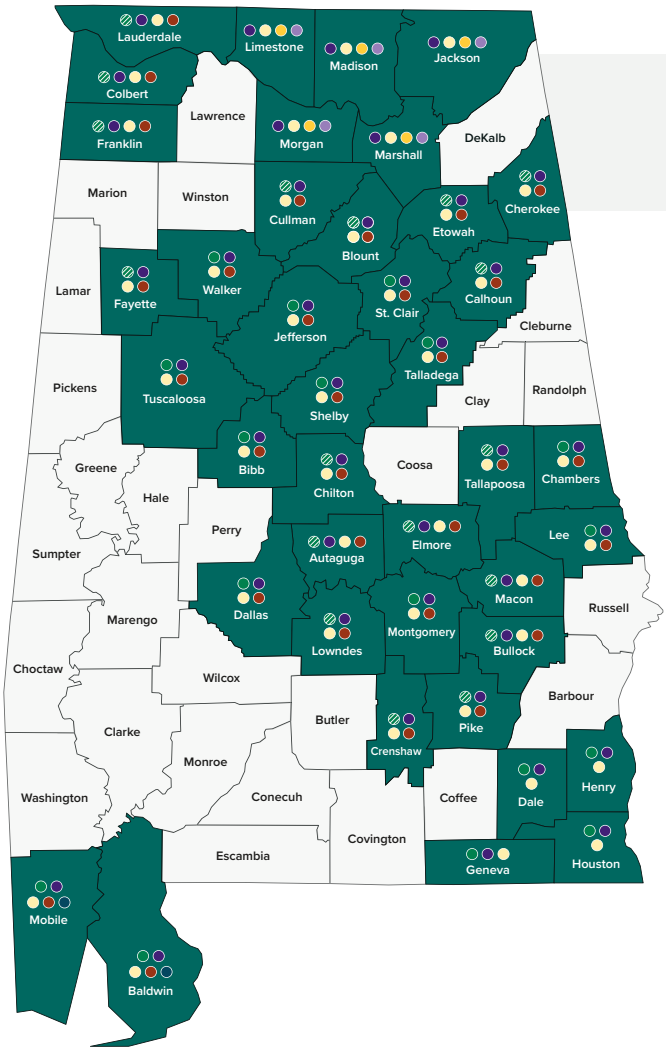
*VIVA MEDICARE members who have selected a PCP in the UAB provider system will be able to see specialists affiliated with any Medical West and UAB St. Vincent's hospital systems. The member's ID cards will reflect this network change and will have a green stripe. The member does not require a referral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

Medicare Advantage 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, Bibb, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, Dallas, 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, and 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

2026 Plan Service Area

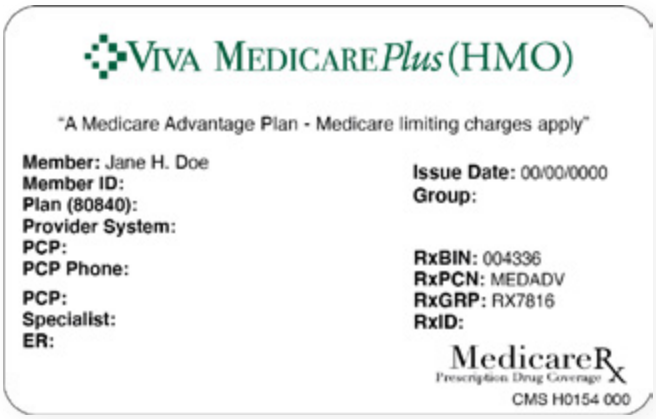
- VIVA MEDICARE *Plus* — **$20** Part B Premium Buy-Down, **$0** Premium
- VIVA MEDICARE *Plus* — **$2** Part B Premium Buy-Down, **$0** Premium
- VIVA MEDICARE *Premier* — **$99** Premium
- VIVA MEDICARE *Select* — **$65** Part B Premium Buy-Down, **$0** Premium
- VIVA MEDICARE *Extra Value* — **$0** Premium
- VIVA MEDICARE *Classic* — **$2** Part B Premium Buy-Down, **$0** Premium
- VIVA MEDICARE *Extra Care* — **$0** Premium
- VIVA MEDICARE *Infirmary Health Advantage* — **$25** Part B Premium Buy-Down, **$0** Premium

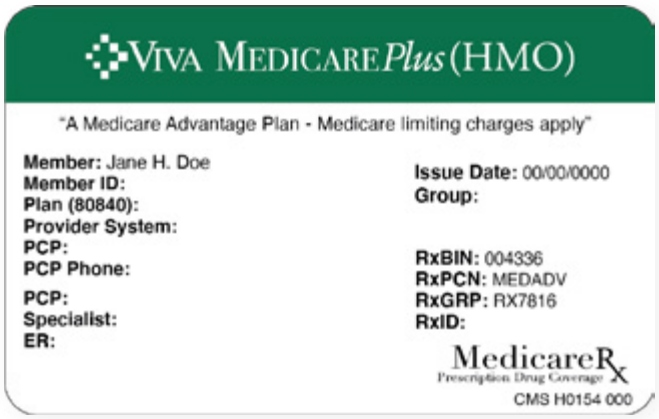
2026 VIVA MEDICARE Plans

Below is a brief overview of the 7 Medicare Advantage plans offered by VIVA MEDICARE in 2026. To be eligible for VIVA MEDICARE, members must still pay their Part B premium to Medicare.

VIVA MEDICARE *Plus* (HMO)*

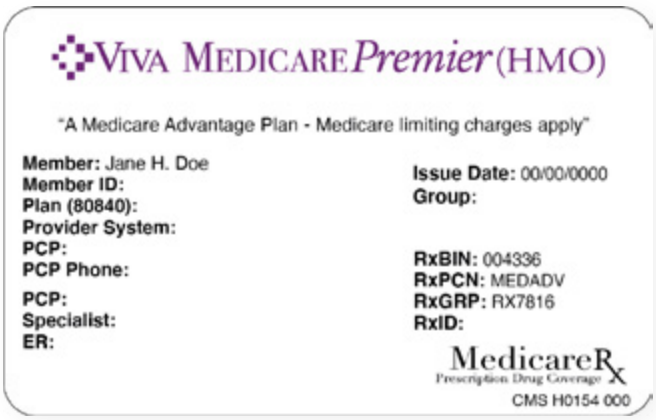
- Includes both medical and Part D prescription drug coverage for a $0 monthly premium.

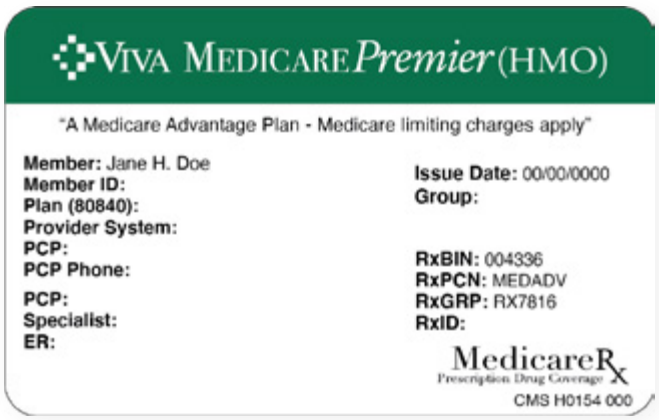




VIVA MEDICARE *Premier* (HMO)*

- For an additional monthly premium of $99, 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.



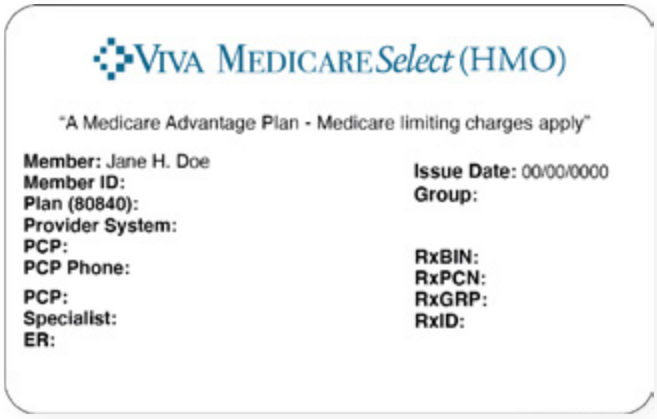


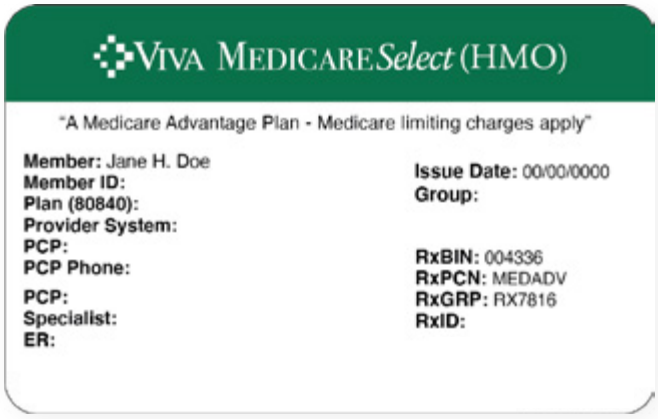
**A green stripe at the top of the card indicates that the member has a Primary Care Provider in the UAB Hospital System.*

2026 Viva Medicare Plans

Viva Medicare *Select* (HMO)*

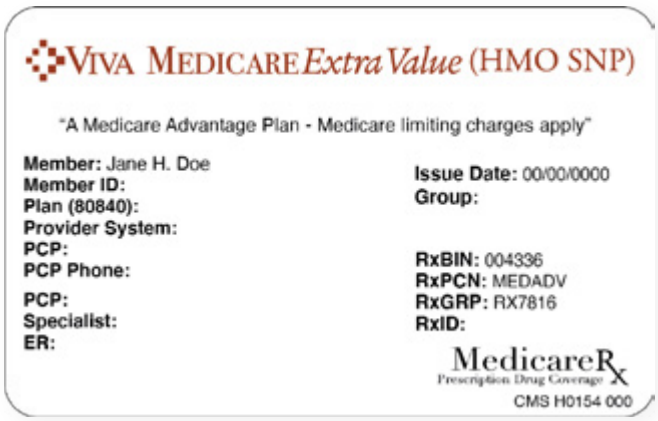
- A Medicare Advantage plan with only medical coverage and no monthly premium. Designed for individuals who have prescription drug coverage through another source.

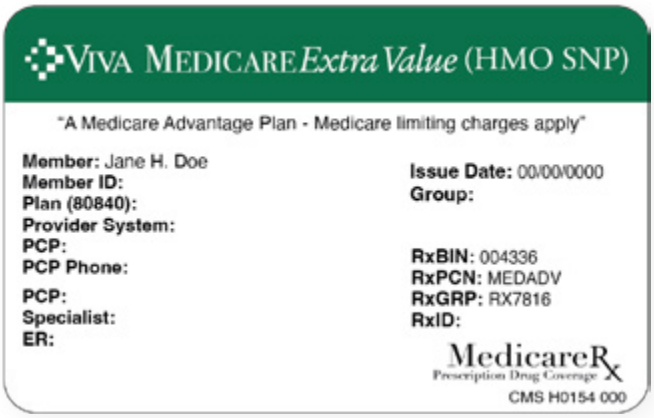




Viva Medicare *Extra Value* (HMO SNP)*

- 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.



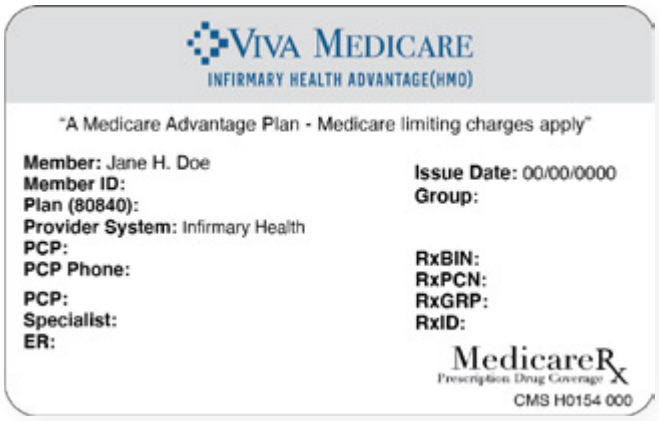


**A green stripe at the top of the card indicates that the member has a Primary Care Provider in the UAB Hospital System.*

2026 Viva Medicare Plans

Viva Medicare *Infirmary Health Advantage* (HMO)

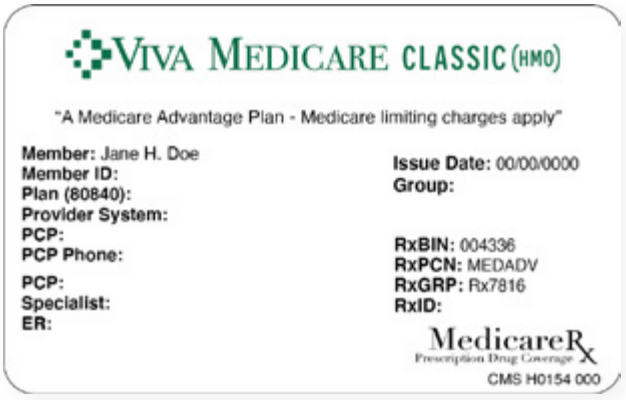
- This plan is offered in partnership with Infirmary Health and is available only in Mobile and Baldwin Counties. This plan has a limited network; members must receive their care within the Viva Medicare *Infirmary Health Advantage* closed provider system.



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.

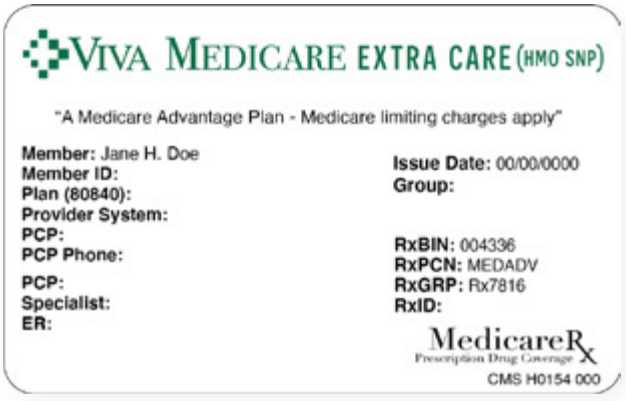
Viva Medicare *Classic* (HMO)

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



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.



Provider Participation Requirements

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

- Complete provider demographic form by visiting: https://www.vivahealth.com/provider/become-a-provider/
- 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 94.

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

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.

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 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.

Provider Credentialing/Recredentialing & Provider Sanctioning

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.

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.

Provider Credentialing/Recredentialing & Provider Sanctioning

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.

Provider Information Updates

Network Accuracy Requirements

The Consolidated Appropriations Act of 2021, signed on December 27, 2020, includes the No Surprises Act, aimed at enhancing patient protection by improving provider directory accuracy. It mandates self-insured group health plans and health insurance issuers like VIVA to:

1. Establish a provider data accuracy verification process.
2. Create a response protocol for network status inquiries.
3. Maintain a publicly accessible and accurate database of in-network providers and facilities.

BetterDoctor

VIVA utilizes Quest Analytics' BetterDoctor services to fulfill these requirements. As a participating provider, you are prompted to attest to your information every 90 days via BetterDoctor. You may be contacted through email, fax, mail, or phone. Each service location may require separate attestations. Updates will reflect in the directories within two business days of verification. Failure to respond may lead to your practice being excluded from the directories, so prompt attention is crucial.

For Groups with 10+ Practitioners:

Organizations with more than ten practitioners are encouraged to use BetterDoctor's streamlined roster solution for quarterly data attestations.

For details, contact the BetterDoctor Rosters support via email at rosters@questanalytics.com.

For questions, contact BetterDoctor at support@betterdoctor.com or (844) 668-2543 (8 AM – 5 PM CST), or you may call VIVA HEALTH Provider Services at 1-800-294-7780 (8 AM – 5 PM CST, Mon-Fri).

2026 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 18,000 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 evidence based prevention strategies. Outlined below are organizational goals for the population in 2026.

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 2024 and 2025 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 Full Dual members by eliminating cost sharing for PCP and specialist office visits.

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. 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 annually, we attempt to engage enrollees to assess medical, cognitive, functional, psychosocial, mental health needs and Social Determinants of Health such as transportation challenges, food insecurity and housing insecurity.
- **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, measureable, 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 year (CY) 2024 is 15.9%. VIVA HEALTH addresses this goal, in conjunction with the Transitions goal, by providing all 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 85% of SNP members seeing the PCP at least once annually for CY 2024. 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.

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

2026 Special Needs Plan Model of Care

- **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 Executive Director, 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 all SNP enrollees have an Individualized Care Team reflective of their identified and individualized needs. At a minimum, the ICT consists of the enrollee/caregiver, the PCP, and VIVA MEDICARE'S VCare Manager. As a provider of care to our enrollees, you are an integral part of the team, and will 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. This includes our Vice President, Clinical Services 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.

2026 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 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 the Provider Website www.VivaHealth.com/Provider.

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:

Mary McWhirter, SNP Administrator: mmcwhirter@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 who care for Medicare/Medicaid dual-eligible members. 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/.

For all questions regarding the Model of Care Attestation, please contact vivamoctraining@uabmc.edu.

Provider Portal

Provider Portal

The VIVA HEALTH Provider Portal includes a user friendly design and self registration feature for your designated practice/facility portal account administrator. The portal gives your account administrator the ability to manage additional user set up and portal role assignment within the practice or facility as needed. Additional portal features include access to claims payment information, eligibility, benefits, authorization status, and the ability to submit authorization request for the below services:

- Chemo Support Drugs
- Durable Medical Equipment (DME)
- Diagnostic Imaging
- Genetic Testing Labs
- Habilitative Occupational Therapy Outpatient
- Habilitative Physical Therapy Outpatient
- Habilitative Speech Therapy Outpatient
- Home Health Episodic
- Home Health Fee for Service
- Hyperbaric Oxygen Therapy (HBOT)
- In-Office Services
- Outpatient Surgery
- Pain Management
- Planned Admission
- Rehabilitative Occupational Therapy
- Rehabilitative Physical Therapy
- Rehabilitative Speech Therapy Outpatient
- Specialty or Part B Medications
- Sleep Study
- Wound Care

Accessing the Provider Portal

To access the portal please visit https://vivaproviders.com. **The following information is required for self registration:**

- Tax ID number
- Group billing NPI number (This is **not the same** as 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.

Third Party Administrators

Third Party Administrators (TPAs) will have the ability to self-register; however, self registration will only allow access to a non-active account. Once a TPA creates their account, notification will be sent via the portal to the designated practice/facility portal account administrator for review. The TPA will not have access to any provider or member data until the practice/facility portal account administrator grants final approval.

Provider Portal Access Issues and Questions

If you have any provider portal questions or need to link Tax ID numbers for single sign on access, please email vivaproviderportal@uabmc.edu or contact Provider Customer Service directly at 205-558-7474.

Medical Management

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

The Vice President, Clinical Services 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 Vice President, Clinical Services or physician designee for review.

Peer-to-Peer

As part of the inpatient hospitalization review process, VIVA HEALTH will offer a peer-to-peer option for treating providers. For any cases that are reviewed by the VIVA HEALTH Vice President, Clinical Services or physician designee and the intent is to deny, the treating provider will be offered the opportunity to complete a peer-to-peer within 24 hours of notification of the intent to deny. If a request is not made within 24 hours of notification or if the member has already discharged, peer-to-peer is no longer an option. In these cases, the provider must file an appeal of the determination.

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 Vice President, Clinical Services or physician designee, as needed, to determine medical necessity. The Vice President, Clinical Services or physician 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 Attachment A, Schedule of Benefits 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 Vice President, Clinical Services 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.

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 Vice President of Clinical Services 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 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 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) reporting. 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 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 as well as reduction in inappropriate emergency room use.
- 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 members in the chronic kidney disease/end stage renal disease (CKD) measure who were dispensed nephrotoxic medications. VIVA interdisciplinary teams provide education and outreach to providers and members regarding the adverse effects of nephrotoxic medications on kidney function and overall health. Staff will monitor and identify prescription drug data before and after intervention with the goal of decreasing the HEDIS potential harmful drug/disease (DDE) measure.
- 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: VIVA HEALTH receives and reviews performance on select quality measures stratified by various demographic and socioeconomic characteristics of members (i.e., race, disability, dual eligibility for Medicaid and Medicare, etc.).

Quality Improvement Program

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. 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 Quality of Care 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
- Blood Pressure

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. They are adopted based on the identified needs of our member population.

Disclaimer: Guidelines are only intended for your consideration. **They are not:**

- 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.
- A substitute for provider assessment and advice. Guidelines do not take into account the unique needs and resources of the particular patient and community.

- 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.
- 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:

- **Adult Major Depression Guideline for Initial Outpatient Treatment of Adults**
  Major Depression Guideline for Initial Outpatient Treatment of Adults
  Source: American Psychiatric Association
- **Advisory Committee on Immunization Practices (ACIP)**
  This standard can be reviewed by visiting https://www.cdc.gov/vaccines
- **American Academy of Pediatrics Recommended Immunization Schedule U.S.**
  This standard can be reviewed by visiting: http://www.aap.org
- **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
- **Cardiovascular Disease Prevention and Management**
  American Heart Association and American College of Cardiology
- **Diabetes Management**
  Standards of Medical Care in Diabetes
  Source: American Diabetes Association
  This standard can be reviewed by visiting https://diabetesjournals.org/care/issue/48/Supplement_1
- **Clinical Adult Preventive Care Recommendations**
  U.S. Preventive Services 2025 Recommendations care be found at
  https://www.uspreventiveservicestaskforce.org/uspstf/
- **Medicare Benefit Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Services**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c02.pdf
- **Pediatric Care**
  Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents
  Source: American Academy of Pediatrics
- **U.S. Preventive Services Task Force; recommendations with an "A" or "B" rating**

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

- **Women's Preventive Services Guidelines**
  Source: U.S. Health Resources and Services Administration
- **Women's Prevention Services Initiative (WPSI)**
  This standard can be reviewed by visiting https://www.womenspreventivehealth.org/recommendations

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. Additionally, VIVA HEALTH produces member educational materials that are available for provider use. Materials are posted to https://www.vivahealth.com/medicare/member-resources/.

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 Primary Care Providers (PCPs). Additionally, a dedicated nurse clinician may be provided as a resource to support PCPs by fostering provider engagement and promoting member satisfaction through proactive collaboration in 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 transitions of care.

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

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
- Inpatient rehabilitation or day treatment
- Testosterone pellets
- For obstetrical admissions, notification is required only if the hospitalization spans longer than 96 hours.
- Non-emergent and non-urgent 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**
- Some arteriograms
- 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_criterian
- Intensive Outpatient Programs (IOPs)
- Proton beam radiotherapy
- Genetic and Genomic testing

**** Not Applicable to VIVA MEDICARE Members***

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

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.

Labor and Delivery Global Fee

The following services are covered:

- 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 96 hours and newborn placement in an intensive care nursery still require prior authorization.

Diabetic Testing Supplies

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)
- 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.

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.

Emergency Services

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.

Accessing Mental Health/Substance Abuse Services

VIVA HEALTH provides covered mental health services through an extensive, statewide network. 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) 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.

Obligations for Providers Treating Substance Abuse Disorders (SUDs)

This section of the manual summarizes the importance of the Confidentiality of Substance Use Disorder (SUD) Patient Records regulation found at 42 CFR Part 2 (referred to as "Part 2"), and explains certain obligations required of VIVA HEALTH contracted Part 2 SUD providers (referred to as "Part 2 providers").

The Part 2 rule defines privacy standards for SUD health information for certain types of federally assisted programs (known as "Part 2 programs") and plays a vital role in maintaining the privacy and dignity of patients receiving treatment for SUD.

Key reasons Part 2 is important:

1. **It offers confidentiality protection:** Part 2 ensures that sensitive information about patients' SUD is safeguarded and kept confidential. This protects patients from the risk of stigma, discrimination, and potential negative consequences that could arise from their SUD status being disclosed without their consent.
2. **It requires informed consent to share SUD data:** It mandates that patient consent is obtained before disclosing SUD treatment information. This consent process empowers patients to control who has access to their sensitive data, fostering trust in the health care system.
3. **It integrates with Health Insurance Portability and Accountability Act (HIPAA):** Part 2 complements privacy protections of HIPAA by addressing the unique concerns associated with SUD treatment, ensuring that privacy protections are robust and specific to this sensitive area of health care.
4. **It encourages patients to get treatment:** By protecting the privacy of individuals seeking SUD treatment, Part 2 helps reduce barriers to accessing care. Patients are more likely to seek help when they know their information will be handled with the highest level of confidentiality.

Part 2 Providers' Obligations to VIVA HEALTH:

1. **Obtain patient consents:** All Part 2 providers contracted with VIVA HEALTH are required to obtain a single patient consent form from their patients who are members of the plan. The consent must comply with the Part 2 requirements for valid consents. The consent allows VIVA HEALTH to use and further disclose the member's SUD data for treatment, payment, or health care operations (TPO) as defined by the Privacy Rule under 45 CFR 164.501, including any amendments or updates.
2. **Provide Notification:** In the event a contracted Part 2 provider is unable to obtain the required patient consent, the provider must immediately notify VIVA HEALTH via email at vivaproviderservices@uabmc.edu.
3. **Reach out with questions/concerns:** For any questions, or to report issues related to the consent process, please contact the Provider Services Department at vivaproviderservices@uabmc.edu.

The final Part 2 Rule may be downloaded at https://www.federalregister.gov/public-inspection/2024-02544/confidentiality-of-substance-use-disorder-patient-records. You may also find helpful FAQs and other resources on the Department of Health and Human Services' (HHS) website at www.hhs.gov, and the Substance Abuse and Mental Health Services Administration's (SAMHSA) website at www.samhsa.gov.

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 provider. 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 <u>not</u> 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.

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

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

Medicare Advantage Risk Adjustment Validation Audit

- **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.

Claims Submission

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 diagnosis 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 1 (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 Optum iEDI 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. The claims will be processed as usual and an Explanation of Payment (EOP) will be issued for each claim filed.

Claims Submission

Claims Information for Dental Providers

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

- Routine cleanings
- Fillings
- Tooth removals
- Bridges
- Dentures
- Crowns
- Implants
- Partial and complete dentures
- Other services not considered to be cosmetic

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 https://www.vivahealth.com/medicare/provider-search/.

Dental providers 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 1 (800) 294-7780
- **Fax:** (205) 449-7849

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

Electronic Claim Filing

VIVA HEALTH has selected Optum iEDI as its electronic claims clearinghouse. Providers can submit the 837P Professional and Vision claims, 837I Institutional hospital or facilities, and 837D Dental claims using 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 rending 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 front of card.*

For Commercial members – 10 digit member ID is on the front 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 front 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 front 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 rendering providers and/or billing providers (if no rendering provider is submitted) who have not yet registered with VIVA HEALTH.

To correct this issue, contact VIVA EDI Services at VivaEDIServices@uabmc.edu.

Electronic Funds Transfer (EFT) and 835 Electronic Remittances

VIVA HEALTH has selected Zelis as its electronic payment and remittance reporting vendor. There is no cost for you to use Zelis ePayment center and enrollment is free. You may upgrade to Zelis ACH+ through the Zelis Payment network.

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).

Zelis Contact Information

For EPC (835) related questions: 1-833-306-0337

For ACH Enrollment: 1-855-496-1571

For general questions, concerns or requests for payment method change:

Phone: 855-774-4392

Email: help@epayment.center

Unique Billing Situations

Provider Reimbursement Methodologies	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.
Office Visits on the Same Day as Surgery	Bill for office visits on the same day as surgery in the following instances only: • 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
Multiple Procedures	When a claim is received for multiple procedures performed on the same day, applicable procedures may be reimbursed at a reduced rate. ***Multiple procedure reimbursement methodology does not apply when a facility is contracted to receive a specific contracted or case rate.*
Assistant Surgeons	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.
Telephonic Care	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.
Rebundled Charges	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.
Photocopy Charges	Photocopy charges are generally not reimbursable by VIVA HEALTH. Please refer to your Provider Agreement for additional information.

Unique Billing Situations

Administrative Fees	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.
Anesthesia Codes	Every anesthesia code should be submitted with a payment modifier. Time-based anesthesia codes will be rejected if a modifier is not included. The accepted payment modifiers include: **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	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 the applicable global delivery CPT code. 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.
Coordination of Benefits	VIVA HEALTH is responsible for coordinating benefits with the member's **primary insurance**. Please note the following guidelines: **When Primary Insurance Pays:** VIVA will cover the **member's patient responsibility** (e.g., copayments, coinsurance, or deductibles) not to exceed **VIVA's allowed amount**. No prior authorization from VIVA is required for services that are covered and paid by the primary insurance. **When Primary Insurance Denies the Claim:** If the **primary insurance denies** the service because it is **not covered** or **not authorized**, VIVA will process the claim as **primary – provided the services are covered under the VIVA plan**. **Standard processing rules** will apply. The member's **normal copayment or coinsurance, or deductibles** will be required. **Authorization is required** if normally applicable. If **authorization is on file**, the claim will be **considered for payment**. If **no authorization** is obtained when required, the claim will be **denied**.

Unique Billing Situations

Subrogration	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.
Unlisted Codes	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: • 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 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.

Provider Fee Schedules

VIVA HEALTH agrees to compensate providers at the rates in the VIVA HEALTH and/or applicable VIVA MEDICARE fee schedule set forth at the time of contracting/credentialing. If you would like a copy of your current fee schedule, please contact vivaproviderservices@uabmc.edu.

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 in a separate envelope) rather than paper. Only send those records relevant to the appeal as sending extraneous information may delay a decision or result in an ineffective review of your appeal. Appeals will generally be reviewed within 60 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. VIVA HEALTH has selected MCMC as the 3rd party reviewer for eligible appeals. MCMC has over 30 years of experience in providing evidence-based independent medical review services and holds both a URAC (IRO Comprehensive) and NCQA (Utilization Management) accreditation. The initiating party will be responsible for the cost of the second level review by MCMC. Fees are billed by the hour. Hourly rates vary based on service type and review complexity. 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. Providers will receive documentation at the end of each quarter that includes the second level of appeal invoice with payment instructions, case details, and the upheld denial letter for review. Please settle invoice balances promptly. Providers that carry a year end balance will not have the ability to submit second level appeals until all invoice balances have been satisfied for the previous year. New information not 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) 449-7915 if there are 20 pages or less. Appeals with more than 50 pages should be submitted on a CD (with password in a separate envelope) rather than in paper.

Complaint Procedure

For Employer Group Members

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 at 205-558-7474 or toll-free at 1-800-294-7780 (TTY: 711) or in person at the address below 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.

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.

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 15 days of the receipt date of the formal complaint for pre-service complaints and 30 days for postservice complaints. 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 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 from 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.

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:

- 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
- 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.

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:

1. **The grievance process**
2. **The Medicare appeals process**

There is also a special review process available from the local Quality Improvement Organization (QIO) for discharge decisions in:

- **Hospital Inpatient Facilities**
- **Skilled Nursing Facilities (SNFs)**
- **Home Health Agencies (HHAs)**
- **Comprehensive Outpatient Rehabilitation Facilities (CORFs)**

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.

Complaints, Grievances, Appeals & QIO Review

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.

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 an appeal within sixty-five (65) calendar days (unless there is good cause for an extension) from the date on the written 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.

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.

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.

Complaints, Grievances, Appeals & QIO Review

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 Acentra Health, 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 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.

Complaints, Grievances, Appeals & QIO Review

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 Acentra Health 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 page 116 for instructions for the "Notice of Medicare Non-Coverage" (NOMNC) as well as a link to the CMS-approved form that must be used.

If Acentra Health 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. Acentra Health will make this decision within one full day after it receives the information it needs to make a decision.

If Acentra Health 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 Acentra Health 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 Acentra Health for a review by the deadline, the member may still ask VIVA MEDICARE for a "fast appeal."

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 pharmacy information can be found on the member's VIVA HEALTH identification card.

The information below pertains to employer groups. For Medicare, see pages 69-77 of this manual.

1. Pharmacy RX Benefit Information

VIVA HEALTH employer groups typically have a 4, 5, or 6 tier cost-sharing structure for employer group members. The lower cost-sharing is for generics, the middle cost-sharing is for preferred brand drugs on the Commercial Formulary, the higher cost-sharing is for non-preferred 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:

- Always prescribe covered drugs on the Commercial Formulary.
- 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 cost-sharing.
- If a generic alternative isn't available, see if another drug listed on the Commercial Formulary on the next lowest tier 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.

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 view the current Commercial Formulary by visiting https://www.vivahealth.com/provider/resources/.

3. Specialty Drugs

VIVA HEALTH works with Accredo to dispense covered specialty drugs to our members and providers. Accredo provides services to individuals with various chronic or genetic disorders. The VIVA HEALTH Commercial Formulary indicates which products are considered specialty.

Commercial Pharmacy Information

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. Commercial Coverage Determinations

VIVA HEALTH provides an enhanced platform that allows electronic Prior Authorization (ePA) to be submitted within a physician's EHR in real time during the prescribing event. The platform is integrated with CoverMyMeds®, and Surescripts® portals to enable physicians to submit real-time ePA requests for pharmacy prior authorizations. The platform responds to ePA requests electronically, either with approval or notice that the request requires further review by a pharmacist. ePA is the preferred method because it improves turnaround times of prior authorizations beginning when all information required to perform the review is obtained.

Fax capability remains the same utilizing the same fax number 205-872-0458. This form can be accessed online at: https://www.vivahealth.com/download?ID=1035.

Part D Prescription Drug Benefit

VIVA HEALTH uses CVS/Caremark as the Pharmacy Benefit Manager (PBM) 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 under "Legal Documents" 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.

Part D Prescription Drug Benefit

The VIVA Pharmacy Department will notify you if the coverage determination is approved, denied, or requires additional information before a final coverage decision is rendered by VIVA MEDICARE.

- A listing of the prior authorization criteria can be found on our website under "Pharmacy Policies - Medicare Part D" at https://www.vivahealth.com/provider/resources/#Formulary_Information_List.

Real-Time Benefits (RTB)

- 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)

- electronic Prior Authorization (ePA) is the electronic transmission between the prescriber and a payer to determine whether or not a medication request is granted.
- An ePA can be accessed through ePA platforms such as CoverMyMeds and Surescripts which can be connected to your Real-Time Benefit tool.
- ePA requests via your EHR are in many cases processed within minutes or hours. Some ePA requests are processed in near real-time for certain approval scenarios. When using this prospective approach, the average turn-around-times for ePA requests meeting criteria for approval is only 3 minutes, opposed to the days your staff would have expended addressing retrospective medication requests from a pharmacy.
- ePA functionality works for the following types of coverage determination requests: prior authorizations, non-formulary exceptions, quantity limit exceptions.

For more information on RTB and ePAs, please visit this link: https://www.vivahealth.com/download?ID=35672

Processing of drugs under Medicare Part B vs Medicare Part D

VIVA HEALTH must perform its due diligence to ensure appropriate payment for drugs under the Medicare Part B or Medicare Part D benefit. Per Medicare regulations, if a drug as prescribed and dispensed or administered is available under Medicare Part B, the drug is not eligible under Medicare Part D. An example where VIVA HEALTH performs this type of review is with Insulin. If a review determines Insulin is administered via a non-disposable pump, then it's appropriate for VIVA HEALTH to authorize payment under the Medicare Part B benefit.

Payment Processing for Immunosuppressant Drugs

If VIVA HEALTH has received information from CMS or identified information in VIVA HEALTH's medical claims data indicating that a beneficiary has received a Medicare-covered transplant, VIVA HEALTH cannot cover immunosuppressant drugs used for transplant rejection under Medicare Part D, even if the prescriber indicates that Medicare did not cover the transplant. For this reason, VIVA HEALTH will not perform outreach to prescribers to inquire about Medicare coverage of the transplant.

Part D Prescription Drug Benefit

Medicare Prescription Payment Plan (MPPP)

MPPP is a government program that lets Medicare members make monthly payments for high-cost prescription drugs throughout the year (January – December) instead of paying the full amount at the pharmacy when the prescription is filled.

This is not a program to help members save money or lower drug costs. It is a program to help members manage their monthly expenses by spreading the financial cost during the calendar year.

While this program may be helpful for some members, it's important to know all the facts before recommending MPPP.

Who will NOT benefit from MPPP?

- Members who get Extra Help from Medicare
- VIVA MEDICARE *Extra Value* (HMO SNP) and VIVA MEDICARE *Extra Care* (HMO SNP) members
- Members who qualify for a Medicare Savings Program
- Members who get help paying for their drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage
- Members with low yearly drug costs
- Members with drug costs that are the same each month
- Members considering signing up for the payment option late in the calendar year (after September)
- Members who don't want to change how they pay for their drugs

Biological, Biotechnical, and Injectable Drugs (Specialty)

VIVA HEALTH offers several specialty pharmacies to dispense covered specialty drugs to our members and providers. These specialty pharmacies provide services to individuals with various chronic or genetic disorders.

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

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 65 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
	By submitting a request as expedited, the prescriber certifies that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member's ability to regain maximum function.	
Hospice Drug Classes: analegsics, 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

Members with Part D prescription drug benefits may get standard quantities of Accu-Chek test strips and monitors, including continuous glucose monitors, as well as any brand of lancets, lancet devices and glucose control solutions at any network pharmacy that has them. Continuous glucose monitor brands (Freestyle Libre and all Dexcom) are covered at the pharmacy. 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.

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** and **drug management programs**. Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, patients with sickle cell disease, and patients being treated for cancer-related pain are exempt from these interventions. These policies should not impact patient access to medication-assisted treatment (MAT).

Opioid Safety Alerts

To help prevent and combat prescription opiate overuse, plans are expected to implement safety edits at the point of sale. These safety edits are detailed in the chart below. The prescriber or patient may contact the plan regarding coverage concerns.

Opioid Safety Alert and Rational	Pharmacy and Prescriber's Role
Seven-day supply limit for opioid naïve patients Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 90 days) will be limited to a supply of 7 days or less. *Rationale: The purpose of this alert is to prevent opioid-niave patients from being exposed to excessive quantities of opioids. If a patient switches drug plans, the new plan may not know their current prescription information.*	An opioid-niave patient may receive up to a 7 day supply for an initial opioid fill. Subsequent prescriptions filled within the plan's look back window, of 90 days, are not subject to the 7 days supply limit, as the patient will no longer be considered opioid naïve.
Opioid care coordination alert at 90 morphine milligram equivalent (MME) This safety edit 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.	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. 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.
Concurrent opioid and benzodiazepine use This alert will trigger when opioids and benzodiazepines are taken concurrently. Both opioid and benzodiazepines classes of medications are central nervous system (CNS) active agents and can increase risk of respiratory depression, sedation or overdose. **Duplicative long-acting opioid therapy** This alert will trigger when multiple long-acting opioids have overlapping day supplies. Taking multiple long acting opioids at the same time can increase risk of excessive sedation, respiratory depression and overdose.	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.

Medicare Part D Opioid Policies: Information for Prescribers

Drug Management Programs (DMPs)

Medicare Part D plans have a DMP that monitors and may limit 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/or recent opioid related over-dose, and undergo case management conducted by the plan with the patients' prescribers. VIVA MEDICARE partners with CVS Caremark to complete the case management reviews. 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.

Part D Star Measures

Part D plans are evaluated on the following Star Measures. A plan's performance on these measures will count toward the Plan's overall Star rating.

These measures are **1) Polypharmacy: use of multiple anticholinergic medications in older adults, and 2) Concurrent use of opioids and benzodiazepines.** Because both of these scenarios pose significant safety risk for patients, we are asking that providers reevaluate if using these drugs in combination is truly necessary or if alternative medication regimens can be evaluated. We acknowledge that many patients have been on these medications in combination for years, and changing longstanding drug regimens can be challenging and not always welcome by your patients. However, due to the importance of preventing negative patient outcomes that could occur with both of these situations, we are asking for your assistance.

The use of multiple anticholinergic medications measure identifies patients greater than 65 years of age who are on two or more anticholinergic medications. Concurrent use of these medications in the elderly can increase the risk of multisystem adverse effects such as new or worsening cognitive impairment, acceleration of neurodegenerative processes, development of confusion, psychotic symptoms, functionality disturbances, and new onset or increased severity of dry mouth, urinary retention, constipation, paralytic ileus, tachycardia, and blurred vision. Please assess whether continued use of multiple anticholinergic medications remains appropriate. Consider discontinuing unnecessary medications or switching to non-anticholinergic therapeutics alternative when possible. Additionally, consider using the lowest possible doses and consider deprescribing opportunities to mitigate the potential harms of polypharmacy in the elderly.

Therapeutic categories with anticholinergic effects include the following:

Indication	Anticholinergic Medication(s)	Therapeutic Alternative(s)
Allergies	1st generation antinistamine	Loratadine, fexofenadine
Parkinsonism	Benztropine, trihexyphenidyl	Pramipexole, ropinirole, amantadine
Muscle pain	Cyclobenzaprine, orphenadrine	Tizanidine, baclofen, acetaminophen, ibuprofen
Depression	Tricyclic antidepressants	SSRI, SNRI, bupropion
Neuropathic pain	Tricyclic antidepressants	SNRI, gabapentin, pregabalin
Psychosis	Olanzapine, loxapine, perphenazine	Aripiprazole, risperidone, ziprasidone
Urinary urgency	Antimuscarinics	Mirabegron, vibegron
Diarrhea	Dicyclomine, hyoscyamine, Lomotil	Loperamide
Nausea and vomiting	Prochlorperazine, promethazine	ondansetron

Part D Star Measures

Concomitant use of opioid and benzodiazepine medications will also result in provider notification due to the risk of a safety event. The CDC Practice Guidelines for prescribing opioids for pain recommends additional caution when prescribing opioids and benzodiazepines concurrently. Concomitant use is associated with greater risk of respiratory depression, overdose, and death, especially when prescribed by multiple providers. Consider gradually tapering patients' opioid regimens to lower dosages to minimize symptoms of withdrawal while maximizing use of nonopioid therapies. It may be necessary to coordinate with other providers that your patients may be seeing to ensure a more holistic view of the patient is taken into consideration when determining if concomitant use of opioids and benzodiazepines is appropriate and consider deprescribing either the opioid or benzodiazepine if clinically appropriate to do so based on the unique clinical factors of each patient. If concomitant use is appropriate, consider also prescribing naloxone and educating patients and caregivers on appropriate use of this potentially lifesaving opioid reversal agent.

Glucagon-like Peptide (GLP-1) Drugs

- **Medicare Part D allows coverage of these GLP-1 drugs for a medically-accepted indication**, such as, Type 2 Diabetes Mellitus. New for 2026, VIVA MEDICARE will cover 100-day supply prescription fills.
  - Metabolic syndrome, obesity, pre-diabetes, and weight loss are **not** coverable conditions under Medicare Part D.

GLP-1 Drugs in formulary with Prior Authorization Review			
Mounjaro	Ozempic	Rybelsus	Trulicity

These GLP-1 Drugs are not covered under Medicare Part D when solely used for weight loss.

- Saxenda
- Zepbound
- Wegovy

Inflation Reduction Act

- Insulin costs per the IRA will be the lesser of:
  - $35 per month
  - 25% of the Maximum Fair Price (MFP) if the insulin is one of the medications negotiated by CMS
  - 25% of the approved cost
- 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.

Provider Responsibilities

Primary Care Providers

The Primary Care Provider (PCP) is responsible for coordinating primary and other medical care for VIVA HEALTH plan members. This includes assessing medical needs, facilitating communication among providers, and ensuring members receive necessary care in appropriate settings. PCPs can provide care directly or refer members to other contracted providers, including specialists. PCP Specialties include Family Practice, Internal Medicine, Geriatrics, Pediatrics, General Practice, and OB/GYN (when contracted to provide primary care).

PCPs manage emergency, urgent, routine, and follow-up care, secure referrals to specialists as required, coordinate emergency and out-of-area care, and maintain complete medical records.

Note: VIVA MEDICARE health plan members are required to coordinate all care through their PCP. For certain VIVA HEALTH plans, specialist care must be initiated through a PCP referral. When a member changes PCPs, timely cooperation in transferring medical records is essential for continuity of care and VIVA must reassign the member to a designated PCP.

Basic PCP Services and Responsibilities:

1. Provide services in various settings, including office, home, hospital, and emergency room, typical of general practitioners and specialists.
2. Maintain a safe office environment in compliance with state regulations.
3. Provide or arrange newborn care.
4. Provide or arrange EKGs with interpretation.
5. Administer immunizations and injections (e.g., Polio, MMR, TB, DPT).
6. Conduct Tympanometry, vision screenings, routine hearing exams, and physicals.
7. Advise members on future health care needs and treatment options.
8. Coordinate specialist referrals, ensuring specialist notes are documented and follow-up care is provided. If an in network Specialist is unavailable, contact VIVA HEALTH's medical management for alternate options.
9. Coordinate all medical services related to surgery, therapy, hospital visits, diagnostics, specialist services, and home health care.
10. Offer office visits during regular hours for common medical issues, delegating education to trained staff as needed.
11. Arrange coverage with other participating providers while off-duty or on vacation.
12. Sole proprietors must be on-site at least 32 hours per week.
13. Participation in the VIVA HEALTH Connect for Quality (C4Q) program is highly encouraged.
14. Members may receive services from non-contracted providers only in specific situations:
    a. Emergency care anywhere (notify VIVA HEALTH of non-contracted hospital admissions).
    b. Urgently needed care at an Urgent Care Facility.
    c. Dialysis services away from the service area.
    d. Services pre-authorized by VIVA HEALTH.

Provider Responsibilities

Advanced Practice Providers

VIVA HEALTH recognizes and credentials the following Advanced Practice Providers (APP) as eligible network participants:

- Certified Registered Nurse Practitioner (CRNP)
- Physician Assistant (PA)
- Surgical Physician Assistant (SPA)
- Certified Nurse Midwife (NMW)

An APP is a specially trained, certified, and licensed provider who renders medical services within the scope of their license. APP collaborating or supervising physicians must be a contracted provider with VIVA. An APP and their collaborating or supervising physician must have a matching specialty. The following are considered for specialty matching:

- Internal Medicine
- Family Practice
- Geriatrics
- Emergency Medicine
- Hospitalist
- Urgent Care
- Note: APPs with a Pediatric specialty or any of the above specialties and a collaborating or supervising physician specializing in any of the above or Pediatrics will be considered as having a matching specialty when seeing non-Medicare or pediatric patients.

Specialty Care Providers

Participating Specialty Care Providers (Specialists) provide specialty services within the scope of their specialty and training. Specialists are encouraged to maintain communication with the patient's PCP. Specialists will be compensated for services authorized by VIVA. Participating Specialists 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 a participating provider of the same specialty.

Note: VIVA HEALTH generally does not require PCP referrals for members to see specialists within the network. Members may self-refer to participating specialists.

However, members enrolled in narrow network plans may require a PCP referral to see a specialist outside of their designated specialist panel. Additionally, if a member seeks to see a specialist completely outside of the network, a referral from the PCP is required for services to be covered.

Specialists should ensure the PCP is informed of all diagnoses and treatments provided to the patient to promote care coordination.

Specialist Obligations:

1. Accept all patients referred to them by participating PCPs
2. Submit to VIVA any required claims information
3. Sign and abide by the Participating Specialty Provider Agreement

Provider Responsibilities

If a VIVA HEALTH member comes into your specialist's office for treatment:

- You may provide care without requiring a referral from the PCP for in-network specialist visits (except as noted for narrow network plans).
- Specialists should communicate relevant clinical information, diagnoses, and treatments to the member's PCP whenever possible to support coordinated care.
- For members on narrow network plans, verify if a referral is required for out-of-panel or out-of-network specialist visits.
- For emergencies, standard emergency care protocols apply.
- Specialists must maintain coverage arrangements to ensure 24/7 availability to Viva Health members.
- If a referral is required but the member chooses not to obtain one, the provider may offer to see the patient on a self-pay basis. In this case, the patient must sign a waiver prior to being seen that includes:
  - The patient's name;
  - Confirmation that the patient has been informed by the provider/facility that, due to the absence of a referral or authorization, they will be responsible for all charges related to the episode of care;
  - The specific date of service;
  - The CPT code(s) and associated charges for the services being rendered;
  - An acknowledgment that the patient understands they are financially responsible for these charges;
  - A statement that future services will only be covered if the appropriate referral or authorization is obtained from Viva Health's Medical Management Department.
  - A general financial responsibility form is not sufficient. The waiver must be specific to the episode of care and clearly outline the services and charges involved.
  - Below is a sample waiver for your reference.

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

Provider Responsibilities

Patient Communications and Treatment Planning:

As a VIVA HEALTH participating provider, you are encouraged to ensure VIVA members understand their 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 common terms and 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.

Treatment Plans:

When a 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 assist in the treatment planning effort for VIVA MEDICARE members, VIVA conducts a health risk assessment (HRA) of new enrollees and notifies the PCP if the patient scores in a high-risk classification. Effective treatment plans generally include the following:

- The nature and level of complexity of treatment
- The existence of co-morbidity
- The patient's level of compliance
- Patient score on health risk assessments
- 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.

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.

Provider Responsibilities

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.

All Non-Emergency Hospital Inpatient Admissions Require Prior Authorization

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."

ER Visits:

- Check member's ID card or the VIVA Provider Portal at www.vivaproviders.com 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 authorize all planned admissions.
- 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 unless the stay spans longer than 96 hours after delivery.
- 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 the time frame required by the specific plan, typically 30 days. A separate inpatient copay applies to the baby's stay if the mother is discharged before the baby.

Referrals/Prior Authorizations:

It is the responsibility of the Primary Care Provider (PCP) to initiate 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. Referrals may be requested via mail. Providers should complete the Referral Authorization Form (see page 111 for sample form) and 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

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 be made by using the VIVA HEALTH Provider Portal as described on page 27 of this Provider Manual or by calling (205) 933-1201 or 1-800-294-7780.

Mail Referral Requests To:

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

Providing all pertinent clinical information will allow faster processing of requests. The goal of the Medical Management Department is to turnaround all 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 27 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

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 page 114 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 page 114 for a sample).

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.

Managing 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 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:

- 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

Provider Responsibilities

The PCP's role in care transitions:

- The PCP is responsible for developing and communicating the member's Plan of Care (treatment plan)
- Communicating changes in the member's health status and resulting changes in the Plan of Care to the member by way of written, face-to-face, or telephonic consultation
- Documentation regarding communication to the member or responsible party regarding changes to the Plan of Care and health status should be placed in the member's medical record within 5 business days

The Facility's (Inpatient, Rehabilitation, Skilled Nursing Facility) role in care transitions:

- 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.

The Home Health Agency's role in care transitions:

- 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.

Advance Directives and Hospice Benefits:

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. Advance 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:

1. Living Will
2. Power of Attorney for Health Care Document

An advance directive form is provided in this manual on pages 123-127 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 "Advance Directive for Health care"). 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 advance directive in place.

Provider Responsibilities

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 44-47 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 pages 44-47 for more information regarding hospice.

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.

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 noncoverage 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 114 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.

Provider Responsibilities

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. Medical records should contain the corresponding proper documentation to support codes submitted along with a treatment plan and care coordination actions. If a Provider determines a code has been submitted in error, the Provider should void and resubmit a corrected claim.

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 be 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.

Refer to the Medicare Advantage Risk Validation Audit Section on pages 48-49 for additional information.

VIVA HEALTH follows the ICD-10-CM Official Guidelines for Coding and Reporting. "A joint effort between the health care 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 health care 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."

https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf

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
- Submit EDI claims to Optum iEDI payer ID 63114
- Mail claims for Medicare members to:
  - VIVA MEDICARE Claims
    P.O. Box 55209
    Birmingham, AL 35255-5209

Patient Dismissals

There are instances when a Primary Care Provider (PCP) needs to terminate the patient provider relationship. VIVA HEALTH requires this process be in accordance with legal, ethical, and organizational standards to ensure continuity of care. Patient dismissals cannot be based on a patient's race, gender, disability, age, or due to costly or complex care. VIVA HEALTH requires a 30-day written notice be provided to the patient and health plan. The notice must include the dismissal reason, plan of care during the 30-day period, and instruction regarding medical record access and prescription refills. When applicable, also document previous warnings or attempts to resolve the issue directly with the patient.

Valid Reasons for dismissal include (but are not limited to):

- Repeated non-compliance regarding medical advice or treatment plans
- History of missed appointments without notice
- Disruptive, abusive, or threatening behavior
- Drug-seeking behavior
- Fraudulent use of health services or insurance benefits

VIVA HEALTH will review the dismissal letter to ensure it meets the above guidelines. Notification is sent out to the member advising of the dismissal and instructs the member to contact VIVA Health Member Services for assistance with a PCP change. If the member has not updated their PCP within the 30-day notice window they are eligible for PCP reassignment.

Please note: Patient dismissal does not release the PCP from professional obligations until the transition period ends.

- The PCP remains responsible for providing medically necessary care during the 30-day period.
- Refills of maintenance medications and handling of urgent needs must continue during this time.

PCP-Member Reassignment

VIVA MEDICARE members may update or change their Primary Care Provider (PCP) selection at any time. PCP change requests can be made through the following methods:

Via Phone:

Members may contact VIVA MEDICARE Member Services directly at:

- (205) 918-2067
- 1-800-633-1542 (toll-free)

Via PCP Change Request Form:

Providers/Members may also complete a PCP Change Request Form, which must be:

- Completed and signed by an authorized representative from the newly selected PCP's office
- Signed by the member

Note: All PCP change requests will become effective on the first day of the following month after the request is received and processed. It is the responsibility of the PCP's office to ensure the PCP Change Request form is accurately completed and submitted in a timely manner to avoid delays in the member's PCP reassignment.

You can access the PCP Change Request Form on page 115. If you have any questions, please email vivaproviderservices@uabmc.edu or contact your Provider Representative directly.

Your Role in Improving Member Satisfaction

Access Standards

Members should be able to obtain services in compliance with VIVA HEALTH's Accessibility Standards listed on page 95. These standards are extremely important to ensure timely access to care as well as overall member satisfaction. 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 checkup or routine care as soon as you needed?

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. If a high percentage of your patients speak a particular foreign language, you may consider hiring a bilingual staff member or translator.
- 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. Federal regulations related to the confidentiality and security of patient information have been implemented under the Health

Your Role in Improving Member Satisfaction

Insurance Portability and Accountability Act (HIPAA). VIVA HEALTH and contracted providers must comply with HIPAA requirements. **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.

Communication

CMS surveys VIVA MEDICARE members each year using the Medicare satisfaction survey developed as part of the Consumer Assessment of Health care 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? How often did you get the 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?
- 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?

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.

Your Role in Improving Member Satisfaction

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.

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.

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.

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

- Complete provider demographic form by visiting: https://www.vivahealth.com/provider/become-a-provider/
- Current CAQH Proview application and attestation required
- Current medical or professional license, controlled substance license, and DEA, as applicable

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 Examination 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

Accessibility Standard

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

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.

For Primary Care and applicable specialties, the provider's 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.

The following are not acceptable practices:

- 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
- Systems designed to refer recipients to the provider group's home telephone **OR**
- Systems designed to refer all requests to go to the Emergency Room

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.

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	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.

Federal Register: https://www.ecfr.gov/current/title-42/part-422/section-422.112#p-422.112(a)(6)

VIVA HEALTH adheres to the appointment availability and access to care standards as outlined in 42 C.F.R. § 422.112, which establishes minimum access requirements for Medicare Advantage plans. These standards are used as the baseline for evaluating timely access to services across our provider network.

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/files/general/viva-provider-compliance-training-final). 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 health care 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/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/preclusion-list.

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.

Compliance

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:

- **Phone:** VIVA HEALTH (205) 558-7474 or 1 (800) 294-7780
- **Mail:** VIVA HEALTH
  ATTN: Compliance Officer
  417 20th Street North, Suite 1100
  Birmingham, Alabama 35203
- **Online:** Complete the online reporting tool located at the following address:
  https://www.VivaHealth.com/Medicare/FraudComplaint/
  Reports can be made anonymously.
- Office 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.

VIVA HEALTH Consent/ Gag Clause Prohibition

VIVA HEALTH's provider agreements shall not restrict or prohibit the release of rate or payment information when required by law, such as federal law associated with the No Surprises Act and price transparency. This includes provisions in contracts referred to as "gag clauses" between VIVA HEALTH and providers that directly or indirectly restrict the health plan from disclosing, or a plan sponsor, referring provider, or group or individual market consumer from accessing, provider-specific price, cost, or quality data.

Further, in order to ensure compliance with the Gag Clause Prohibition attestation required under section 9824 of the Internal Revenue Code, section 724 of the Employee Retirement Income Security Act (ERISA), and section 2799A-9 of the Public Health Service Act, as added by section 201 of Title II of division BB of the Consolidated Appropriations Act (CAA), provider agrees that it will not enter into an agreement, and has not, subsequent to December 27, 2020, entered into an agreement with a health care provider, network or association of providers, thirdparty administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict VIVA HEALTH from:

- Making provider-specific cost or quality of care information or data available to active or eligible participants, beneficiaries, and enrollees, of the plan or coverage, plan sponsors, or referring providers;
- Electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee, upon request and consistent with applicable privacy regulations; and
- Sharing such information or data described in (1) or (2), or directing such data be shared, with a business associate, as required by the CAA, consistent with applicable privacy regulations.

Marketing Guidelines

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 health care providers or in the health care 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.

(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.

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 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.
- 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.

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

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, audio, large print, or other alternate formats, 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 our plan can meet these accessibility requirements include, but aren't 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 audio, large print, or other alternate formats at no cost if needed. Please see the Notice of Availability of Language Assistance Services and Auxiliary Aids and Services at the beginning of the plan's *Evidence of Coverage*. We are required to give members information about our plan's benefits in a format that is accessible and appropriate. Members can call Member Services at 1-800-633-1542 (TTY users call 711) 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 our plan's network for a specialty aren't available, it's our 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 our plan for information on where to go to get this service at in-network cost-sharing.

If members have any trouble getting information from our plan in a format that's accessible and appropriate, seeing a women's health specialist, or finding a network specialist, they should call to file a grievance with Member Services at 1-800-633-1542 (TTY users call 711) . 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 at 1-800-368-1019 or TTY users call 1-800-537-7697.

Section 1.2 - We must ensure members get timely access to covered services and drugs, if applicable

Members have the right to choose a Primary Care Provider (PCP) in our plan's network to provide and arrange for covered services. We don't 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 (for members with drug coverage under the plan) or refilled at any of our network pharmacies without long delays.

If members think they aren't getting medical care or Part D drugs (if applicable) within a reasonable amount of time, Chapter 9 in our plan's *Evidence of Coverage* tells what they can do.

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 the 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 don't require us to get a member's written permission first. These exceptions are allowed or required by law.
  - We're required to release health information to government agencies that are checking on quality of care.
  - We're required to give Medicare our Medicare Advantage members' health information including information about Part D prescription drugs (if applicable). If Medicare releases the information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that the information 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 our plan, and to get a copy of the records. We're 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'll work with appropriate health care 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 aren't 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 our 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 at 1-800-633-1542 (TTY users call 711):

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

- **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 drug coverage, if applicable.
- **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 isn't 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 - Members have the right to know their treatment options and participate in decisions about their 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 them make decisions with doctors about what treatment is best, members' rights include the following:

- **To know about all their choices.** Members have the right to be informed about the treatment options that are recommended for their condition, no matter what they cost or whether they're 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. 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's to be done if they can't 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, *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.

Legal documents members can use to give directions in advance of these situations are called **advance directives.** Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How members can set up an advance directive to give instructions:

- **Get a form.** They can get an advance directive form from a lawyer, a social worker, or some office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare. Members can also call Member Services at 1-800-633-1542 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where the form is obtained, it's a legal document. Members should consider having a lawyer help prepare it.
- **Give copies of the form to the right 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 did not sign an advance directive form, the hospital has forms available and will ask if they want to sign one.

Filling out an advance directive is the member's choice (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.

If the member's instructions aren't followed

If a member signed an advance directive, and a doctor or hospital didn't follow the instructions in it, the member can 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 ask us to reconsider decisions we made

If members have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 in the plan's *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're required to treat them fairly.**

Section 1.7 - If they believe they are being treated unfairly, or their rights are not being respected

If members believe they have been treated unfairly or their rights haven't been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age, 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), or they can also call their local Office for Civil Rights.

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

- **Call Member Services** at 1-800-633-1542 (TTY users call 711).
- **Call your local SHIP** at 1-877-425-2243 (TTY users call 711).
- **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

Members can get more information about their rights from these places:

- **Call Member Services** at 1-800-633-1542 (TTY users call 711).
- **Call your local SHIP** at 1-877-425-2243 (TTY users call 711).
- **Contact Medicare:**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf).
  - Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 – Members responsibilities as a member of our plan

Things members need to do as a member of our plan are listed below. For questions, they should call Member Services at 1-800-633-1542 (TTY Users call 711).

- **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's covered and the rules that must be followed to get covered services.
  - Chapters 3 and 4 of the *Evidence of Coverage* give details about medical services.
  - Chapters 5 and 6 of the *Evidence of Coverage* give details about Part D drug coverage, if applicable.
- **If members have any other health coverage or drug coverage in addition to our plan, they are required to tell us.** Chapter 1 of the plan's *Evidence of Coverage* tells them about coordinating these benefits.
- **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 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 the drugs they are taking, including over-the-counter drugs, vitamins, and supplements.
  - If they have questions, they should make sure to ask and get answers they can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of doctors' offices, 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 stay a member of the plan.
  - For most of their medical services or drugs covered by our 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 stay a member of our 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* our plan service area, they can't remain a member of our plan.**
- If they move, they should notify Social Security (or the Railroad Retirement Board).

Referral Authorization Form

Attention:
This transmission is private, confiden al, 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.

MAIL THIS COMPLETED FORM TO: VIVA HEALTH
Attention: Medical Management | 417 20th Street North, Suite 1100 | Birmingham, Alabama 35203

Referral #: _____ Expires: _____

Member Name:	Member #:	DOB:	Refer to Provider:	Specialty:

Please check the requested services:	☐ Evaluation and Recommendation	☐ Evaluate and Treat
☐ OPS	☐	☐ 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 #:	

MEDICAL INFORMATION

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

FOR OFFICE USE ONLY

PCP Provider #:		Refer to Provider:
Member Effec ve 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.

This form can be accessed online at: https://www.vivahealth.com/download?ID=1223

Inpatient and Outpatient Precertification Form

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

VIVA HEALTH USE ONLY
☐ Medicare
☐ Commercial

TO BE COMPLETED BY ADMITTING PHYSICIAN:

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

Member Number: _____ Group Number: _____

Person Completing Form: _____ Phone: _____ Fax: _____

Admitting MD: _____ Facility Name: _____

MD NPI: _____ Facility 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 transmission is private, confidenal, 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.

This form can be accessed online at: https://www.vivahealth.com/download?ID=1222

Appointment of Representative Complaint Form For Commercial/Employer Group Members

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).

This form can be accessed online at: https://www.vivahealth.com/files/members/welcome/complaint-rep-appt-form

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**

PCP Change Request Form

PRIMARY CARE PHYSICIAN (PCP) CHANGE REQUEST FORM

Today's Date: _____ Date of 1st Appointment: _____

Member Name: _____ Member ID#: _____

Member Phone: _____ Member Email: _____

New PCP Name: _____

New PCP Individual NPI#: _____

Practice Contact Name: _____ Practice Tax ID #: _____

Practice Contact Phone: _____ Practice Contact Email: _____

Practice Authorized Party Signature: _____

Member or Legal Representative Signature: _____

PLEASE RETURN THIS FORM VIA EMAIL

Email: MSAPCPCHANGE@uabmc.edu

Allow two business days for processing

VIVA HEALTH INTERNAL USE ONLY	
Request Approved	Yes: ☐ No: ☐
Provider System	• If Provider System is changing from an open or to a closed Provider System, change the Provider System effective 1st day of next month. • If new Provider System is closed and will limit access to providers used in the past, contact member to inform. • Mail the member a Medical Records Transfer form and Provider Directory for new Provider System (if changing) • Document Change in PowerStePP or PURAVIVA
Effective Date	

417 20th Street North, Suite 1100, Birmingham, Alabama 35203
Phone (205) 939-1718 • www.vivahealth.com

Notice of Medicare Non-Coverage Forms (NOMNC)

HHAs, SNFs, Hospices, and CORFs are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending. The most updated NOMNC form, Instructions for completing the NOMNC, and additional resources related to Medicare Non-Coverage can be accessed online at: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc

Commercial Pharmacy Coverage Determination Form

417 20th Street North, Suite 1100, Pharmacy Department, Birmingham, AL 35203 | Fax Number: (205) 872-0458

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: ☐ Provider's Stock (Buy & Bill) ☐ Pharmacy's Stock

Must check one: ☐ Brand ☐ 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:

☐ 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:

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 th 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.

Revised: 08/16/2023

Medicare Coverage Determination Form

Use this form to ask our plan for a coverage determination. You can also ask for a coverage determination through our website at https://www.vivahealth.com/Medicare or by phone at 1-800-294-7780.You, your doctor or prescriber, or your authorized representative can make this request.

Plan Enrollee

Name	Date of birth
Street address	City
State	ZIP
Phone	Member ID #

If the person making this request isn't the plan enrollee or prescriber:

Requestor's name
Relationship to plan enrollee
Street address (include City, State and ZIP)
Phone
☐ Submit documentation with this form showing your authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or equivalent). For more information on appointing a representative, contact our plan or call 1-800-MEDICARE. (1-800-633-4227). TTY users can call 1-877-486-2048.

Name of drug this request is about (include dosage and quantity information if available)

Type of Request

☐ My drug plan charged me a higher copayment for a drug than it should have

☐ I want to be reimbursed for a covered drug I already paid for out of pocket

Medicare Coverage Determination Form

VIVA MEDICARE

☐ I'm asking for prior authorization for a prescribed drug (this request may require supporting information)

For the types of requests listed below, your prescriber MUST provide a statement supporting the request. Your prescriber can complete pages 3 and 4 of this form, "Supporting Information for an Exception Request or Prior Authorization."

☐I need a drug that's not on the plan's list of covered drugs (formulary exception)

☐ I've been using a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)

☐ I'm asking for an exception to the requirement that I try another drug before I get a prescribed drug (formulary exception)

☐ I'm asking for an exception to the plan's limit on the number of pills (quantity limit) I can get so that I can get the number of pills prescribed to me (formulary exception)

☐ I'm asking for an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).

☐ My drug plan charges a higher copayment for a prescribed drug than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception)

☐ I've been using a drug that was on a lower copayment tier before, but has or will be moved to a higher copayment tier (tiering exception)

Additional information we should consider *(submit any supporting documents with this form)*:

_____

_____

_____

_____

Do you need an expedited decision?

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we'll automatically give you a decision within 24 hours. If you don't get your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. (You can't ask for an expedited decision if you're asking us to pay you back for a drug you already received.)

☐ **YES, I need a decision within 24 hours.** If you have a supporting statement from your prescriber, attach it to this request.

Signature:	**Date:**

This form can be accessed online at: https://www.vivahealth.com/download?ID=1232

Medicare Coverage Determination Form

How to submit this form

Submit this form and any supporting information by mail or fax:

Address:
VIVA MEDICARE
Pharmacy Department
417 20th Street North
Suite 1100
Birmingham AL 35203

Fax Number:
205-449-2465

Supporting Information for an Exception Request or Prior Authorization
To be completed by the prescriber

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber Information

Name
Street Address (Include City, State and ZIP)
Office phone
Fax
Signature Date

Diagnosis and Medical Information

Medication:	Strength and route of administration:
Frequency:	Date started: ☐ **NEW START**
Expected length of therapy:	Quantity per 30 days:
Height/Weight:	Drug allergies:

This form can be accessed online at: https://www.vivahealth.com/download?ID=1232

Medicare Coverage Determination Form

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	**ICD-10 Code(s)**
Other RELAVENT DIAGNOSES:	**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY	
Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?	☐ **YES** ☐ **NO**
Any concern for a **DRUG INTERACTION** when adding the requested drug to the enrollee's current drug regimen?	☐ **YES** ☐ **NO**
If the answer to either of the questions above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety	

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?	☐ **YES** ☐ **NO**

OPIOIDS – (answer these 4 questions if the requested drug is an opioid)	
What is the daily cumulative Morphine Equivalent Dose **(MED)**? **mg/day**	
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	☐ **YES** ☐ **NO**

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Medicare Coverage Determination Form

Is the stated daily MED dose noted medically necessary?	☐ YES	☐ NO
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ YES	☐ NO

RATIONALE FOR REQUEST

☐ **Alternate drug(s) previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [If not noted in the DRUG HISTORY section, specify below: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed]

☐**Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement.** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required.

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐ **Request for formulary tier exception** If not noted in the DRUG HISTORY section, specify below: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Other** (explain below)

_____

_____

_____

_____

_____

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.

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.

This form can be accessed online at: https://www.vivahealth.com/download?ID=1232

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

Advance Directive Form

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.

Advance Directive Form

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

Advance Directive Form

*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: _____

This form can be accessed online at: https://www.alabamapublichealth.gov/cancer/assets/advdirective.pdf

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