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- Medical Procedures
- Inpatient Admissions
- Drug Authorizations
- Other Prior Authorizations

Customer Service for Providers and Employer Groups
- Assistance with Benefits
- Claims Inquiry
- Assistance with Payment Questions
- Assistance with Eligibility

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

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

- Information is subject to change. Please visit our provider website at www.vivahealth.com/provider for the latest information.
Contact Information

Medicare Member Services

• Member Assistance with Benefits
• Member Assistance with Payment Questions
• Member Assistance with Eligibility

(205) 918-2067 or 1-800-633-1542
TTY: 711
Regular Office Hours: 8:00 a.m. to 8:00 p.m., Monday through Friday (October 1 to March 31: 8:00 a.m. to 8:00 p.m., 7 days a week). You can reach a VIVA HEALTH on-call nurse 24 hours a day, 7 days a week in case of emergency.

Pharmacy Department

• Medicare Part D Prescription Drug Prior Authorization Requests
• Medicare Part D Prescription Drug Step Therapy Requests
• Medicare Part D Prescription Drug Exception Requests

(205) 558-7474 or 1-800-294-7780
FAX: (205) 449-2465
Regular Office Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday

Internet Resources

• www.vivahealth.com/provider
  VIVA HEALTH website for providers. This page includes a link to the VIVA HEALTH Provider Portal, VIVA HEALTH’s Internet access to check member eligibility, authorization information, and claims status.

• www.vivahealth.com
  General VIVA HEALTH website with links to all sites including information for VIVA HEALTH commercial members.

• www.vivahealth.com/medicare
  VIVA HEALTH website for VIVA MEDICARE members and Medicare beneficiaries to learn more about VIVA MEDICARE.

• www.cms.hhs.gov
  CMS website. Go to “Medicare” and then “Health Plans” for information on Medicare Advantage plans like VIVA MEDICARE.
Managed Care Expertise...

VIVA HEALTH, Inc. is a 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 physicians and hospital providers in the market.

Community...

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

Continuum of Care...

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

Extensive Provider Network...

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

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

VIVA HEALTH’s Commitment...

We commit to set the standard in health care excellence, promoting high quality and outstanding value for all of our members.
**ViVa Health** offers several different products and benefits plans tailored to the needs of particular employers and member populations. For some products, such as **ViVa Health** (PCP referral needed to see a specialist) and **ViVa Access** (No PCP referral needed to see a specialist), product design is the same but benefit levels and costs 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. Copies of the benefit plans are also available on **ViVa Health**’s provider website at [www.vivahealth.com/provider](http://www.vivahealth.com/provider). Some of the most common copayment amounts are also 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 6.

All **ViVa Health** products require members to utilize participating providers for services to be covered except in emergency situations, for urgently needed care when traveling, and for **ViVa Medicare** members requiring out-of-area dialysis. Some products limit members to sub-networks called Provider Systems within the **ViVa Health** network of participating providers. All **ViVa Health** 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. All referrals are limited by number of visits and dates.

**EMPLOYER GROUP PLANS (for employers other than UAB, MedWest, and Baptist Montgomery)**

**ViVa Access**
The **ViVa Access** product is **ViVa Health**’s open access product, meaning a Primary Care Physician (PCP) referral is not required for specialist visits to be covered. Identification cards for **ViVa Access** members indicate “No PCP Referral Required” in the PCP field. **ViVa Access** members may use any participating provider.

**ViVa Health**
The **ViVa Health** product is **ViVa Health**’s gatekeeper product, meaning a Primary Care Physician (PCP) referral is required for specialist visits to be covered. No PCP referral is required to visit a participating OB/GYN, optometrist, or ophthalmologist. Identification cards for **ViVa Health** members indicate the name and phone number of the member’s selected PCP. **ViVa Health** members may use any participating provider.
UAB EMPLOYEES

ViVa Health Access for UAB

The ViVa Health Access product for UAB employees is an open access product, meaning a Primary Care Physician (PCP) referral is not required in order for specialist visits to be covered. Identification cards for UAB employees who choose the ViVa Health option will indicate “No PCP Referral Required” in the PCP field, and these members may use any participating provider. Members may use any participating OB/GYN, but copays will be waived if UAB OB/GYNs are seen. Similarly, copays for OB/GYN services will be waived at UAB facilities.

ViVa UAB

The ViVa UAB product is a ViVa Health product offered to UAB employees. The ViVa UAB product is a gatekeeper product meaning a Primary Care Physician (PCP) referral is required for specialist visits to be covered. No PCP referral is required to visit a participating OB/GYN, optometrist, or ophthalmologist. No PCP referral is required, but ViVa UAB members must see a UAB OB/GYN. Identification cards for ViVa UAB members have a green stripe across the top and indicate the name and phone number of the member’s selected PCP. ViVa UAB adult members must use UAB Health System providers except that any participating provider may be used for vision or pain management services. ViVa UAB dependents under age 18 may use any provider in ViVa Health’s network.

ViVa Medicare

ViVa Medicare is ViVa Health’s Medicare Advantage Program for Medicare eligibles residing in Autauga, Baldwin, Blount, Bullock, Calhoun, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, DeKalb, Elmore, Etowah, Franklin, Geneva, Henry, Houston, Jefferson, Lauderdale, Lee, Lowndes, Macon, Mobile, Montgomery, Pike, Shelby, St. Clair, Talladega, Tallapoosa or Walker counties. Identification cards for ViVa Medicare members indicate the name and phone number of the member’s selected PCP and Provider System. While ViVa Medicare members each choose a PCP, for most plans no PCP referral is required for a member to see a specialist within his/her selected Provider System with the exception of pain management services.

ViVa Medicare Me is a limited network plan for members who reside in Blount, Chilton, Dale, Geneva, Henry, Houston, Jefferson, Shelby, St. Clair, Talladega, or Walker County. ViVa Medicare Me has a limited network and is affiliated with either the Brookwood Baptist Health Me plan hospital network (Princeton, Shelby, Citizens, Brookwood, and Walker), the Southeast Health Me plan hospital network, or the St. Vincent’s Me plan hospital network (St. Vincent’s Birmingham, Blount, East, St. Clair, and One Nineteen). A member does not require a PCP referral to see a specialist in either the Baptist Physician Alliance, the Southeast Health Statera Network, or the St. Vincent’s Physician Alliance. However, a PCP referral will be required to see a specialist in either the ViVa Medicare Me at Brookwood Baptist Health supplemental network, the ViVa Medicare Me at Southeast Health supplemental network, or the ViVa Medicare Me at St. Vincent’s supplemental network and for pain management services.

Please see the ViVa Medicare section of this provider manual for more information on ViVa Health’s Medicare plans.

Note: Please visit www.vivabhealth.com/provider for the most current listing of sample identification cards and a brief product description of the different ViVa Health Benefit plans.
Internet Access to Eligibility, Authorization, and Claims Information

Participating providers with Internet access may want to take advantage of our VIVA HEALTH Provider Portal, a free web-based application to check member eligibility, authorizations, and claims status. This information is accessed using a secure user ID/password combination provided by VIVA HEALTH, and only information pertinent to your entity will be provided. Like all internet applications, response times will depend on the speed of your internet connection. Most dial-up connections will not be able to make efficient use of the information presented.

Getting a User ID and Password

Providers may obtain a user ID and password by going to the VIVA HEALTH website for providers, www.vivahealth.com/provider, and clicking on the “Provider Portal” tab and selecting Portal Information, contacting their Provider Services Representative, or e-mailing vivaproviderportal@uabmc.edu with the following information:

- Provider name
- NPI #
- Federal Tax ID #
- Address
- Phone number
- E-mail address

Access will only be granted to contracted VIVA HEALTH providers. Due to the sensitive nature of the Protected Health Information (PHI) concerned, third parties such as billing companies will not be given access by VIVA HEALTH. Access may be requested by the contracted provider who may in turn grant the access to their third party business associate. Obligations under the Health Insurance Portability and Accountability Act (HIPAA) and the VIVA HEALTH Provider Portal User Agreement remain the contracted provider’s responsibility.

Logging On to the VIVA HEALTH Provider Portal

The VIVA HEALTH Provider Portal can be accessed by going to www.vivahealth.com/provider and entering your username and password. Your initial password will be randomly assigned by VIVA HEALTH, but once you have logged in successfully, you may change your password by selecting the “Administration” tab, selecting “Change Password” from the drop-down menu, and following the prompts.

In some cases, providers may add additional users with their own passwords. This is done by selecting the “Administration” tab, selecting “User Maintenance” from the drop-down menu, and following the prompts.
**VIVA Health’s Accessibility Standard**

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

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

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 can be faxed to (205) 558-7477 or emailed to vivaproviderservices@uabmc.edu. If a member selects a participating provider as his/her 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 his/her panel to established patients who elect a **VIVA Health** or **VIVA Medicare** plan.

Appointments must be available to **VIVA Health** members within the prescribed standard listed below and must be expedited based on medical need. Please note **VIVA Health** monitors the compliance of the accessibility standard through random monthly audits.

<table>
<thead>
<tr>
<th>Appointment type:</th>
<th>Time Elapsed Standard:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Communication about a life-threatening situation should be addressed with the member immediately.</td>
</tr>
<tr>
<td>Urgent</td>
<td>A member with an unforeseen illness or injury; appointment available within 24 hours of the request.</td>
</tr>
<tr>
<td>Post Discharge Follow Up</td>
<td>A member who is discharged from the hospital; appointment available within 7 calendar days of the discharge notice.</td>
</tr>
<tr>
<td>Routine</td>
<td>A member with a routine care need; appointment available within 14 calendar days of the request.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>A member with a preventive health need; appointment available within 30 calendar days of the request.</td>
</tr>
<tr>
<td>In Office Wait Time</td>
<td>For scheduled appointments, the wait time from the appointment time to seeing the physician should be 30 minutes or less (except if a provider is called away for an emergency). If wait time is greater than 30 minutes, the member should be informed of the circumstance and/or provided an alternative appointment.</td>
</tr>
</tbody>
</table>

(Chief Wellness Officer Surveys inquire if members are usually seen by his/her provider within 15 minutes of the scheduled appointment. Providers are urged to adopt this as a best practice.)
**VIVA HEALTH’s Practice Site Visit Standard**

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

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

**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 Standard:**

<table>
<thead>
<tr>
<th><strong>Physical Accessibility:</strong></th>
<th><strong>Physical Accessibility:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate general parking</td>
<td>Adequate seating in waiting area</td>
</tr>
<tr>
<td>Designated disabled parking space</td>
<td>Adequate privacy at registration</td>
</tr>
<tr>
<td>Wheelchair accessible ramps</td>
<td>Treatment room has adequate treatment space</td>
</tr>
<tr>
<td>If office is located off main level, an elevator is available for public use</td>
<td>Seating available in treatment room</td>
</tr>
<tr>
<td>Restrooms are accessible to all patients including physically disabled</td>
<td><strong>Medical Records/ Security</strong></td>
</tr>
<tr>
<td></td>
<td>Patient medical records are in secure/confidential filing system</td>
</tr>
<tr>
<td></td>
<td>If using electronic records, medical records are password protected</td>
</tr>
<tr>
<td><strong>Physical Appearance:</strong></td>
<td>Patient medical records are legible</td>
</tr>
<tr>
<td>Practice location identified by visual signage</td>
<td>Patient notification of Privacy Policy</td>
</tr>
<tr>
<td>Visual cleanliness of restroom, waiting room, and treatment room</td>
<td>Patient notification of HIPAA Policy</td>
</tr>
<tr>
<td>Well lit waiting and treatment area</td>
<td>Prescription pads are secure at all times</td>
</tr>
<tr>
<td>Exit sign is visible</td>
<td>Narcotics are under lock and key at all times</td>
</tr>
<tr>
<td>Exits and hallway are clear from obstruction</td>
<td>Medications are accessible by staff only</td>
</tr>
<tr>
<td>Fire extinguisher visible and checked annually</td>
<td></td>
</tr>
<tr>
<td>Biohazard disposal system</td>
<td></td>
</tr>
<tr>
<td>Needle disposal system</td>
<td></td>
</tr>
<tr>
<td>Medication/laboratory refrigeration is kept separate from food</td>
<td></td>
</tr>
</tbody>
</table>
Your Role in Improving Member Satisfaction

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

Access Standards
Members should be able to obtain services in compliance with Viva Health’s Accessibility Standards listed on page 7.

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

• Remember that cultural gaps can lead to miscommunications. Take steps to better understand your patients’ perspectives by studying the health-related beliefs of cultures represented in your patient population. Be willing to listen and learn from your patients with diverse cultural backgrounds.

• The more closely your staff reflects the diversity of your patient base, the better you will be able to serve your patients. For example, if a high percentage of your patients speak a particular foreign language, you may wish to consider having someone on staff who also speaks that language.

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

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

• Keep patient files under lock and key and limit access to those persons for whom access is required to perform job responsibilities.

• Adopt confidentiality policies and procedures and train all staff on them. Have each staff member agree in writing to abide by the procedures and not disclose medical information for purposes not related to work.
Your Role in Improving Member Satisfaction

• If you keep patients’ medical information in an electronic format, strict confidentiality policies and limited access are even more critical.
• Federal regulations related to the confidentiality and security of patient information have been implemented under the Health Insurance Portability and Accountability Act (HIPAA). ViVa Health and contracted providers must stay abreast of the regulations and comply with their requirements.

Communication

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

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

The scores on these four questions are among the most important indicators of whether ViVa Health is delivering a quality product to our ViVa Medicare members. In today’s fast-paced world, consumers often feel hurried and may not always receive all the information necessary to make informed choices. Unfortunately, the health care industry is no exception. ViVa Health encourages doctors 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 physicians communicate findings and treatment plans back to the PCP to enhance continuity of care. These findings should be communicated to the PCP within 30 days of the last visit to the specialist for a course of evaluation or treatment.

Prevention of Discrimination

All ViVa Health providers agree by contract not to discriminate in the treatment of members based on race, color, national origin, ancestry, religion, marital status, sexual orientation, gender, age, or disability. Providers agree to make services available to all ViVa Health members in the same manner, in accordance with the same standards, and with the same availability as to non-members. We ask that providers work with office staff to promote an accepting environment for all patients. We also ask that providers adopt and distribute an office policy supporting non-discriminatory practices.
The Centers for Medicare & Medicaid Services standards strictly prohibit health screening of eligible enrollees at the time of enrollment. Similarly, encouraging the disenrollment of a member in poor health based on financial motives (i.e., to avoid liability for the member’s claims) is equally prohibited. The standards apply to both Viva Health and Viva Medicare contracted providers.

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

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 physician if the patient changes doctors. Records should be provided promptly and in a manner that safeguards the privacy of the patient. Viva Health can provide a medical record transfer form to assist in expediting this process when necessary. To get copies of this form, please call your Provider Services Representative.

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.
The Role of the Primary Care Physician

The Primary Care Physician (PCP) is a participating physician who has the responsibility for directing the complete care of his/her members. The PCP will provide the care him/herself or refer the care to an appropriate Viva Health participating provider.

**PCPs include the following specialties:**

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

The PCP manages the health care needs of Viva Health members who select him/her as their personal physician. The PCP provides the member with emergency, urgent, routine, and follow-up care within that physician's scope of medical training and practice. In addition to managing all services for office care, PCPs are responsible for obtaining referrals to specialists (SCPs) when required by the member's plan, obtaining authorizations for hospital admissions when he/she is the admitting physician, coordinating emergency, urgent and/or out-of-area care when possible, and maintenance of the member's complete medical record.

**The basic PCP services and responsibilities are:**

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

**For Members.** Arrangements for coverage while off duty or on vacation must be made with participating physicians. The PCP is responsible for the management of all medical services for his/her Viva Health patients, including the management of referrals to Specialty Care Physicians (SCPs) when required by the member’s plan, facilities, or other providers. Services to be coordinated by the PCP include, but are not limited to:

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

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

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

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

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

Fax referral requests to:
Birmingham (205) 449-7049

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

- The VIVA HEALTH Medical Management Department will inform the requesting provider of the prior authorization approval for approved services. The PCP notifies the member 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 6 of this Provider Manual.

Physician Extenders:
A physician extender is a specially trained, certified, and licensed provider who renders medical services within the scope of his/her license. VIVA HEALTH credentials a physician extender and requires that the collaborating physician for the physician extender is a credentialed provider with VIVA HEALTH and resides in the same practice location for at least 32 hours per week. VIVA HEALTH recognizes the following physician extenders as eligible network participants: a certified registered nurse practitioner (CRNP), a physician assistant (PA), and a surgical physician assistant (SPA).
Referral Authorization Form

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

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

Referral #: ____________________________ Expires: ____________________________

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member #</th>
<th>DOB</th>
<th>Refer to Provider</th>
<th>Specialty</th>
</tr>
</thead>
</table>

| Please check the requested services: | ☒ Evaluation and Recommendation | ☒ Evaluate and Treat |
| ☒ OPS | ☒ One Follow-Up Visit | ☒ Send Report to PCP |

Number of Visits: (If Pain Mgmt, Limited to 6 visits/6 months) Appointment Date: ____________________________

MEDICAL INFORMATION

Diagnosis: ____________________________ ICD-10 Code: ____________________________

Symptoms: ______________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Previous Treatment (if pertinent for referral): __________________________________________________________
__________________________________________________________________________________________________

Lab/X-Ray Finding (if pertinent for referral): _____________________________________________________________
__________________________________________________________________________________________________

Medical Record #: ____________________________

AUTHORIZATION

<table>
<thead>
<tr>
<th>PCP Name:</th>
<th>Phone #: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Fax #: ( )</td>
</tr>
</tbody>
</table>

FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>PCP Provider #:</th>
<th>Refer to Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Effective Date:</td>
<td>Auth Type:</td>
</tr>
<tr>
<td>Auth Start Date:</td>
<td>Auth End Date:</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Date:</td>
</tr>
<tr>
<td>Entered by:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

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

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

The Specialty Care Physician’s obligations include the following:

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

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

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

For those plans that require a PCP referral to a specialist, referral requests must be approved by Viva Health Medical Management prior to the member’s visit to the Specialty Care Physician. 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 member cannot be billed for those services unless the patient signed a specific waiver (see next page for a sample).

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

All referrals are limited by number of visits and dates. 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 member cannot be billed for those services, unless the patient signed a specific waiver (see next page for a sample).
Responsibilities of the Specialist

Termination of Viva Health Members with Prior Authorizations/Covered Services

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

If a Viva Health member comes into your specialist’s office for treatment without a referral, you may:

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

SAMPLE WAIVER

I, [patient’s name], verify that I have been informed by [physician/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 [physician/facility name], I must obtain proper referral/authorization from Viva Health’s Medical Management Department.

__________________________________ ___________________________
Patient’s Signature Date of Signature
Responsibilities of the Hospital

**Authorizations:**
It is the responsibility of the hospital to confirm proper authorization has been obtained for all non-emergency admissions and outpatient procedures/services, including observation units, 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 physician claims. Participating hospitals may not bill Viva Health members for services denied due to lack of proper authorization.

**ER Visits:**
- Check member’s ID card or the Viva Provider Portal at [www.vivahealth.com/provider](http://www.vivahealth.com/provider) for applicable ER copay amounts.
- Waive ER copay if patient is admitted within 24 hours from ER and apply appropriate copay.
- Authorization must be obtained for all emergency inpatient or observation admissions no later than 5 p.m. the next business day.

**Admissions:**
- Except in emergencies, admit Viva Health patients only from participating physicians.
- Except in emergencies, Viva Health must approve all hospital admissions in advance.
- Authorization must be obtained for all emergency inpatient or observation admissions no later than 5 p.m. the next business day.
- When a Medicare patient is admitted to the hospital and insurance information cannot be verified, the hospital should check Medicare’s Common Working File to see if the patient is a member of Viva Medicare so that proper authorization of the admission can be obtained timely.

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

**Claims Filing:**
- To be considered for payment, claims must be received within 180 days from the date of service. (Members may not be billed for claims denied due to late filing).
- Include authorization and tax ID number
- Mail claims for employer groups to: Viva Health Claims
  P.O. Box 55926
  Birmingham, AL 35255-5926
- Mail claims for Medicare members to: Viva Medicare Claims
  P.O. Box 55209
  Birmingham, AL 35255-5209
- Submit EDI claims to Change Healthcare payer ID 63114
Except in emergencies, contact Viva Health for certification prior to the patient being admitted to the hospital at (205) 933-1201 or 1-800-294-7780.

Guidelines for Inpatient Admissions:
Recognizing the significance of hospital costs, Viva Health does not rely solely upon retrospective review or financial incentives to contain inpatient expenses, but prospectively works with the provider on each admission to ensure the appropriate setting and medical necessity of the proposed inpatient services.

- Notify Viva Health no later than 5 p.m. the next business day for emergency admissions. There is a Viva Health nurse 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 member is admitted. Lack of notification within 24 hours or the next business day may result in a denial for lack of timely notification and the member cannot be billed.

- Provide the coordinator with the following information:
  - Member’s name
  - Diagnosis/procedure requiring hospitalization
  - Admitting physician’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

- Concurrent review is performed on all admissions. During the member’s hospitalization, a Viva Health coordinator will contact the hospital to obtain additional medical information. If the member’s condition warrants further hospitalization, contact Viva Health to request an extended length of stay.

- Participating hospitals and physicians who do not comply with the prior authorization policy will be subject to the Viva Health sanction process. Members may not be billed for claims denied due to lack of prior authorization.

- Viva Health may not pay for services related to medical errors, avoidable readmissions, and/or “never events.”

All Non-Emergency Hospital Inpatient or Observation Admissions Require Prior Authorization.
All Viva Health and Viva Medicare members require the Primary Care Physician 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.
- Most in-office surgeries

- All inpatient and observation admissions (For emergencies, an authorization must be obtained no later than 5 p.m. the next business day.)
- All scopes performed outside the physician’s office excluding Colonoscopy and EGD

- Outpatient surgery, including wound care
- Arteriograms

- For obstetrical admissions, authorization is required if mother or baby stay longer than 48 or 96 hours after delivery.
- Angiograms except when CT guided

- Inpatient rehabilitation or day treatment (letter of medical necessity required)
- Cardiac caths

- Non-emergent out-of-network, out-of-panel, or out-of-area services
- Cardiac and pulmonary rehab

- Non-emergent ambulance transport
- Holter monitors worn longer than 24 hours

- Transplant services
- PET scans, Myelograms, and Discograms

- All sinus or nasal surgery (copies of medical records required), excluding in-office scopes
- Sleep Studies: C-PAP, MSLT, PSNG (copies of medical records with symptoms listed required)

- All Plastic Surgery regardless of the place of service (copies of medical records, pre-op photos and letter of medical necessity required)
- Pain clinic care

- Skilled Nursing Facility admissions
- All Ancillary Services (home health, IV therapy, hospice care, orthotics, prosthetics, etc.)

- Rehabilitation services: physical, occupational, and speech therapy
- DME: If DME equipment is distributed by the physician’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 physician does not require an authorization, except diabetic shoes/inserts, which always require an authorization.
Procedures Requiring Prior Authorization

Continued from previous page

<table>
<thead>
<tr>
<th>• Photodynamic therapy regardless of place of service</th>
<th>• Prescriptions requiring prior authorization <a href="https://www.vivahealth.com/provider/Resources/#Viva_Health_Coverage_policies_and_criterian">https://www.vivahealth.com/provider/Resources/#Viva_Health_Coverage_policies_and_criterian</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neuropsych testing</td>
<td>• Radiology (MRI, MRA, PET, CT, 3DI, nuclear cardiology)</td>
</tr>
<tr>
<td>• Partial Hospitalization Programs (PHPs)</td>
<td>• Intensive Outpatient Programs (IOPs)</td>
</tr>
</tbody>
</table>

EXTENDED REFERRALS

Physical Therapy:
• A set number of visits will be initially granted.
• Physical, occupational, and speech therapy providers must fax requests for further extension of services to (205) 449-7049.

Specialist Referrals:
• Specialist referrals must be approved by Viva Health for the initial visit(s). Additional visits may be requested by the specialist.

VIVA MEDICARE ME Prior Authorization Requirements

All Medicare plans except for VIVA MEDICARE ME follow the Viva Health prior authorization guidelines. The VIVA MEDICARE ME prior authorization guidelines are listed below. Viva Health requires the PCP or specialist to contact the Medical Management Department for the following:*  

- VIVA MEDICARE ME is a Limited Network and requires a referral to see a specialist outside of the Brookwood Baptist Physician Alliance network, the St. Vincent’s Physician Alliance network, or Southeast Health Statera network.
- Angiogram, except when CT guided

Continued on next page
### Procedures Requiring Prior Authorization

*Continued from previous page*

- All inpatient and observation admissions *(For emergencies, an authorization must be obtained no later than 5 p.m. the next business day.)*  
  - Most in-office surgeries
- For obstetrical admissions, authorization is required if mother or baby stay longer than 48 or 96 hours after delivery.  
  - Cardiac caths
- Outpatient surgery, including wound care  
  - Myocardial Perfusion Imaging (Cardiac Pet, MUGA Scan, SPECT Scan)
- Inpatient rehabilitation or day treatment (letter of medical necessity required)  
  - Cardiac and pulmonary rehab
- **Non-emergent care outside of Viva Medicare Me Network**  
  - Holter monitors worn longer than 24 hours
- Non-emergent ambulance transport  
  - MRI (including open MRI)
- Transplant services  
  - Myelogram and Discogram
- All sinus or nasal surgery (copies of medical records required), **excluding in-office scopes**  
  - PET scans
- All plastic surgery regardless of the place of service (copies of medical records, pre-op photos and letter of medical necessity required)  
  - Sleep studies: C-PAP, MSLT, PSNG (copies of medical records with symptoms listed required)
- Skilled Nursing Facility admissions  
  - Pain clinic care
- Rehabilitation services: physical, occupational, and speech therapy  
  - All Ancillary Services (home health, IV therapy, orthotics, prosthetics, etc.)
- Photodynamic therapy, regardless of place of service  
  - DME: If DME equipment is distributed by the physician’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 physician does not require an authorization, except diabetic shoes/inserts, which always require an authorization.
**Procedures Requiring Prior Authorization**

- All scopes performed outside the physician’s office, *excluding colonoscopy and EGD*
- Prescriptions requiring prior authorization
- Arteriogram
- Neuropsychological testing
- Nuclear stress tests
- Pain management requires a PCP referral

Extended referrals may be requested for **Viva Medicare** members under the following guidelines:

**Physical Therapy:**
- A set number of visits will be initially granted.
- Physical, Speech, and Occupational Therapy providers MUST fax requests for further extension of services to (205) 449-7049.

**Outpatient Referrals:**
- Outpatient referrals will be approved for a set number of visits. A referral is valid for specific time frames only which will be communicated at the time the authorization is given. The PCP or specialist may request additional visits as needed.

Failure to secure required prior authorization will result in non-payment and the member may not be balanced billed.

*The Prior Authorization lists for **Viva Health** and **Viva Medicare** plans are subject to change. For the most current version of the authorization list, please refer to **Viva Health**’s provider website at [www.vivahealth.com/provider](http://www.vivahealth.com/provider).*
TO BE COMPLETED BY ADMITTING PHYSICIAN:

<table>
<thead>
<tr>
<th>Patient Name: ___________________________________</th>
<th>Date of Birth: ___________</th>
<th>Other Insurance: ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Number: ____________________________</td>
<td>Group Number: ___________</td>
<td></td>
</tr>
<tr>
<td>Person Completing Form: _______________________</td>
<td>Phone: _________________</td>
<td>Fax: ______________________</td>
</tr>
<tr>
<td>Admitting MD: ____________________________</td>
<td>Facility Name: ___________</td>
<td></td>
</tr>
<tr>
<td>NPI: ____________________________</td>
<td>Tax ID: __________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis: ___________________________________</th>
<th>ICD-10 Code: ___________</th>
<th>Procedures: _______________</th>
<th>CPT: ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admit Date or Procedure Date: _________________</th>
<th>Requested Length of Stay: _________________</th>
</tr>
</thead>
</table>

Prior Level of Function: _________________
Current Level of Function: _________________
Past Medical History:

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

Medical Indication for Requested Service:

Treatment Plan:

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

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

This facsimile is private, confidential, and intended only for the recipient named hereon. If you receive this transmission in error, please contact VIVA HEALTH’s Medical Management Department at (205) 933-1201.
Procedures That Do Not Require Prior Authorization

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

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

Note:
*Diagnostic testing will only be covered when performed at participating radiological facilities. Please refer to the most current VIVA HEALTH provider directory at www.vivabealth.com/provider for a list of these facilities.
At Viva Health, we encourage good health habits for our members and are working to minimize barriers to quality health care. As part of this effort, we have eliminated the requirement for prior authorization for the following diabetic testing supplies effective January 1, 2019: non-continuous glucose monitors (HCPCS codes E0607, E2100, E2101), spring-powered device for lancets (HCPCS code A4258), lancets (HCPCS code A4259), and test strips (HCPCS code A4253) when such supplies are provided in accordance with Medicare coverage guidelines. Viva Medicare members have the added option of getting Accu-Chek brand diabetic supplies from a network pharmacy. Additionally, commercial members have access to One Touch and Free Style brand supplies through a network pharmacy.

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

LCD weblink: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33822&ContrId=140&ver=17&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&Lcntrctr=140*2&bc=AgACAAQAAAAA&

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 member must be held harmless.

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

Diabetic Supplies: Update for 2020

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

Services Covered Under the Global Delivery Fee

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 member can see a participating OB/GYN for any problem pertaining to obstetric or gynecological care without obtaining a referral from her Primary Care Physician.

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

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

In-office surgical procedures, not including plastic surgery, do not require prior authorization. The specialist must obtain a referral from the PCP if the member’s plan requires a PCP referral.
If the member’s network is a provider system, then surgeries generally must be performed at facilities within that provider system. Non-covered Ambulatory Surgical Procedures include, but are not limited to, the following:

### Non-Covered Procedures:

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

**Note:**

*ViVa Health follows Medicare guidelines for ViVa Medicare members.*
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 her 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 Member Do in an Emergency?

- If time or the member’s condition does not permit him/her to call the PCP first, the member 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 member is unsure if the situation is an emergency, the member may call the PCP for advice. The PCP may authorize treatment in the emergency room, elect to treat the patient himself 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 member 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 Physician.

No prior authorization of emergency services from Viva Health is required. Viva Health will 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 member 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 inpatient admission.
The Medical Management Department is comprised of specially trained individuals including registered nurses and referral coordinators. The plan’s Medical Director oversees the staff to ensure that appropriate utilization, quality control, and departmental procedures are followed.

The Medical Director is supported by the UM/QI Committee, comprised of participating Primary Care Physicians 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:

**Admission Review**

Admission Review is used to establish the medical necessity of a proposed inpatient medical service prior to admission and channel, when appropriate, to a setting of lesser intensity of service. All inpatient admissions are reviewed by a licensed clinician, after obtaining all pertinent clinical information from the physician’s chart and staff, using Interqual 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 admission criteria are met, an initial stay of one day will be assigned. The case will be forwarded to a case manager for follow up and additional days will be approved as needed. If admission criteria are not met, the UM staff will speak with the attending MD or the case will be referred to the Chief Medical Officer or physician designee for review.

**Concurrent Hospital Review**

Concurrent hospital review provides a daily evaluation of the medical necessity of inpatient care, verifies that the hospital setting is consistent with the patient’s needs, monitors and ensures efficient use of resources, and evaluates length of stay. Concurrent review is performed on site or telephonically using established criteria. A Medical Management licensed clinician will authorize an extended length of stay based on meeting guidelines or refer the case to the Chief Medical Officer or physician designee for review.

**Case Management**

Case Management is the systematic process of assessing, planning, implementing, and evaluating services and resources required to respond to an individual’s health care needs. Case Management establishes an organized process of coordinating care for patients with catastrophic illness or special needs. Case Management facilitates the coordination of available health care options and resources; it promotes quality, cost-effective health care. Case Management is an ongoing process working hand in hand with the concurrent review, discharge planning and other Viva Health processes; cases with high utilization, costs > $10,000, or catastrophic diagnosis automatically trigger a Case Management review. Otherwise, Case Management is implemented as needed.
**Discharge Planning**

All inpatients are evaluated by the Medical Management licensed clinician upon admission and concurrently 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.

**Physician Sanctioning**

When a participating physician repeatedly fails to comply with medical management requirements, physician sanctioning provides a remedy. Medical Management compiles reports for the Medical Director 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 physician and adversely affect or limit the physician’s participation in the Viva Health network, the physician will have a right to an appeal in accordance with the Provider Hearings Section of this Provider Manual. Further, if the physician’s provider agreement with Viva Health or the Medicare Advantage rules, regulations, or policies, if applicable, entitle the physician to a hearing when sanctions are applied, the physician 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 to the Medical Management department for requesting of medical records, review, and payment determination. Medical Management is responsible for expediting such requests and ensuring receipt of medical records needed to determine claims payment status. Medical records must be received within 60 days of request in order for the claim to be eligible for payment. If medical records are not received within 60 days, the claim will be denied and neither Viva Health nor the member will be responsible for payment. Upon receipt of the records, Medical Management confers with the Chief Medical Officer or physician designee, as needed, to determine medical necessity. The Chief Medical Officer or physician designee is responsible for deciding claims issues related to medical necessity with input from other physicians, as needed/required.

**Benefit Verification**

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

As needed, the Medical Management Department under the direction of the Chief Medical Officer will update or establish new policies based on medical indications, changes in technology, regulatory requirements, or other factors.

CUSTOMER CARE THAT ACTUALLY CARES

You can rest assured that your patients are in good hands with Viva Health. Year after year, Viva Health scores significantly above the national average for overall satisfaction with our plans.¹

¹Based on the 2003-2019 annual Medicare Survey Overall Rating of Health Plans
VIVA HEALTH’s Quality Improvement Program

VIVA HEALTH maintains an active Quality Improvement 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 Committee serves as a formal mechanism for the health plan to consult with physicians 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 Committees’ membership consists of the following:

- Minimum of three to four participating providers representative of specialties relevant to the health plan’s member demographics (such as family practice, internal medicine, pulmonary medicine, oncology, and behavioral health)

- Additional specialty providers may be appointed as ad hoc voting members as necessary, for clinical issues (e.g., dentists, pharmacists, chiropractors)

The Committee meets a minimum of quarterly and reports subsequently to the Board of Directors. Physician members are appointed for three-year terms which may be extended at the plan’s discretion. VIVA HEALTH’s Chief Medical Officer is the Chair of the Committee. Board-certified physicians who are not members are invited to attend the meeting or otherwise advise the Committee when appropriate to meet Committee objectives or provide expert opinion.

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

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

VIVA HEALTH complies with various CMS or other mandates and other activities related to specific QI Program activities. Examples are discussed below.
Participation in the Healthcare Effectiveness Data and Information Set (HEDIS): The Healthcare Effectiveness Data and Information Set (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 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, so 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 service for our members. Viva Health providers may be asked to participate in improvement project initiatives as part of the broader Quality Improvement program. Viva projects may include focused improvement in difficult HEDIS measures or Pharmacy quality measures. Many improvement projects are facilitated by the C4Q nurses. Examples include improving statin use in members with diabetes or cardiovascular disease, increasing medication adherence in members with chronic disease, assisting members obtain recommended health screenings and services, or initiatives to reduce the risk of readmission following discharge.

Conducting a multi-year Chronic Care Improvement Program (CCIP): Viva is required to conduct Chronic Care Improvement Program (CCIP) initiatives. CCIPs must promote effective management of chronic disease, improve care and health outcomes for our members with chronic conditions. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for Viva and our members. The current Viva CCIP targets improving follow-up after hospital discharge for members with mental illness, especially major depression. Viva contacts these members, facilitates making appropriate MD appointments after discharge, and/or sends care management RNs and social workers into the community to work with our members.

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 physician. These include ease of getting needed care and seeing specialists, getting appointments and care quickly, doctors 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.

Quality of Care Oversight: ViVa Health monitoring for events that may indicate a break-down in the provision of quality care such as readmissions, the occurrence of post-operative and other medical complications, infection, and deaths. ViVa Health also monitors reports to determine potential over utilization, underutilization, provider performance and member needs or gaps in care. ViVa Health maintains mechanisms for our members and providers to report potential quality of care and quality of service issues through our customer service or provider services areas. All potential problems with clinical care and services identified are reported to a Medical Director for review. 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.

Assisting members receive necessary screening or other health services. In addition to providing member benefits for services, ViVa Health holds regular member health fairs and assists in arranging member access to necessary testing. ViVa Health also has the ability to provide the following on-demand health screening services either directly or through special provider partnerships:

- Hemoglobin A1C testing
- Heel or wrist scans for bone density testing for potential osteoporosis
- Fecal immunochemical test (FIT) kits for colon cancer screening
- Retinal scans
- Seasonal Flu vaccination events

ViVa Health also 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 if you have patients you would like to refer to ViVa for any of these services.

Maintenance of Clinical Practice Guidelines: From time to time ViVa Health distributes 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 ViVa Health’s Utilization Management/Quality Improvement Committee from a nationally recognized public source such as the Agency for Healthcare Research and Quality, the National Institute of Health, or medical specialty societies. Guidelines are adopted based on the identified needs of our member population.

**DISCLAIMER**

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

1. Fixed protocols that must be followed. Patients’ needs should be considered on an individual basis and in some cases appropriate treatment may differ from the guideline.
2. A substitute for physician assessment and advice. Guidelines do not take into account the unique needs and resources of the particular patient and community.

3. 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.

4. Designed to limit communication. VIVA HEALTH providers are encouraged to discuss all available treatment options with our members and to consult with other physicians and information sources as necessary to provide high quality care.

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

VIVA HEALTH has adopted the following Practice Guidelines:

**Diabetes Management**  
*Standards of Medical Care in Diabetes -2020*  
Source: American Diabetes Association

**Cardiovascular Disease Prevention and Management**  
American Heart Association and American College of Cardiology

**Attention Deficit/Hyperactivity Disorder Child and Adolescent**  
*ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*  
Source: American Academy of Pediatrics

**Adult Major Depression Guideline for Initial Outpatient Treatment of Adults**  
*Major Depression Guideline for Initial Outpatient Treatment of Adults*  
Source: American Psychiatric Association

**American Academy of Pediatrics Recommended Immunization Schedule U.S.**  
- This standard can be reviewed by visiting: http://www.aap.org

**Guidelines for Adult Preventive Care Recommendations 2014**  
- This standard can be reviewed by visiting: http://www.ahrq.gov

**U.S. Preventive Services Task Force**  
- This standard can be reviewed by visiting: http://www.uspreventiveservicestaskforce.org

**Member Educational Information**  
- Advancing Medical Professionalism to Improve Health Care (ABIM) Foundation *Choosing Wisely®*.  
*Choosing Wisely®* is an initiative of the ABIM 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 Needed to Assure Timely Claims Payment

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

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

Claims should be submitted to:

- Submit EDI claims to Change Healthcare payer ID 63114

For Employer Group Plan Members

- VIVA HEALTH Claims
  P.O Box 55926
  Birmingham, AL 35255-5926

For Medicare Advantage Plan Members

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

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

Filing Claims When Capitated

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

**VIVA HEALTH** has contracted with Change Healthcare Online as its electronic claims clearinghouse. Providers may bill claims electronically to **VIVA HEALTH** by providing their electronic claims vendor with **VIVA HEALTH**’s Payer ID Number, 63114.

When billing electronically, it is critical that a member’s correct 10-digit **VIVA HEALTH** ID Number be used (8-digit Family ID Number and 2-digit ID Suffix). Electronic claims may be rejected if incomplete ID numbers, or ID numbers not matching the member’s date of birth, gender, name, etc., are used.

Please note that electronically filed “corrected claim” or claim with new/other information for dates of service previously billed electronically should indicate the following for HCFAs and UBS: Enter Claim Frequency Type (billing code) 7 for a replacement/correction in the 2300 loop in the CLM*05 03. Please indicate reason for resubmission in the loop 2300 NTE segment (ADD) qualifier.

Please contact Jennifer Brookshaw for EDI assistance (205) 558-7447.

**Electronic Funds Transfer (EFT)**

**VIVA HEALTH** has selected Change Healthcare (formerly Emdeon) as its electronic payment and remittance reporting provider. There is no cost to you to use Change Healthcare ePayment and enrollment is free. You can switch from paper to electronic payments over the phone, online, through the mail, or via fax:

**Medical Providers:**

To enroll by mail, email, or fax, download the enrollment form at [www.ChangeHealthcare.com/eft](http://www.ChangeHealthcare.com/eft)

- **Call:** 866-506-2830
- **Fax:** 615-238-9615
- **Enroll by email:** send completed PDF form to: EFTenrollment@changehealthcare.com
- **Enroll mail:** send complete form to:
  - Change Healthcare
    ATTN: Electronic Payment Service Enrollment
    P.O. Box 148850
    Nashville, TN 37214

Remember to have all your **VIVA HEALTH** Vendor IDs available when you enroll for Change Healthcare ePayment EFT. **VIVA HEALTH** Vendor IDs can normally be found on the EOP remittances which accompany payments.
Every VIVA MEDICARE plan offers a dental allowance that VIVA MEDICARE members can use for any preventive, diagnostic, or comprehensive dental service. These services include:

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

VIVA MEDICARE members can use their dental allowance toward any dental service. 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.

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

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

- **Telephone:** (205) 558-7474 or (800) 294-7780
- **Fax:** (205) 449-7849
- **Website:** www.vivahealth.com/provider
- **Provider Services Email:** vivaproviderservices@uabmc.edu

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

VIVA MEDICARE

P.O. Box 55209

Birmingham, AL 35255-5209

### Unique Billing Situations

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<thead>
<tr>
<th>Provider Reimbursement Methodologies</th>
<th>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.</th>
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</table>
| 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 surgical procedures performed on the same day but through separate operative fields, then surgeries are reimbursed according to the following:  
| | • 100% of the fee schedule for the highest value procedure  
| | • 50% of the fee schedule for the remaining medically appropriate surgical procedures  
| | When a claim is received for multiple procedures performed on the same day through the same operative field, then only the highest value procedure is reimbursed. |
| 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 physicians’ on-call or after-hours service outside normal office hours or for return calls by the physician, 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. |
| Photocopy Charges | Photocopy charges are generally not reimbursable by Viva Health. Please refer to your Provider Agreement for additional information. |
| 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. |
| Facility Fees for Professional Office Visit Services | These fees frequently billed under revenue codes 510 through 519 are not considered covered expenses. The portion of these fees that are for facility overhead should be recovered from the professionals billing for the services. These fees are not billable to Viva Health or the Viva Health member. |
| Anesthesia Codes | Every anesthesia code should be submitted with a payment modifier. Anesthesia codes 00100-01999 will be rejected if a modifier is not included. The accepted payment modifiers include:  
| | AA  Anesthesia service performed personally by anesthesiologist  
| | AD  Medically supervised by a physician 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 physician (currently payable only for Viva Medicare)  
| | QY  Medical direction of one CRNA by an anesthesiologist  
<p>| | QZ  Anesthetist service without medical direction of a physician (currently payable only for Viva Medicare) |</p>
<table>
<thead>
<tr>
<th>Unique Billing Situations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity Care</strong></td>
</tr>
<tr>
<td>Maternity care is included under the global maternity code (CPT Code 59400 or 59510). A copay will be charged at the first office visit. You may not bill for each office visit for routine maternity care; these visits will be included in the payment for your global maternity bill. If global maternity services include VBAC (vaginal birth after C-section) or complicated delivery, please add the modifier 22 to CPT code 59400. Include supporting documentation for complications, such as Operative Summary or Discharge Summary. If you are not responsible for the entire maternity care, please contact Medical Management at 1-800-294-7780.</td>
</tr>
<tr>
<td><strong>Coordination of Benefits</strong></td>
</tr>
<tr>
<td>If Viva Health or Viva Medicare is secondary to a member's other insurance, Viva Health will pay the amount (i.e., copays, coinsurance) for covered services that is the member's responsibility under the primary insurance. Where the allowed amount of the primary insurance is less than the allowed amount for Viva Health/Viva Medicare, total payment to the provider shall not exceed the amount allowed by the primary insurance. In instances where primary insurance has denied covered services for failure to follow their plan guidelines, Viva Health/Viva Medicare may, at its discretion, deny payment as secondary coverage. Effective March 1st, 2018, Coordination of Benefits claims for all lines of business (i.e., Commercial, Medicare) must be filed within 18 months from the date of service in order to be considered for secondary payment.</td>
</tr>
<tr>
<td><strong>Subrogration</strong></td>
</tr>
<tr>
<td>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 member, provider, and attorney and assists with settlements.</td>
</tr>
<tr>
<td><strong>Unlisted Codes</strong></td>
</tr>
</tbody>
</table>
| 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. |
**Fe Schedule Changes**

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

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

**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 rather than paper. Appeals will generally be reviewed within 45 days of receipt and a written decision 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 should be sent to:**

- **Viva Health**
  
  ATTENTION: PROVIDER APPEALS
  
  417 20th Street North, Suite 1100
  
  Birmingham, Alabama 35203

**Appeals may also be faxed to the attention of Provider Appeals at (205)449-7542 if there are 20 pages or less.**
**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 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 the Compliance Plan Training. 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 his/her hospital privileges, DEA permit, State Controlled Substances Certificate, or physician license, the loss of or a change in malpractice coverage, or Medicare sanction.

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

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

Provider Sanctioning
If the VIVA HEALTH Medical Director at any time determines that there are reasonable concerns about the
quality of care or level of service being provided to VIVA HEALTH’s members by a provider, corrective action
may be taken against the provider. Corrective action includes, but is not limited to, the following:
• Individual discussion with a provider, including issuance of a verbal warning;
• Formal letter of reprimand;
• Development of an improvement or corrective action plan;
• Reduction, suspension, or restriction of the privilege to provide specified services
to VIVA HEALTH members;
• Suspension from participation with VIVA HEALTH; or
• Termination of the provider’s agreement with VIVA HEALTH.

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

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 his/her 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 his/her provider agreement with
VIVA HEALTH or under the Medicare Advantage rules, regulations, or policies, if applicable.

Except as set forth directly above, 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.
**Accessing Mental Health/Substance Abuse Services**

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

- **Members who should use UAB Department of Psychiatry providers for mental health services.** **Viva** UAB adult members (18 and older) and the **Viva Medicare** members selecting a UAB PCP receive mental health services from providers in the UAB Department of Psychiatry. The UAB Department of Psychiatry can be reached by calling (205) 934-7008 or 1-800-782-1133.

- **Members who should use American Behavioral participating providers for mental health services.** All members with behavioral health benefits through **Viva Health**, except **Viva UAB Adults** (age 18 and older) and **Viva Medicare** members with a UAB PCP, receive mental health services from American Behavioral participating providers. American Behavioral can be reached by calling (205) 871-7814 or 1-800-677-4544.
**Viva Health** currently works with Express Scripts, a pharmacy benefit management company, to administer the prescription drug program for its employer group plans that include drug benefits. Note that some employers have carved prescription drug benefits out to another vendor.

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

1. **Pharmacy RX Benefit Information**

**Viva Health** employer groups typically have a four-tiered copay structure for employer group members. The lower copayment is for generics, the middle copayment is for brand drugs on the Custom Drug List, the higher copayment is for other covered brand drugs and the last tier is for specialty drugs. Here are a few tips to help our employer group members use their RX benefit appropriately.

**To help the members save money on copayments:**

- Prescribe generics whenever possible. If for any reason a member uses a brand drug when a generic is available, the member will pay the difference between generic and brand price, plus the higher brand copayment.
- If a generic isn’t available, see if a drug listed on the Custom/Preferred Drug List will meet the patient’s needs.
- If the member would like to use the mail order pharmacy for long-term medications, you will need to write two scripts. One for a 30-day supply and one for the 90-day supply, which can be sent to the mail-order pharmacy.
- Use the half-tab and proper dosing program guidelines, when applicable to the drug. (See information about these programs below).

**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** Drugs Requiring Prior Authorization List. If applicable, make sure your office has obtained the necessary authorizations from **Viva Health** before the member gets to the pharmacy.
- When requesting a prior authorization for Part B drugs, always include the HCPCS codes.

2. **Viva Health** Drugs Requiring Prior Authorization List

Please review the **Viva Health** Drugs Requiring Prior Authorization List. This list is posted on the **Viva Health** provider website, [www.vivahealth.com/provider](http://www.vivahealth.com/provider), and is updated periodically as drugs change in the market. Many pharmacy and member complaints are due to members not having prior authorizations in place. A few minutes spent on getting the drugs authorized can eliminate unnecessary work and aggravation at the pharmacy.
3. **Viva Health and Viva Medicare Drug Lists**

The Viva Health and Viva Medicare drug lists change periodically. When a drug becomes available in the generic form or over the counter, it is automatically removed from the Drug Lists. Throughout the year, other changes can occur if new drugs are added or removed from the marketplace. The brochures are typically only re-printed once a year. To see the most current lists, visit our website at [www.vivahealth.com/provider/Resources/default.aspx#Formulary Information List](http://www.vivahealth.com/provider/Resources/default.aspx#Formulary Information List). You can contact Viva Health’s Provider Customer Service Department at (205) 558-7474 or 1-800-294-7780 to get a current listing mailed to you.

4. **Biological, Biotechnical, and Injectable Drugs**

Viva Health works with Caremark Therapeutic Services (CTS) for Viva Medicare members, and with Accredo for employer group members to distribute covered self-administered injectible biological and biotechnical drugs to our members. These specialty pharmacies provide services to individuals with various chronic or genetic disorders such as Crohn’s Disease, Cystic Fibrosis, Hemophilia, Hepatitis C, Immune Disorder, Multiple Sclerosis, Rheumatoid Arthritis, and to members who require growth hormones or drugs for RSV Prevention.

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

- CTS at 1-800-237-2767 for Viva Medicare Members
- Accredo at 1-844-516-3320 for employer group members

Once they receive the completed enrollment form, prescription, and requested clinical notes from your office, they will guarantee shipment of the drug within 48 hours to either the member’s home or your office.

5. **The formulary, prior-authorizations, and quantity limits.**

The formulary (list of covered drugs) is available on our website at [www.vivahealth.com/provider/Resources/default.aspx#Formulary Information List](http://www.vivahealth.com/provider/Resources/default.aspx#Formulary Information List).

6. **RX Rider**

Members through employer groups who have purchased an RX Rider through Viva Health have pharmacy benefits. The pharmacy information can be found on the member’s Viva Health identification card. Look for “Pharmacy: YES” on the front of the card.
# Commercial Pharmacy Coverage Determination Form

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

<table>
<thead>
<tr>
<th>Patient Information:</th>
<th>Prescriber Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Prescriber:</td>
</tr>
<tr>
<td>Member ID #:</td>
<td>Office Phone #:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Fax #:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>NPI #:</td>
</tr>
<tr>
<td>Address:</td>
<td>Office Contact:</td>
</tr>
</tbody>
</table>

**View Commercial Plan Formulary at:** [http://www.vivahealth.com/provider/resources](http://www.vivahealth.com/provider/resources)

## Medication and Diagnosis Information:

- **Medication:**
- **Strength:**
- **Must check one:**
  - Brand
  - Generic
- **Route:**
- **Frequency:**
- **Quantity:**
- **Diagnosis:**

**Alternate Drug(s) Previously Tried or Contraindicated:**

<table>
<thead>
<tr>
<th>Drug:</th>
<th>Date(s) Used:</th>
<th>Outcome:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug:</td>
<td>Date(s) Used:</td>
<td>Outcome:</td>
</tr>
<tr>
<td>Drug:</td>
<td>Date(s) Used:</td>
<td>Outcome:</td>
</tr>
</tbody>
</table>

**Rationale for Request:** (Please attach relevant labs and clinic notes)

**Prescriber or Authorized Representative Signature:**

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Prescriber Specialty:</th>
<th>Request for expedited review</th>
</tr>
</thead>
</table>

**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.

Revised: 1/17/2020
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 physician or other 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 him/her.
- give his/her informed consent before the start of any surgical procedure or treatment.
- refuse any drugs, treatment, or other procedure offered to him/her by the health maintenance organization or its providers to the extent provided by law and to be informed by a physician 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 his/her medical care, unless access is specifically restricted by the attending physician for medical reasons.
- be advised if a health care facility or any of the providers participating in his/her care propose to engage in or perform human experimentation or research affecting his/her care or treatment. A member or legally responsible party on his/her behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which he/she has previously given informed consent.
- 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.
- 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 his/her health care.
- a candid discussion of appropriate or medically necessary treatment options for his/her conditions, regardless of cost or benefit coverage.

**VIVA HEALTH members have the responsibility to:**

- provide, to the extent possible, information needed by professional staff to care for the member and to follow instructions and guidelines given by those providing health care services.
- to obtain all medical care, except emergency services and urgently needed care when outside of the service area, through a participating provider.
- only use emergency room services for emergency medical conditions (see section on Emergency Services).
- to always carry his/her membership ID card, show it to the provider each time health services are received, and never permit its use by another person.
- to notify the plan of any changes in address, eligible family members, and marital status or if secondary health insurance coverage is acquired.
- to pay all applicable coinsurance, copayments, and/or deductible directly to the participating provider who renders care at the time of service.

**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.**
FOR EMPLOYER GROUP MEMBERS

(See Viva Medicare section for Medicare Complaint Procedure)

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

If a member has a question about the services provided, the member should call Customer Service at the number indicated in his/her 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.

The Complaint Procedure consists of the following levels for review:

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

B. Informal Complaint. If the member’s problem cannot be resolved to the member’s satisfaction by the Customer Service Representative at the inquiry level or the member requires a written response, the member may file an informal complaint. Informal complaints may be made verbally or in writing. A decision regarding an informal complaint and the mailing of a written notice to the member is completed within 45 days of the receipt date of the informal complaint (for members employed by an employer subject to ERISA, this timeframe is shortened to 30 days on post-service claims and 15 days on pre-service claims). 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.
C. Formal complaint. A formal complaint is the subsequent written expression of dissatisfaction by or on behalf of a member regarding the resolution of an informal complaint. A formal complaint must be filed within 12 months of Viva Health’s receipt of the original informal complaint. Viva Health may allow an extension of the 12-month limit due to extenuating circumstances. Formal complaints may be submitted by written letter or using a Formal Complaint Form available from Viva Health. The formal complaint should be sent to:

Viva Health
ATTENTION: COMPLAINT COORDINATOR
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

A provider may act on behalf of the member in the informal complaint process if the provider certifies in writing to Viva Health that the member is unable to act on his or her 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 informal complaint.

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

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

If the Expedited Formal Complaint Committee determines the complaint justifies an expedited review, the Expedited Formal Complaint Committee will review the complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than three working days after the day the request was received (72 hours for members employed by an employer subject to ERISA). 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 working days after the day the decision is made. Members of plans offered under Viva Health, Inc.’s HMO license have a right to a Third
ViVa Health’s Complaint Procedure

Level Review by the State Health Officer or the Alabama Insurance Commissioner. Also, Members in non-grandfathered health plans have a right to an external review by an independent review organization to appeal certain adverse benefit determinations. Please see Section F. below for more information.

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.

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 State Health Officer or the Commissioner of the Alabama Department of Insurance. Members of plans administered by ViVa HEALTH for an employer may contact the employer’s human resource department.

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 Patient Protection and Affordable Care Act was enacted in March 2010 or plans that have had substantial changes since that time. 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. 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.

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

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

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

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

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

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

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

**Member Identification Card**
A Viva Medicare identification card is issued to each member to present at physician appointments and any other time health services are received. Sample Viva Medicare identification cards are shown in a following section. Viva Medicare members are instructed to carry their membership identification cards with them at all times. The card should be presented whenever services are received, whether from the member’s PCP, a specialist, hospital, or other health care provider. Each ID card includes the member’s name and member number, card issue date, some of the most common plan copayments, the selected Primary Care Physician, 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 member states he/she is 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 Medicare Customer Service Department at (205) 558-7474 or 1-800-294-7780 for any questions about a Viva Medicare member’s eligibility or, for registered Viva Health Provider Portal users, visit www.vivahealth.com/provider and click on the Viva Health Provider Portal Login link.
Premiums and Copays

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

Coinsurance

Some plans have a 20% coinsurance on certain benefits such as DME, prosthetics, renal dialysis, and Part B drugs. Again, coinsurance is not required from those ViVa Medicare members who are eligible for full Medicaid benefits. Coinsurance is paid to the provider by the member 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 member pays on the plan overall. After this limit is reached, ViVa Medicare will pay 100% of the cost of the benefit for the rest of the calendar year. The out-of-pocket maximum does not apply to Part D prescription drug benefits.

Member Complaints/Grievances and Appeals

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

• The Medicare Appeals process is for concerns involving the denial of a claim, referral, or service that the member feels should have been covered and for disputes related to the discontinuation or reduction of services. An expedited appeal should be requested when a member’s life, health, or ability to regain maximum function could be jeopardized by a delay. There is a separate Medicare appeals process for Medicare Part D prescription drug coverage.

• If a member disputes a hospital inpatient, SNF, HHA or CORF discharge decision, he/she may request a review of the decision by the local Quality Improvement Organization (QIO). If a member fails to exercise QIO review rights, he/she may still utilize the Medicare appeals process.

• The ViVa Medicare Grievance Process is for all other complaints including complaints about the quality of care or service received.

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 or another acute, general, or short-term hospital.

ViVa Health reviews the following readmission categories:

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

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

- 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 he/she 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 member 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 physician, 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 member reasonably believes that his/her health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse. Prior authorization is not required for emergency services to be covered. Urgently needed services are covered from non-contracted providers without prior authorization when members are traveling away from the service area and have an unforeseen illness or injury. Urgently needed services from a non-contracted provider are covered within the service area only in the extraordinary circumstance that no contracted provider is available. For both emergency and urgently needed care, the member or hospital must contact ViVa Health within 24 hours of receiving services or as soon as possible. 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 member cannot be billed.
VIVA HEALTH Medicare Advantage Plans

VIVA HEALTH offers several Medicare Advantage plans to suit the needs and budgets of Medicare-eligible recipients. Each plan offers all the services and supplies offered by traditional Medicare, plus some services and supplies not covered by Medicare. Plan benefits, member cost sharing and premiums change from year to year. Visit www.vivahealth.com/Medicare/MemberResources/ 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 “credible” coverage) after he/she was first eligible or had a continuous period of 63 days or more when he/she didn’t have credible prescription drug coverage, the patient will pay a late enrollment penalty if he/she joins a Medicare prescription drug plan. Even if patients are not taking many prescription drugs now, they may in the future and would be penalized for joining a Medicare prescription drug plan late.

Which Plan Is Best for My VIVA MEDICARE Patients?
Patients should compare monthly plan premiums, benefits, and out-of-pocket costs to determine which VIVA MEDICARE plan best meet their needs.

How Can My Patients Enroll in a VIVA MEDICARE plan?
If you have a patient interested in learning more about a 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 CST
(October 1 - March 31: 7 days a week, 8am - 8pm CST)

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.
All Viva Medicare identification cards will indicate the member’s plan, chosen Primary Care Physician (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.” Except for pain management specialists, members in an open provider system do not require referrals to see any participating Viva Medicare Specialist and can receive care at any participating hospital.

**Viva Medicare Closed Provider System:** Viva Medicare members who have selected a PCP in the UAB, Medical West, St. Vincent’s East, Blount, and St. Clair provider system are considered to be in a closed network. This means the member must receive all care from providers within their chosen provider system. The member’s identification card, next to provider system, will indicate the hospital in which the member provider system is affiliated. The member does not require referrals to specialists within the chosen provider system, except for pain management.

**Viva Medicare Me:** Viva Medicare Me members have access to a limited network and must receive all care within their selected Viva Medicare Me network. There are three Viva Medicare Me networks: Brookwood Baptist Health, Southeast Health, and St. Vincent’s. The member’s identification card will contain both the Viva Medicare logo AND EITHER the Brookwood Baptist Health System logo, the Southeast Health logo, or the St. Vincent’s logo. Next to provider system, on the card it will list either “Viva Medicare Me at Brookwood Baptist Health,” “Viva Medicare Me at Southeast Health,” or “Viva Medicare Me at St. Vincent’s.” The Viva Medicare Me at Brookwood Baptist Health’s network is affiliated with the following Brookwood Baptist Health facilities: Brookwood, Citizens, Princeton, Shelby, and Walker. The Viva Medicare Me at St. Vincent’s network is affiliated with the following St. Vincent’s facilities: St. Vincent’s Birmingham, St. Vincent’s St. Clair, St. Vincent’s Blount, St. Vincent’s East, and St. Vincent’s One Nineteen. Viva Medicare Me members do not require a PCP referral to see specialists in either the Baptist Physician Alliance network, the Southeast Health Statera network, or the St. Vincent’s Physician Alliance network. However, a PCP referral is required to see a specialist in the Viva Medicare Me supplemental network and also for pain management. Please refer to the Viva Medicare Me provider directories for a complete listing of the providers affiliated with the two Viva Medicare Me networks.

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:

<table>
<thead>
<tr>
<th>Viva Medicare Provider System</th>
<th>Oral Maxillofacial Surgery</th>
<th>Dermatopathology</th>
<th>Physical Medicine and Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist Shelby</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
</tr>
<tr>
<td>Brookwood</td>
<td>Open</td>
<td>Open</td>
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<tr>
<td>East Alabama</td>
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</tr>
<tr>
<td>Montgomery</td>
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<td>Princeton</td>
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<td>St. Vincent's Bham</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
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<tr>
<td>St. Vincent's East</td>
<td>Closed</td>
<td>Open</td>
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</tr>
<tr>
<td>Trinity</td>
<td>Open</td>
<td>Open</td>
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<tr>
<td>UAB</td>
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<tr>
<td>Walker PORG MWAL</td>
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<tr>
<td>Mobile</td>
<td>Open</td>
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</tr>
<tr>
<td>Baptist Me</td>
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<tr>
<td>St. Vincent's Me</td>
<td>Open</td>
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<tr>
<td>Southeast Health Me</td>
<td>Open</td>
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</tbody>
</table>

**REFERRAL REQUIRED**

Last Updated 10/25/19
Below is a brief overview of the 6 Medicare Advantage plans offered by Viva Medicare in 2020. To be eligible for Viva Medicare, members must still pay their part B premium to Medicare.

**Viva Medicare Plus**

- Includes both medical and Part D prescription drug coverage.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:
Purple: St. Vincent’s East/Blount/St. Clair
Green: Medical West
Orange: UAB Medical Center
Blue: Viva Medicare Me at Brookwood Baptist Health or Southeast Health
Pink: Viva Medicare Me at St. Vincent’s*

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

- For an additional monthly premium of $104, 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.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:
Purple: St. Vincent’s East/Blount/St. Clair
Green: Medical West
Orange: UAB Medical Center
Blue: VIVA MEDICARE Me at Brookwood Baptist Health or Southeast Health
Pink: VIVA MEDICARE Me at St. Vincent’s*

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

- For an additional monthly premium of $45, 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.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are: Purple: St. Vincent’s East/Blount/St. Clair  
Green: Medical West  
Orange: UAB Medical Center  
Blue: Viva Medicare Me at Brookwood Baptist Health or Southeast Health  
Pink: Viva Medicare Me at St. Vincent’s  

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

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

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:
Purple: St. Vincent’s East/Blount/St. Clair
Green: Medical West
Orange: UAB Medical Center
Blue: Viva Medicare Me at Brookwood Baptist Health or Southeast Health
Pink: Viva Medicare Me at St. Vincent’s*

If a member is in the open panel provider system, there is no stripe and the member may use any Viva Medicare specialist or hospital.
Viva Medicare Me at Brookwood Baptist Health

• Includes both medical and Part D prescription drug coverage with many lower out-of-pocket costs than the Viva Medicare Plus plan and no monthly premium. Designed for members who seek care exclusively from the Brookwood Baptist Health System. This plan has a limited network.

Viva Medicare Me at Southeast Health

• Includes both medical and Part D prescription drug coverage with many lower out-of-pocket costs than the Viva Medicare Plus plan and no monthly premium. Designed for members who seek care exclusively from the Southeast Health System. This plan has a limited network.

Viva Medicare Me at St. Vincent’s

• Includes both medical and Part D prescription drug coverage with many lower out-of-pocket costs than the Viva Medicare Plus plan and no monthly premium. Designed for members who seek care exclusively from the St. Vincent’s Health System. This plan has a limited network.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:
Purple: St. Vincent’s East/Blount/St. Clair
Green: Medical West
Orange: UAB Medical Center
Blue: Viva Medicare Me at Brookwood Baptist Health or Southeast Health
Pink: Viva Medicare Me at St. Vincent’s

If a member is in the open panel provider system, there is no stripe and the member may use any Viva Medicare specialist or hospital.
Viva Medicare Extra Value

- 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.

*The color of the stripe at the top of the card represents the provider system a member joins. The colors representing each provider system are:
Purple: St. Vincent’s East/Blount/St. Clair
Green: Medical West
Orange: UAB Medical Center
Blue: Viva Medicare Me at Brookwood Baptist Health or Southeast Health
Pink: Viva Medicare Me at St. Vincent’s

If a member is in the open panel provider system, there is no stripe and the member may use any Viva Medicare specialist or hospital.
Provider Responsibilities

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

VIVA MEDICARE Me supplemental network and pain management specialists require a PCP referral.

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

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

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

Patient Communication:

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

Treatment Plans:

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

- The seriousness, progression, and expected duration of the patient’s diagnosis.
- The nature and level of complexity of treatment. Generally, the more complicated and/or difficult the treatment, the more useful a detailed treatment plan will be.
- The existence of co-morbidity. Diagnoses that taken individually may not be as serious, when
Once the PCP identifies a patient with a complex or serious condition, the PCP is responsible for addressing and/or monitoring the patient’s conditions and developing an appropriate treatment plan. To be most effective, the treatment plan should include:

- the timeframe covered.
- individual goals for the patient.
- needed 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 his/her own health.

**Advance Directives:**

The PCP is expected to advise each VIVA MEDICARE member regarding his/her future health care needs and available options for treating those needs. VIVA MEDICARE acknowledges the member’s right to make an advance directive. There are two ways to make a formal advance directive:

- Living Will
- Power of Attorney for Health Care Document

Documentation of the PCP’s discussion of advance directives with his/her patients must be maintained in the medical record.

**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 87-90 for additional information.

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

**Your Role in Care Transitions:**

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

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

**PCP**

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

**Facility (Inpatient, Rehabilitation, Skilled Nursing Facility)**

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

**Home Health**

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

**Change of Member’s PCP:**

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

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 non-coverage for the requested item or service (e.g., via a clear exclusion in the EOC or by a denial letter issued by the plan). Providers cannot bill a member more than the normal member cost-sharing owed as a member of VIVA MEDICARE unless the provider confirms the plan has denied the requested item or service, or the item or service is clearly excluded in the member’s EOC.

If a member has been notified in advance of the non-covered item or service (as described above) and chooses to receive the item or service regardless, providers may have the member complete the Patient Liability Form on page 76 and may hold the member financially responsible for the charges. It is important to give the member a copy of this form and retain a copy in the patient’s chart for your records. VIVA MEDICARE or CMS may require a copy of this form if the item or service is later disputed.

IMPORTANT NOTE: Providers cannot issue an Advance Beneficiary Notice (ABN) to MA plan members as documentation of the member’s liability for non-covered items or services. CMS regulations indicate the ABN is only to be used for beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program, not for MA plan members.
ADVANCE DIRECTIVE FOR HEALTH CARE  
(Living Will and Health Care Proxy)

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

Section 1. Living Will

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

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

If I become terminally ill or injured:

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

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

Place your initials by either “yes” or “no”:
I want to have life sustaining treatment if I am terminally ill or injured. _____ Yes _____ No

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

Place your initials by either “yes” or “no”:
I want to have food and water provided through a tube or an IV if I am terminally ill or injured. _____ Yes _____ No
If I Become Permanently Unconscious:

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

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

Place your initials by either “yes” or “no”:
I want to have life-sustaining treatment if I am permanently unconscious. ____ Yes ____ No

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

Place your initials by either “yes” or “no”:
I want to have food and water provided through a tube or an IV if I am permanently unconscious. ____ Yes ____ No

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

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

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

____ No, I do not have any other directions.
Section 2. If I need someone to speak for me.

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

*Place your initials by only one answer:*

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

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

**First choice for proxy:** ______________________________________

Relationship to me: __________________________________________

Address: ____________________________________________________

City: ____________________________ State _______ Zip ___________

Day-time phone number: _______________________________________

Night-time phone number: _____________________________________

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

**Second choice for proxy:** ______________________________________

Relationship to me: __________________________________________

Address: ____________________________________________________

City: ____________________________ State _______ Zip ___________

Day-time phone number: _______________________________________

Night-time phone number: _____________________________________

**Instructions for Proxy**

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

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. _____ Yes _____ No
Place your initials by only one of the following:

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

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

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

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

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

  ____________________________________________
  ____________________________________________

Section 4. My signature

Your name: ____________________________________________
The month, day, and year of your birth: ____________________________
Your signature: ____________________________________________
Date signed: ____________________________________________
Section 5. Witnesses (need two witnesses to sign)

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

Name of first witness: ___________________________________
Signature: _____________________________________________
Date: _________________________________________________

Name of second witness: ___________________________________
Signature: _____________________________________________
Date: _________________________________________________

Section 6. Signature of Proxy

I, ____________________________________________, am willing to serve as the health care proxy.
Signature: ____________________________________________ Date: _________________________

Signature of Second Choice for Proxy:

I, __________________________, am willing to serve as the health care proxy if the first choice cannot serve.
Signature: ____________________________________________ Date: _________________________
I. Provider Information (to be completed by the provider)

Provider’s Name: __________________________

Patient’s Name: __________________________

Patient’s Member Number: __________________________

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

______________________________________________________________________________

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

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

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

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

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

__________________________________________  ______________________
Patient’s Signature                          Date
Medicare Advantage Risk Adjustment Validation Audit

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

The Centers for Medicare & Medicaid Services (CMS) conducts data validation every year after risk adjustment data are 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 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 physician)
  - Physician data source (refer to RA physician specialty list)

Technical Medical Record Requirements

A medical record represents one face-to-face encounter on one date of service (for outpatient and physician 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 physician specialty.

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

The primary goals of risk adjustment data validation are to:

- Identify
  - Continued risk adjustment discrepancies
  - Organizations in need of technical assistance to improve quality of risk adjustment data
- Measure
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- Improve/Inform
  - Quality of risk adjustment data
  - The CMS risk adjustment models
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 CMS Medicare Managed Care Manual related to provider-based activities. The full document is available on the Internet at [www.cms.gov/manuals/downloads/mc86c03.pdf](http://www.cms.gov/manuals/downloads/mc86c03.pdf). 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) 558-5534.

From Medicare Communications and Marketing Guidelines (MCMG) Section 60.3 – Contracted Provider Oversight Responsibilities (Issued: 9-5-2018): 42 CFR §§ 422.2268 and 423.2268.

CMS holds plan sponsors responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. The plan sponsor must ensure that any providers contracted (and its subcontractors, including downstream providers or agents) with the plan sponsor comply with the requirements outlined in this chapter.

The plan sponsor must ensure that any providers contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting a health screening, providers may not distribute plan information to patient.

**CMS is concerned with provider activities for the following reasons:**

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary’s provider.

Providers may face conflicting incentives when acting as a plan sponsor representative. For example, some providers may gain financially from a beneficiary’s selection of one plan over another plan. Additionally, providers generally know their patients’ health status. The potential for financial gain by the provider influencing a beneficiary’s selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential plan enrollee.

Beneficiaries often look to health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, and eligibility requirements for SNPs). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary’s needs and potential plan sponsor options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.

All payments that plans make to providers for services must be fair market value, consistent for necessary
services, and otherwise comply with all relevant laws and regulations, including the Federal and any state anti-kickback statute.

For enrollment and disenrollment guidance related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application), please refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.

**Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions.** Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accepting enrollment applications for MA/MA-PD plans or PDPs.
- Making phone calls or directing, urging, or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health screening is a prohibited marketing activity.
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.

**Providers contracted with plan sponsors (and their contractors) are permitted to do the following:**

- Provide the names of plan sponsors with which they contract and/or participate (See § 70.12.3) for additional information on affiliation.
- Provide information and assistance in applying for the LIS.
- Make available and/or distribute plan marketing materials, including provider affiliation materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates.

**To that end, providers are permitted to:**

- Provide objective information on plan sponsors’ specific plan formularies, based on a particular
patient’s medications and health care needs.

• Provide objective information regarding plan sponsors’ plans, including information such as covered benefits, cost sharing, and utilization management tools.

• Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications, for all plans with which the provider participates.

• Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS’ website at www.medicare.gov or 1-800-MEDICARE.

• Print out and share information with patients from CMS’ website.

The “Medicare and You” Handbook or “Medicare Options Compare” (from www.medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.
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 a mandatory incentive program for Viva Medicare participating PCPs, when their membership is within the required guidelines. Viva Medicare provides a nurse clinician as a resource to C4Q PCPs to promote physician engagement and member satisfaction by proactively supporting the PCP/patient relationship.

PCPs can realize generous bonus incentives by working collaboratively with their C4Q nurse. C4Q encourages the completion of annual preventive visits, preventive screenings, aggressive management, and optimal member outcomes for chronic diseases such as diabetes and hypertension, and medication adherence and reconciliation for Viva Medicare members.

C4Q activities are calendar-year based and reflect STARS and HEDIS measures that are best achieved through physician 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 preventive visit, with completion of the Comprehensive Review Form (CRF) screening tool;
- Facilitating physician 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 and medication reconciliation.

For more information about the Connect for Quality program, please contact your Viva Health Provider Services representative.
Compliance is a very important component of daily operations and core values at Viva Health. We define Compliance as meeting and/or exceeding all Federal and state regulatory requirements, as well as being vigilant against Fraud, Waste and Abuse (FWA).

**Why We Conduct Compliance Training**

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

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

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

**Viva Health’s Compliance Mission**

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

**Code of Conduct**

Viva Health adopted the following Code of Conduct as a cornerstone of our Compliance Plan:

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

**What Are My Responsibilities as a Partner?**

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

- Comply with all licensing requirements mandated by Federal and state regulatory agencies.
- Report any suspected violations of laws, regulations, or the Viva Health Code of Conduct.
- Assist in prevention, detection, and elimination of FWA.
- Cooperate with any investigation of suspected violations.
**Fraud, Waste and Abuse (FWA)**

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

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

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

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

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

- Waiving or reducing a copay or deductible for reasons other than real financial hardship or other allowable exceptions
- Accepting payment different from fair market value as a means to obtain more business
- Demanding or requesting a kickback (i.e., gifts, cash, write-offs, free supplies) for referring patients to specific providers

Failure to comply with these laws can result in fines, jail, and/or exclusion from Medicare, Medicaid, or other Federal and state health programs.

**False Claims Act (FCA)**
The FCA is another Federal law that applies to Federal and state programs. The FCA prohibits knowingly submitting false, fictitious, or fraudulent claims to obtain payment from Federal or state programs. Knowingly and/or willfully making a false claim is a Federal felony. Penalties for FCA violations can result in significant fines, jail time, and/or exclusion from participation in Federal and state programs.
Criminal Activity
Any felony convictions or other criminal activity (not including minor traffic violations) must be disclosed to Viva Health. This includes anything that occurred prior to contracting with Viva Health or that occurs during the contract period. Evidence of criminal activity will be reviewed during the initial credentialing and subsequent recredentialing processes.

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

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

Preclusion List
Beginning January 1, 2019, CMS provides a preclusion list to Medicare Advantage (MA) plans on the 1st of each month. The preclusion list is a list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. The list was created to ensure patient protections and safety and to protect the Trust Funds from prescribers and providers identified as bad actors.

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

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

OR

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

The monthly preclusion list is reviewed by the plan, and members are notified by letter if they have received services or Part D drugs that were furnished or prescribed in the past 12 months by a provider on the list. The provider is copied on all member letters. The letter indicates the date (no earlier than 60 days from the date of the letter) by which claims for health care items or services must be denied, pharmacy claims must be rejected, or member requests for reimbursement must be denied. After the expiration of the 60-day period specified in 42 CFR §422.222, the provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per 42 CFR §422.504(g)(1)(iv). The provider will hold
financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider will have already received notification of the preclusion. [422.504(g)(1)(v)]. Any provider/prescriber on the preclusion list will have been notified by CMS and given an opportunity to appeal before being precluded. As a VIVA MEDICARE provider, you must ensure payments are not made to individuals and entities included on the preclusion list, defined in §422.2. [42 CFR 422.504.(i)(2)(v)]. For more information about the preclusion list, visit CMS's website at https://www.cms.gov/Medicare/Provider-Enrollment-And-Certification/MedicareProviderSupEnroll/PreclusionList.html

**Confidential Information**

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

**Monitoring and Auditing**

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

**Records**

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

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

- **VIVA HEALTH**
  (205) 558-7474 or 800-294-7780

- **VIVA HEALTH**
  Attn: Compliance Officer
  417 20th Street North, Suite 1100
  Birmingham, Alabama 35203

- Officer of Inspector General (OIG)
  **Hotline**: 800-447-8477
  **E-mail**: HHSTips@oig.hhs.gov
  **Mail – HHS Tips Hotline:**
  PO Box 23489
  Washington DC
  20026-3489

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

**FWA Issues**
- Health Integrity
- Attn: MEDIC
- 877-7SafeRx (877-772-3379)

**Compliance Issues**
- SafeGuard Services (SGS)
- 717-975-4442 (fax)

Compliance Investigations

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

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

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

Compliance Summary

The material and policies in this Provider Manual and associated training materials are mandatory. Ethical behavior can never be sacrificed in the pursuit of other objectives. VIVA HEALTH is committed to the highest standards of ethics and compliance. Everyone is responsible for their own conduct and behavior. If you are not sure about a potential compliance or FWA issue, please ask.
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 Plan is a Dual Eligible SNP (D-SNP) called ViVa Medicare Extra Value (HMO SNP). It consists of dual-eligible individuals who qualify for both Medicare and Medicaid.

ViVa Health Extra Value became effective January 1, 2010 and is a Medicaid subset, $0 cost-sharing, D-SNP. Individuals eligible for D-SNP membership must live in ViVa Medicare Extra Value’s geographic service area and be enrolled in Medicare Part A and Medicare Part B without a disqualifying End-Stage Renal Disease (ESRD) diagnosis at the time of enrollment. 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.

Individuals with Medicare and the following categories of Medicaid are eligible to enroll in the D-SNP plan:
- Qualified Medicare Beneficiary without other Medicaid (QMB only)
- Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits (QMB+)
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only)
- Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+)
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)
- Other Full Benefit Dual Eligible (FBDE)

The Model of Care submitted to CMS in 2019 (for 2020) was scored at 95%, allowing for a three-year approval period. In order to make the SNP Model of Care meaningful, individualized to the unique characteristics of ViVa Health’s SNP population, and measurable on an ongoing basis, all performance and access goals are specific and measurable with specific contingencies for ongoing monitoring and adjustment, as needed if progress is not being made toward those goals. Goals below address access issues, coordination of care, transition measures, and utilization of preventive services for both chronic and acute conditions.

**Goal 1 – Providing and Maintaining Improved Access 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 specialist. We will continue using the CMS benchmark to ensure robust access. ViVa Health maintained a benchmark audit score of 100% during CMS network
Goal 2 – Providing and Maintaining Improved Access of Care to SNP Members

VIVA HEALTH’s secondary goal related to providing and maintaining improved access and affordability of care focuses on grievances received regarding plan benefits. The Extra Value Plan has enjoyed a very low level of complaints/grievances regarding this plan’s benefits; analysis of 2018 demonstrates 1.2 grievances per 1,000 SNP members regarding plan benefits. It is our goal to maintain this low number, but not to exceed 1.4 grievances per thousand SNP members annually.

Goal 3 – Providing and Maintaining Affordability of Care to SNP Members

The identified goal is zero Part C cost-sharing for the lowest income members and $0 copay for PCP visits and non-emergency transportation for all SNP members. Prescription drugs are offered at the low-income subsidy levels or lower to ensure cost is not a significant barrier. VIVA HEALTH reviews and adjusts the design of its Extra Value Plan yearly, maintaining costs as low as possible. Hence, this outcome measure is adjusted and reviewed yearly, with reporting to senior leadership, pharmacy, and the Medicare Operations Team.

Goal 4 – Improve Coordination of Care through the Direct Alignment of the HRAT, ICP, and IDCT

In an effort to improve health outcomes for SNP members, VIVA HEALTH focuses on improving health outcomes through a systematic process of communication, management, and coordination of care. Members who engage in VCare (Intensive Care Management Services) receive enhanced assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavior, and psychosocial needs while promoting quality and cost-effective outcomes. The focus of the program is to foster medication adherence, self-management skills, increased member participation in his/her plan of care, and ultimately, to improve outcomes and maintain the member in the least restrictive setting.

VIVA HEALTH’s goal is improve coordination of care and outcomes by increasing the number of SNP members engaged in VCare to 23 members per 1,000 SNP members. Current analysis demonstrates an average of 22 per 1,000 SNP members engaged in VCare Intensive Care Management on a monthly basis, either face-to-face or telephonically, through November 2018.

Goal 5 – Enhanced Care Transitions to SNP Members

VIVA HEALTH recognizes the importance of assisting members in navigating the complexities of the health care system. Accordingly, VIVA HEALTH maintains a comprehensive approach to transitions that focuses on coordination of care throughout transitions, connecting members to the appropriate providers, and providing needed education and self-management support. VIVA HEALTH strives to empower members to be accountable for their care and to better understand how to manage their health across the care continuum.

VIVA HEALTH’s policies and procedures document the process for linking members to services including
care transitions. The Health Services department oversees care transitions by adhering to the Transition of Care policy and procedures. VIVA HEALTH’s goal is to enhance safe transitions for SNP members across the continuum of care by reaching 95% or greater of SNP members experiencing an acute transition for safe transitions outreach through VIVA HEALTH’s Case and Care Management team.

Goal 6 – Reduction of Readmission Rates for SNP Members
VIVA HEALTH’s goal is to reduce the number of 30-day SNP readmissions to 10% over a 3 year period. Reporting will be reviewed on a monthly basis, and this number will be reported as a yearly average, keeping in mind this number is scalable based on member population. This number represents 50 less readmits each calendar year. Benchmark findings for this measure for CY 2017 and YTD 2018 were identified at 11% for 30 day readmissions.

Goal 7 – Ensuring Appropriate Utilization of Services for Preventive Health and Chronic Conditions
Recognizing that 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 establish a relationship with their PCP and visit that 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 cumulative total is available at the turn of a calendar year. The most recent annual measurement of this metric was 82.84% of SNP members seeing the PCP at least once annually for CY 2017. Realizing the significant need for the primary care physician to be the driver of the member’s health care plan VIVA HEALTH will continue the goal related to 90% of SNP members to see their PCP at least annually.

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

- Contracted Providers – includes a broad range of primary care physicians, specialists (including mental health providers), facilities, and pharmacies to fully meet the special needs of the target population.
- Pharmacists – provide clinical support for other clinicians, 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 includes Utilization Review staff and Case Managers that serve in clinical roles and in coordination of the member’s care. Care management staff includes RNs, LPNs, and Licensed Social Workers to support members with care coordination needs, and assist members in maximizing their health status in the least restrictive environment.
- Connect for Quality – works in conjunction with Primary Care Physicians 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 when directly interacting with SNP members at Health Fairs and during telephonic outreach.

Oversight of the Special Needs Plan
Primary Oversight of the Special Needs Plan is provided by the Director of Health Services Programs and the SNP Administrator. Secondary oversight is through the 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
VIVA HEALTH maintains a formal Interdisciplinary Care Management Team (IDCT) consisting of VIVA HEALTH’s Medical Director, physicians, clinical pharmacists, licensed nurses, social workers, and a mental health professional. Other disciplines may be included on an ad hoc basis. The team reviews and discusses the needs of the SNP members and develops or revises plans of care. Specific complex cases are presented for team discussion. SNP members in VCare, and/or their caregivers, are encouraged to participate in the IDCT meetings. Members are informed of the IDCT, and are given the opportunity to participate in their own case presentation in person or by telephone. Any VIVA HEALTH provider may request an IDCT review of a member at any time by contacting the VCare staff at 1-855-698-2273.

Interdisciplinary Care Team Operation and Communication
The Chief Medical Officer, Executive Director of Health Services, Manager of Care Management, and SNP Administrator drive the initiatives of the IDCT. Meetings are scheduled every 2 months for a minimum of 6 meetings per year. Interdisciplinary conferences also take place via phone conferences with home health, durable medical equipment representatives, behavioral health agencies, and through collaboration with the PCP.

Provider Network and Use of Clinical Practice Guidelines
The SNP provider network covers the full spectrum of primary and specialty care. Physicians 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
Training is required for all VIVA HEALTH staff and providers serving the Special Needs Program population. A mandatory annual staff training module is completed through the Learning Management
System. For providers, the Model of Care (MOC) training is included in the Provider Manual and on the provider website. The SNP Administrator, in conjunction with the Corporate Trainer, is responsible for developing and coordinating all MOC training and for its oversight. The Corporate Trainer tracks training completion for new employees and the annual training for staff.

**Health Risk Assessment (HRA)**

The Health Risk Assessment (HRA) is an internally developed tool that allows the member to self-report health status, functional status, and psychosocial issues. The HRA data is imported into VIVA HEALTH’S Care Management documentation system and available for all members of the clinical teams. The HRA is required within 90 days of enrollment and annually thereafter.

Data from the HRA is reviewed by the SNP team, and assists with identifying members at risk for more complex health problems and care management needs. HRA data is reported to the IDCT and the UM/QI committees.

**Identification of Vulnerable Members for Care Management**

A variety of data sources are used to identify the most vulnerable subpopulation:

- HRA Data
- Transition Reports
- Admissions Data
- Re-admissions
- ER Reports

Benefits and interventions are designed to address gaps. In addition to plan-designed benefits, care managers have “tool boxes” that provide additional assistance, such as scales and medication planners.

**Individualized Care Plan**

The member’s answers to the HRA questions, encounter data, claims data, and clinician assessments can be used to develop individualized plans of care. The PCP is ultimately responsible for directing the plan of care. High risk members are further assessed by a nurse or social worker. All SNP members receive an annual plan of care. Care plans are updated through assessments and IDCT meetings.

**Communication Network**

Communication with members takes place in a variety of ways: the VivaHealth.com website, the Evidence of Coverage, Summary of Benefits, formularies, directories, contacts such as case and care management, newsletters, and VIVA HEALTH Cafés. Internal communication takes place via the provider website, town hall meetings, and the Learning Management System.
Performance and Outcome Measures

Outcomes are measured in a variety of ways, such as HEDIS® measures. Interventions are designed to improve outcomes on health and wellness screenings and disease management. Utilization measures are also used to pinpoint areas where care and case management efforts can focus on maintaining the member in the least restrictive setting. Disenrollment measures are reviewed to determine why members leave the plan. Additionally, member satisfaction with care management is evaluated annually.
Viva Health has an agreement with the Alabama Medicaid Agency to better serve certain persons who are both Medicaid eligible and enrolled in the Viva Medicare product (“dual eligible”). The agreement allows us to eliminate or reduce out-of-pocket expenses for those dual-eligible Viva Medicare members enrolled in Medicaid’s QMB, QMB Plus, and SLMB, QI-1, and Full Medicaid programs.

Identification cards for full-benefit dual eligible members reflect $0.00 in the copayment fields. Partial benefit dual eligible members pay reduced copayments or coinsurances as reflected on the identification cards. Providers should not collect any amount other than a copayment or coinsurance (if applicable) from partial benefit dual eligible members. Full-benefit dual eligible members are not responsible for any plan cost-sharing for Medicare A and B services.

A transportation benefit is provided by Medical Transport of Alabama (MTA). Dual eligible members in the Viva Medicare Extra Value plan are allowed 12 round trips or 24 one-way trips for medical services per year free of charge. To schedule, members call 1-888-318-6362. Transportation must be scheduled no later than 2 p.m. the day before the appointment or no later than 2 p.m. on Friday for Saturday, Sunday and Monday appointments, so encourage patients who need a ride to or from an appointment to call ahead. The transportation benefit may help improve appointment fulfillment and the member’s timeliness of arrival.


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 his/her terminal illness. Home care is provided along with necessary inpatient care and a variety of services not otherwise covered by Medicare.

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

When all requirements are met, Medicare hospice benefits include:

- Physician 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 Providers

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

Coverage of Hospice Services

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

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

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

Payment for Hospice Services Provided to Viva Medicare Members

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

- **Drugs or biologicals:** The hospice can charge 5% of the reasonable cost, up to a maximum of $5, for each prescription for outpatient drugs or biologicals for pain relief and symptom management.

- **Inpatient respite care:** The hospice may periodically arrange for inpatient care for the patient to give temporary relief to the person who regularly provides care in the home. Respite care is limited each time to a stay of no more than 5 days. The patient can be charged about $5 per day for inpatient respite care. The charge, which is subject to change each year, varies slightly depending on the geographic area of the country.

Services not covered under hospice

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

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

When a Medicare beneficiary chooses hospice care, he/she gives 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 physician to a Medicare Advantage member who has elected hospice are non-hospice services if the physician 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 his/her 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 physician) 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 physician if the physician 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 physicians 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 physician type of services) for billing rules.

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

Instructions for completing the NOMNC can be found at:  
Notice of Medicare Non-Coverage

Patient name:     Patient number:

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

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

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

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

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011)    OMB approval 0938-0953
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

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

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

Additional Information (Optional):

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

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

__________  
Signature of Patient or Representative  
Date
ViVa Health uses CVS/Caremark as the Pharmacy Benefit Manager for the ViVa Medicare business.

ViVa Medicare members cannot enroll in stand-alone Medicare prescription plans. Members of Medicare Advantage plans like ViVa Medicare must get their Part D Medicare drug insurance from that plan. If a ViVa Medicare member signs up with any stand-alone Medicare prescription drug plan, his/her membership in ViVa Medicare will automatically end and he/she 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, prior-authorizations, and quantity limits.
The formulary (list of covered drugs) is available on our website at www.vivahealth.com/provider/Resources/#Formulary_Information_List. You can find the drugs that are covered in the back index. Go to the page listed for each covered drug to see its tier. If a drug has “PA” next to it, it requires prior authorization. Please fax our Pharmacy Department at (205) 558-7506 or complete a request online at www.vivahealth.com/provider/Resources/#Forms to request authorization before going to the pharmacy. The Pharmacy Department will notify you if the prior authorization is approved, denied, or needs additional information. A listing of the prior authorization criteria can be found on our website at www.vivahealth.com/provider/Resources/#Prior_Authorization_List. If a drug has “QL” next to it, there is a quantity limit on the number of pills that will be covered in a 30-day supply or a 365-day supply. If a drug has “ST” next to it, there is a step therapy requirement meaning the patient has to try and fail an alternate drug before that drug will be covered. The step therapy drug criteria can be found on our website www.vivahealth.com/provider/Resources/#Prior_Authorization_List.

Members may request exceptions to the formulary, quantity limits, and step therapy requirements and may appeal any denials. Please see the section on exception requests below.

ViVa Medicare plans have the following coverage steps:
(Unless members qualify for the low-income assistance described later.)

Step One: Deductible - Members of some ViVa Medicare plans pay a Part D deductible each year. Some ViVa Medicare plans have no drug deductible.

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

Step Three: Coverage gap - After total drug costs for the year reach a certain level defined by Medicare, there is a coverage gap. At this point, the member pays a percent of the costs of covered drugs until his/her out-of-pocket drug spending for the year reaches a certain level, also defined by Medicare (25% for generics and 25% for brands in 2020).

Step Four: Catastrophic coverage - Once a member spends a given amount in a year, the member only pays a copay or a 5% coinsurance for the rest of the year, whichever is greater.

Diabetic Supplies
Benefits are provided for diabetic testing supplies under all ViVa Medicare plans with no prior authorization and at no cost to the member. 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 www.vivahealth.com/medicare/Download.aspx?ID=35233&Type=doc. Members with Part D prescription drug benefits may get standard quantities of Accu-Chek test strips, monitors, and glucose control solutions at any network pharmacy that has them as well as any brand of lancet devices and lancets.
**MEDICARE PART D COVERAGE DETERMINATION FORM**

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

<table>
<thead>
<tr>
<th>Patient Information:</th>
<th>Prescriber Information:</th>
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<tbody>
<tr>
<td>Patient Name:</td>
<td>Prescriber:</td>
</tr>
<tr>
<td>Member ID #:</td>
<td>Office Phone #:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Fax #:</td>
</tr>
<tr>
<td>Phone #:</td>
<td>NPI #:</td>
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<tr>
<td>Address:</td>
<td>Office Contact:</td>
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</tbody>
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**Medication and Diagnosis Information:**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Strength:</th>
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<tbody>
<tr>
<td>Must check one:</td>
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</tr>
<tr>
<td>□ Brand</td>
<td>□ Generic</td>
</tr>
<tr>
<td>Route:</td>
<td></td>
</tr>
<tr>
<td>Frequency:</td>
<td>Quantity:</td>
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</table>

If Injectable or Nebulized: where is being administered? Must check one:

- □ Home (Self-Administered)
- □ Long-Term Care
- □ Skilled Nursing Facility
- □ Provider’s Stock (Buy & Bill)
- □ Provider’s Office (Patient Provides)

Diagnosis: (Please attach all office notes and labs supporting diagnosis)

**Request for Expedited Review:**

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

Please provide an afterhours contact and direct number: ________________________________________________

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

Revised: 1/17/2020
Exception requests require the patient to have tried and failed the following:

- 1 formulary alternative if there are 1-3 formulary alternatives available
- 2 formulary alternatives if there are 4-6 formulary alternatives available
- 3 formulary alternatives if there are greater than 6 formulary alternatives available

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

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

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

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

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**Prescriber or Authorized Representative Signature:**

Signature: ___________________________ Date: ___________________________

Revised: 1/17/2020
Member’s Rights & Responsibilities

Viva Health recognizes certain rights and responsibilities members have 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 your rights as a member of the plan

Section 1.1
We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or in audio)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or in audio if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan’s benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2
We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3
We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a Primary Care Physician (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet).

As a plan member, you 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 you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
Section 1.4

We must protect the privacy of your personal health information

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

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.

- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

  1. For example, we are required to release health information to government agencies that are checking on quality of care.

  2. Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on page 2 of this manual).
**VIVA HEALTH Notice of Health Information Practices**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Protected Health Information: This notice describes the health information practices of VIVA HEALTH, Inc. We understand that your health information is personal and we are committed to protecting this information as required by law. This notice will summarize the ways in which we may use and disclose protected health information about you. It will also describe your rights and certain obligations we have regarding the use and disclosure of such information. We are generally required by law to: (1) make sure that such information that identifies you is kept private, (2) give you notice of our privacy practices with respect to such information about you, and (3) follow the terms of the notice that is currently in effect.

**How We May Use And Disclose Protected Health Information About You.**

The categories below describe different ways that we use and disclose protected health information. Not every use or disclosure in a category will be listed. We have provided a few examples of the types of uses and disclosures we are permitted to make without your authorization. Any other uses and disclosures will be made only with your written authorization.

**For Treatment and Treatment Alternatives.**
For example, we may disclose protected health information about you to your doctor for your treatment by him or use your protected health information to tell you about health-related benefits or services that may be of interest to you.

**For Payment.**
For example, we may use and disclose protected health information about you to process claims for covered health care services, to coordinate benefits with other benefit plans, to pursue recoveries from third parties (subrogation), or to provide eligibility information to a health care provider.

**For Health Care Operations.**
For example, we may use and disclose protected health information about you to conduct quality assessment and improvement activities, for underwriting, premium rating, or other activities relating to the issuing, renewal or replacement of a group policy, to engage in care coordination or case management, and for business management and general administrative activities related to our organization and the services we provide such as customer service and other activities that help us run our business.

**Individuals Involved in Your Care or Payment for Your Care.**
For example, we may disclose protected health information about you to the subscriber, to a friend or family member who is involved in your medical care or with payment for your health care and to your personal representatives appointed by you or designated by applicable law.

**Business Associates.**
There are some services provided by VIVA HEALTH, Inc. through contracts with business associates. Examples include subrogation companies, consultants, accountants, and lawyers. When services are contracted, we may disclose your protected health information to our business associate so they can perform the job we’ve asked them to do. We require the business associate to appropriately safeguard your health information.
Employers.

**Viva Health**, Inc. may disclose to the employer (if any), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. **Viva Health**, Inc. may also disclose to the employer the fact that you are enrolled in, or disenrolled from, **Viva Health**, Inc. and may also disclose your protected health information to the employer for administrative functions that the employer provides to **Viva Health**, Inc. (for example, if the employer assists its employees in resolving complaints) if the employer agrees in writing to ensure the continuing confidentiality and security of your protected health information. The employer must also agree not to use or disclose your protected health information for employment-related activities.

**As Required By Law.**

We will disclose protected health information about you when required to do so by federal, state or local law.

**Certain Marketing Activities.**

We may use protected health information about you to forward promotional gifts of nominal value, to communicate with you about services offered by **Viva Health**, Inc., to communicate with you about case management and care coordination, and to communicate with you about treatment alternatives.

**Other Permitted Uses and Disclosures:**

- To public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- To a governmental agency authorized to oversee the health care system or government programs.
- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for law enforcement purposes, as required by law.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization, in limited circumstances.
- For research purposes, in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To appropriate military authorities, if you are a member of the armed forces.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes so they may provide protection of the president or other authorized persons or foreign heads of state or conduct special investigations.
- To workers’ compensation or similar programs providing benefits for work-related injuries or illness.
- To the correctional institution or law enforcement official, if you are an inmate of a correctional institution or under the custody of a law enforcement official.

**Your Rights Regarding Protected Health Information About You.**

You may make a written request to the Privacy Officer at the address at the end of this notice to do one or more of the following concerning your protected health information we maintain:
Right to Inspect and Copy Protected Health Information that May Be Used to Make Decisions about Your Care.
In limited cases Viva Health, Inc. does not have to agree to your request. We may charge a fee for the costs of copying, mailing, or other supplies.

Right to Amend if You Feel that Protected Health Information We Have about You Is Incorrect or Incomplete.
You have the right to request an amendment for as long as the information is kept by Viva Health, Inc. You must provide a reason that supports your written request. We may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the protected health information we keep; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures.
This is a list of the disclosures we made of protected health information about you for reasons other than treatment, payment, or health care operations. Your written request must state a time period, not longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to Request Restrictions or Limitation on the Protected Health Information We Use or Disclose about You for Treatment, Payment or Health Care Operations.
You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. In your written request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications with You about Medical Matters in a Certain Way or at a Certain Location.
For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate reasonable requests to the extent possible. Your request must specify how or where you wish to be contacted. Even though you requested that we communicate with you in confidence, Viva Health, Inc. may give the subscriber cost and payment information.

Right to Revoke Authorization to Use or Disclose Your Protected Health Information Except to the Extent that Action Has Already Been Taken in Reliance on Your Authorization.
Member’s Rights & Responsibilities

Right to a Paper Copy of This Notice. You may ask us to give you a paper copy of this notice at any time.

Your Responsibilities Regarding Protected Health Information.
As a member, you are expected to help us safeguard your protected health information. For example, you are responsible for letting us know if you have a change of address and for keeping your member ID card safe. If you have online access to plan information, you are responsible for establishing a password and protecting it. If you suspect someone is trying to access your records or those of another member without approval, let us know as soon as possible so we can work with you to determine if additional precautions are needed.

Changes to This Notice.
We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for protected health information we already have about you, as well as any information we receive in the future. If we make a material change to this notice, ViVa HEALTH, Inc. will send a new notice to all subscribers covered by ViVa HEALTH, Inc. at that time. The currently effective notice will be posted on ViVa HEALTH, Inc.’s web site at www.vivahealth.com at all times.

For More Information or To Report A Problem.
If you have questions or would like additional information, you may contact ViVa HEALTH, Inc.’s Privacy Officer at 417 20th Street North, Suite 1100, Birmingham, Alabama 35203 or by email at vivamedicarememberhelp@uabmc.edu or by telephone at 1-800-294-7780. For TTY services, please call 711. Office hours are Monday-Friday, 8 a.m. to 5 p.m. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer in writing at the address above or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

ViVa HEALTH Notice of Financial Information Practices
ViVa HEALTH, Inc. is committed to maintaining the confidentiality of your personal financial information. We may collect and disclose non-public financial information about you to assist us in providing your health care coverage or to help you apply for financial assistance from federal and state programs. Examples of personal financial information may include your:

- name, address, phone number (if not available via a public source)
- date of birth
- social security number
- income and assets
- premium payment history
- bank routing/draft information (for the collection of premiums)

We do not disclose personal financial information about you (or former members) to any third party, unless required or permitted by law.

We maintain physical, technical, and administrative safeguards that comply with federal standards to guard your personal financial information.
Section 1.5
We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back cover of this booklet):

- Information about our plan. This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- Information about our network providers including our network pharmacies.
  1. For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  2. For a list of the providers in the plan’s network, see the Provider Directory.
  3. For a list of the pharmacies in the plan’s network, see the Pharmacy Directory.
  4. For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at www.vivahealth.com/Medicare/MemberResources/.

- Information about your coverage and rules you must follow when using your coverage.
  1. In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  2. To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  3. If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).

- Information about why something is not covered and what you can do about it.
  1. If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  2. If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered...
for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

3. If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6
We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

• **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are on the back cover of this booklet).

• **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

• **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

• If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

• If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with the Alabama Board of Medical Examiners at 1-800-227-2606.

Section 1.7
You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the back cover of this booklet).
Section 1.8
What can you do if you think you are being treated unfairly or your rights are not being respected?

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it’s not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9
How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.

  1. You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at www.medicare.gov/Pubs/pdf/1134-Medicare-Rights-and-Protections.pdf)
  2. Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2
You have some responsibilities as a member of the plan

Section 2.1
What are your responsibilities?

Things you need to do as a member of the plan are listed on the following page. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We’re here to help.
**Member’s Rights & Responsibilities**

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  1. Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  2. Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
  1. We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  1. To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  2. Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  3. If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps your doctor’s office, hospitals, and other offices run smoothly.

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**TRUSTED AND PROVEN**

We’re located right here in Alabama. When your office calls Viva Health, you will talk to a plan representative located here at home, not in another state or overseas.
Pay what you owe. As a plan member, you are responsible for these payments:

1. In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.

2. For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

3. If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
   - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

4. If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

Tell us if you move. If you are going to move, it’s important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).

1. If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.

2. If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.

Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
It is Viva Health’s intention to provide prompt and equitable solutions to any concerns that Viva Medicare members may have. Viva Health is responsible for examining the concern from a Viva Medicare member and determining which procedure is appropriate for processing. There are two types of procedures for addressing member concerns: the grievance process and the Medicare appeals process. There is also a special review process available from the local Quality Improvement Organization (QIO) for hospital inpatient, Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Comprehensive Outpatient Rehabilitation Facility (CORF) discharge decisions.

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

- Quality of care or services
- Wait times for appointments and in the physician’s office
- Physician or office staff demeanor and behavior
- A decision by Viva Health not to expedite a member’s appeal

For concerns that do not qualify as appeals, the grievance process for Viva Medicare members is much the same as the complaint process for Viva Health employer-group members:

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

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

The member is notified of the response in writing.

**Medicare Appeals Process:**
When a member 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 his/her 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.

a. **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.

b. ** 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 physician acting on behalf of the member to be significant to the life or health of the member or the member’s ability to regain maximum function. Because of the time sensitive nature of expedited appeals, the time frames for processing expedited appeals are shorter and some of the notices normally required in writing may be made verbally. The party filing the appeal must request an “expedited” or “fast” appeal.

**Procedure:**

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

(i) ViVa Health will provide the member a written notice of its adverse organization determination within sixty (60) calendar days of an initial request for payment of a claim and within fourteen (14) calendar days of an initial request for provision of services or as quickly as the member’s health requires. The member notice will state ViVa Health’s denial decision and specific reasons for the determination. This notice will also include the member’s right to appeal.

(ii) The member must file a written appeal within sixty (60) days (unless there is good cause for an extension) from the date the member receives notice of ViVa Health’s adverse organization determination. For expedited appeals, the member’s reconsideration request may be made verbally.

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

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

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

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

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

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

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

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

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities are responsible for delivering a “Notice of Medicare Non-Coverage” (NOMNC) to ViVa Medicare members no later than 2 days before the termination of services. This notice fulfills the CMS requirement at 42 CFR 422.624(b) (2) of the Federal Register. See pages 98-100 for instructions for the “Notice of Medicare Non-Coverage” (NOMNC) as well as a copy of the CMS-approved form that must be used.

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

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

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

If the member doesn’t ask KEPRO for a review by the deadline, the member may still ask ViVa Medicare for a “fast appeal.”