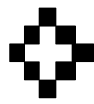


**VIVA HEALTH**

**PROVIDER MANUAL**

2010 EDITION



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## **IMPORTANT CONTACT INFORMATION**

### **Medical Management:**

**1-205-933-1201 or 1-800-294-7780**  
**FAX (205) 933-1232 or 1-800-364-0814**  
**DRUMMOND: 205- 558-7445 or 1 –866-300-0297**

- Specialty Referrals
- Case Management
- Medical Procedures
- Inpatient Admissions
- Benefit Verification
- Drug Authorizations

The above phone numbers are answered 24 hours a day, 7 days a week in case of emergency.

Regular Office Hours: 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday

### **Customer Service for Providers & Employer Groups:**

**1-205-558-7474 or 1-800-294-7780**  
**DRUMMOND: 205- 558-7545 or 1 –866-300-0297**

- Assistance with Benefits
- Claims Inquiry
- Assistance with Payment Questions
- Assistance with Eligibility

The above phone numbers are answered 24 hours a day, 7 days a week in case of emergency.

Regular Office Hours: 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday

### **Provider Services:**

**1-205-939-1718 or 1-800-294-7780 or 1-205-558-7474**  
**FAX (205) 558-7477 or 1-800-364-0814**

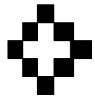
**e-mail: [vivaproviderservices@uabmc.edu](mailto:vivaproviderservices@uabmc.edu)**

- Provider Inquiries
- Provider Changes
- Contracting and Development Questions

Provider Services  
VIVA HEALTH  
1222 14th Avenue South  
Birmingham, Alabama 35205

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

**INFORMATION IS SUBJECT TO CHANGE**  
**PLEASE VISIT OUR PROVIDER WEBSITE AT**  
**[www.vivaprovider.com](http://www.vivaprovider.com) FOR LATEST INFORMATION.**



# ***INTRODUCTION TO VIVA HEALTH***

## **Managed Care Expertise....**

VIVA HEALTH, INC. is a health maintenance organization providing quality, accessible health care. VIVA HEALTH Administration, L.L.C., is its sister company offering 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 healthcare 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.

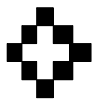
## **Extensive Provider Network....**

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 Review/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 provide 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 PRODUCT DESCRIPTIONS AND BENEFIT PLANS**

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 Out-of-Pocket 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 Attachment A, Schedule of Copayments, and is provided to each member along with the certificate of coverage. Copies of the benefit plans are available on VIVA HEALTH'S provider website at [www.vivaprovider.com](http://www.vivaprovider.com). 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 *e-Power*, VIVA HEALTH'S internet access for participating providers. *e-Power* may also be used to look up authorization information and claims status. This is discussed in more detail below.

All VIVA HEALTH products require that members utilize participating providers for services to be covered except in emergency situations, for urgently needed care when traveling, and for VIVA MEDICARE *PLUS* members requiring out-of-area dialysis. Some products limit members to sub-networks or Provider Systems within the VIVA HEALTH network of participating providers. All VIVA HEALTH products require prior authorization for hospital admissions, surgeries and other procedures and services as described later in this manual under the heading "Procedures Requiring Prior Authorization from VIVA HEALTH." Initial referrals are good for 2 visits over 3 months. If additional visits are needed, either the PCP or the specialist may call VIVA HEALTH. An overview of some of our most popular products is included below.

- **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 will 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 will indicate the name and phone number of the member's selected PCP. VIVA Health members may use any participating provider.

- **STUDENTS**

### **UAB and Jeff State Student Health Plans**

The Student Health Plan is VIVA HEALTH'S product for students attending the University of Alabama at Birmingham or Jefferson State Junior College. The Student Health Plan is a gatekeeper product meaning a Primary Care Provider (PCP) referral is required for specialist visits to be covered. No PCP referral is required to visit a participating OB/GYN, optometrist, or ophthalmologist.

Students must utilize UAB Student Health Service as their PCP. Spouses must choose a PCP in the UAB Health System. Identification cards for Student Health Plan members will indicate the name and phone number of the member's selected PCP. Both students and spouses must use UAB Health System specialists except that any participating provider may be used for OB/GYN and vision services. Dependents under age 18 may use any provider in VIVA HEALTH's pediatric network.

- **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 employees of the University of Alabama at Birmingham. 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 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 pediatric network.

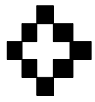
- **VIVA MEDICARE PLUS**

VIVA Medicare Plus is VIVA HEALTH's product for Medicare eligibles residing in Autauga, Blount, Bullock, Calhoun, Cherokee, Chilton, Crenshaw, Cullman, Dekalb, Elmore, Etowah Jefferson, Lowndes, Macon, Mobile, Montgomery, Pike, Shelby, St. Clair or Walker counties. Identification cards for VIVA Medicare Plus members will indicate the name and phone number of the member's selected PCP and Provider System. While VIVA MEDICARE PLUS members choose a PCP, no PCP referral is required for a member to see a specialist within her/her selected Provider System.

Please see the VIVA MEDICARE PLUS section of this Provider Manual for more information on VIVA HEALTH's Medicare Plans.

**Note:**

Please visit [www.vivaprovider.com](http://www.vivaprovider.com) for the most current listing of sample identification cards and a brief product description of the different VIVA HEALTH Benefit plans.



## ***e-POWER: INTERNET ACCESS TO ELIGIBILITY, AUTHORIZATION AND CLAIMS INFORMATION***

Participating providers with Internet access may want to take advantage of *e-Power*, 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, 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.vivaprovider.com](http://www.vivaprovider.com), and clicking on the “Login Request” link for e-Power, contacting their Provider Services Representative or e-mailing [vivawebhelp@uabmc.edu](mailto:vivawebhelp@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 Personal 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 Information Portability and Accountability Act (HIPAA) and the e-Power User Agreement remain the contracted providers’ responsibility.

### **Logging On to e-Power**

e-Power can be accessed by going to [www.vivaprovider.com](http://www.vivaprovider.com) and clicking on “e-Power Login.” Your initial password will be randomly assigned by VIVA, 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.



## ***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.

**PCP's include the following specialties:**

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

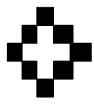
The PCP manages the health care needs of VIVA HEALTH members who select him/her as their personal physician. The PCP provides the member with emergency, urgent, routine, and follow-up care within that physician's scope of medical training and practice. In addition to managing all services for office care, PCPs are responsible for obtaining referrals to Specialists (SCPs) when required by the member's plan, obtaining authorizations for hospital admissions when 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.
9. Provide routine physicals.
10. Advise members regarding their future health care needs and options for treating those needs.
11. Coordinate care when a patient is referred to a specialist, including ensuring that specialist notes are entered in the chart and acted upon as needed, and that the appropriate follow up care is provided.
12. Provide office visits during regular office hours for evaluation/management of common areas of medicine. Patient education functions may be delegated to appropriately trained staff under the physician's supervision.

Participating Primary Care Physicians are also 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. 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. Chiropractic services
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.*

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
- PCP Name
- Referred to Provider Name
- Type Services Requested
- Pertinent Clinical Information
- Member Identification Number
- PCP Fax Number (with Area Code)
- # Visits Requested
- Diagnosis

*Mail referral requests to:*

VIVA HEALTH  
1222 14<sup>th</sup> Avenue South  
Birmingham, AL 35205  
Attention: Medical  
Management

*Fax referral requests to:*

Birmingham (205) 933-1232  
Toll Free 1-800-364-0814

If the member's appointment is 2-7 days away, fax or call in referrals. Please remember to include the above information when you fax. Faxed referrals will be processed within 24-48 hours of receipt. For same or next day referrals, please call VIVA HEALTH's Medical Management Department at (205) 558-7475 or 1-800-294-7780. Please be ready to provide VIVA HEALTH staff with the information described above. Unless additional clinical information is required or additional medical review needed, Medical Management will try to issue approval of the authorization when requested.

- 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. If services are denied, the requesting provider and member are notified by letter.
- Reports from test and x-rays performed by the PCP should be copied and sent to the Specialist to prevent duplication of testing.

# VIVA HEALTH REFERRAL FORM

## Attention

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

**FAX THIS COMPLETED FORM TO: (205) 933-1232 or (800) 364-0814**

Referral #: \_\_\_\_\_ Expires: \_\_\_\_\_

## Patient Information

Member Name:	Member #:	DOB:	Refer to Provider:	Specialty:
Please check the requested services: <input type="checkbox"/> Evaluation and recommendation <input type="checkbox"/> Evaluate and treat <input type="checkbox"/> OPS <input type="checkbox"/> One follow-up visit <input type="checkbox"/> Send report to PCP				
Number of Visits:		Appointment Date:		

## Medical Information

Diagnosis:	ICD-9 Code:
Symptoms: _____ _____ _____	
Previous Treatment (if pertinent for referral): _____ _____ _____	
Lab/X-ray Finding (if pertinent for referral): _____ _____ _____	
Medical Record #:	

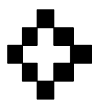
## Authorization

PCP Name:	Phone # (Include Area Code):
Contact Name:	Fax #:

### *For office use only*

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

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



## ***RESPONSIBILITIES OF THE SPECIALIST***

For VIVA Access members, no PCP referral is required for specialist visits. For other VIVA HEALTH 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 VIVA HEALTH employer group members to have an office visit 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. For VIVA HEALTH members a Specialist referral is limited to 2 visits or 3 months, which ever comes first. **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).

The Specialist is paid ONLY for the care that VIVA HEALTH authorized. Care beyond what was authorized will not be paid by the Plan and the participating provider is not allowed to bill the patient due to the hold harmless clause in the participating provider's contract.

The member is responsible for paying the co-payment indicated on his/her identification card to the Specialist at the time services are rendered. The Plan generally does not assist in the collection of this copayment although the plan should be notified of significant collection issues.

Please note the referral/ authorization number on the claim form.



## **VIVA HEALTH MEMBERS WITHOUT A REFERRAL**

For VIVA Access members, no PCP referral is required. For VIVA HEALTH members, a PCP referral is required. 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**

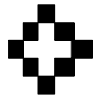
I, (patient's name), verify that I have been informed by (physician/facility name) that because I do not have a referral, I will be responsible for all services rendered to me in association with this office visit on \_\_\_\_\_, including the following procedures and/or services: (Date)

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 my Primary Care Physician.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Signature



## ***MEMBER'S RIGHTS AND 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 personal 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 or her health care.
- a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.

### **VIVA HEALTH Member's 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 anywhere and urgently need 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.**



# **PROCEDURES REQUIRING PRIOR AUTHORIZATION FROM VIVA HEALTH**

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

<ul style="list-style-type: none"> <li>•All inpatient admissions, either elective or emergent (including 23 hour observations). <b>For emergencies, VIVA HEALTH should be contacted within 24 hours of admission (or the next business day).</b></li> </ul>	<ul style="list-style-type: none"> <li>•All sinus or nasal surgery (copies of records required)</li> </ul>
<ul style="list-style-type: none"> <li>•All out of network, out of panel or out of area services</li> </ul>	<ul style="list-style-type: none"> <li>•Sleep studies: C-PAP, MSLT, PSNG (copies of records listing symptoms required)</li> </ul>
<ul style="list-style-type: none"> <li>•All referrals from the PCP to the Specialist (only required for VIVA HEALTH “Gatekeeper” model HMO products), excluding OB/Gyn, ophthalmologist and optometrist services from participating providers</li> </ul>	<ul style="list-style-type: none"> <li>•Arteriograms</li> </ul>
<ul style="list-style-type: none"> <li>•Outpatient surgery including wound care</li> </ul>	<ul style="list-style-type: none"> <li>•All angiograms except CT guided</li> </ul>
<ul style="list-style-type: none"> <li>•Emergency Room visits (within 24 hours or next business day)</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac Caths</li> </ul>
<ul style="list-style-type: none"> <li>•Inpatient Rehabilitation or Day Treatment (letter of medical necessity required)</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac Rehab, Pulmonary Rehab</li> </ul>
<ul style="list-style-type: none"> <li>•Rehabilitation Services: Physical Therapy, Occupational Therapy, and Speech Therapy</li> </ul>	<ul style="list-style-type: none"> <li>•Holter monitors, if worn longer than 24 hours</li> </ul>
<ul style="list-style-type: none"> <li>•Pain Clinic Care</li> </ul>	<ul style="list-style-type: none"> <li>•Myelograms, Discograms, and PET scans</li> </ul>
<ul style="list-style-type: none"> <li>•Prescriptions requiring Prior Authorization</li> </ul>	<ul style="list-style-type: none"> <li>•Orthotics</li> </ul>
<ul style="list-style-type: none"> <li>• All ancillary services (home health, IV therapy, hospice care, durable medical equipment (DME), orthotics, prosthetics, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>•Skilled Nursing Facility admissions</li> </ul>
<ul style="list-style-type: none"> <li>•All scopes performed outside the physician’s office excluding colonoscopy &amp; EGD</li> </ul>	<ul style="list-style-type: none"> <li>•Transplant services</li> </ul>
<ul style="list-style-type: none"> <li>•All plastic surgery, even if performed in physician’s office (copies of records, pre-op photos and letter of medical necessity required)</li> </ul>	<ul style="list-style-type: none"> <li>•Neuropsych Testing</li> </ul>



## **EXTENDED REFERRALS**

### **Physical Therapy:**

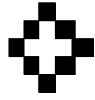
- A set number of visits will be initially granted.
- Physical, Occupational, and Speech Therapy providers **must** fax requests for further extension of services to (205) 933-1232 or 1-800-364-0814.

### **Specialist Referrals:**

- Specialist referrals will be approved for two visits. Specialist may call VIVA HEALTH directly to request additional visits. The referral authorization is valid for up to 90 days from the date the referral authorization is issued by VIVA HEALTH.

**VIVA HEALTH’s requirements are subject to change.**

**Please visit [www.vivaprovider.com](http://www.vivaprovider.com) for the most current listing of services that require Prior Authorization.**



# Prior Authorization Form

## TO BE USED IN/OUT PATIENT

VIVA HEALTH  
1222 14th Avenue South  
Birmingham, AL 35205  
Phone: (205) 933-1201 Fax: (205) 933-1232

### TO BE FILLED IN BY ADMITTING PHYSICIAN

Patient Name \_\_\_\_\_

Birth date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Other Insurance \_\_\_\_\_

Member Number \_\_\_\_\_

Group Number \_\_\_\_\_

Person Completing Form \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Admitting MD \_\_\_\_\_

Hospital \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Procedures \_\_\_\_\_ CPT \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Admit Date \_\_\_\_\_

Requested LOS \_\_\_\_\_

Summary of Previous Outpatient Treatment \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Indication for Hospitalization \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

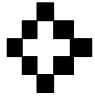
Hospital Treatment Plan \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### For Delivery Admit

EDC \_\_\_\_\_

Expected Type Delivery \_\_\_\_\_

**This approval does not authorize services not covered 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.**



## ***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
- CT Scans and MRIs unless requested to be performed out of panel or out of network
- 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
- GXT's
- HIV Screening
- HTLV III Antibody Detection
- IVP
- Loop/Leep Lasers of Cervix (in office)
- Routine Mammogram
- Manometry Studies
- MRA
- MRIs (including Open MRI)
- 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

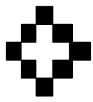
***Note: Diagnostic testing will only be covered when performed at Participating Radiological Facilities. Please refer to the most current VIVA HEALTH provider directory at [www.vivaprovider.com](http://www.vivaprovider.com) for a list of these facilities.***



## ***PRIOR AUTHORIZATION OF DELIVERIES***

Delivery prior authorization is obtained by calling or faxing Medical Management prior to delivery.

<b>Phone Numbers:</b>	(205) 933-1201 (800) 294-7780	<b>Fax Numbers:</b>	(205) 933-1232 (800) 364-0814
<b>DRUMMOND:</b>	(205) 558-7445 (866) 300-0297	<b>Fax Numbers:</b>	(205) 933-1232 (800) 364-0814



## ***SERVICES COVERED UNDER THE GLOBAL DELIVERY FEE***

### **Services included in the Global Fee:**

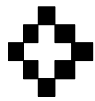
- Physician services including prenatal, delivery, and postnatal care
- Glucose testing
- OB ultrasounds
- OB stay after delivery
- Non-stress test (one)
- Hct / Hgb
- Urinalysis
- Alpha Fetaprotein

### **Women's Access to Health Care Act:**

Under the Women's Access 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. The delivery, stays beyond 48/96 hours, and newborn placement in an intensive care nursery still require prior- authorization.



# 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 HEALTH website ([www.vivaprovider.com](http://www.vivaprovider.com)) for applicable ER copay amounts
- Waive ER copay if patient is admitted within 24 hours from ER and apply inpatient copay
- Notify VIVA HEALTH to request hospital authorization
- VIVA HEALTH must be notified of all emergency admissions within 24 hours or the next working day

## Admissions:

- Except in emergencies, admit VIVA HEALTH patients only from participating physicians
- VIVA HEALTH guidelines must be followed even in secondary coverage situations
- Place the member in a semi-private room, if available (private only if medically necessary and authorized by VIVA HEALTH)
- Except in emergencies, VIVA HEALTH must approve all hospital admissions in advance
- VIVA HEALTH must be notified of all emergency admissions within 24 hours or next working day

## Obstetrical Admissions:

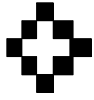
- Notify VIVA HEALTH of admission
- Mother and baby's claim submitted together, unless mother is discharged before baby. In this case, contact VIVA HEALTH for additional authorization number and file separately. The baby's claims will only be covered if baby is added to the plan within 31 days. A separate 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 to:

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

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



## **HOSPITAL INPATIENT PRIOR AUTHORIZATION**

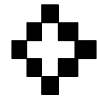
***Except in emergencies, contact a VIVA HEALTH coordinator for certification prior to the patient being admitted to the hospital at (205) 558-7475, (205) 933-1201 or 1-800-294-7780.***

### **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 a VIVA HEALTH coordinator within 24 hours, or next working day, of 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 inpatient hospital copay applied if the member is admitted. Lack of notification within 24 hours or the next business day may result in the days prior to notification being denied for lack of notification and the member cannot be billed.
  
- Provide the coordinator with the following information:
  - Member's name
  - Member's ID number
  - Diagnosis/procedure requiring hospitalization
  - Date of admission
  - Admitting physician's name
  - Anticipated length of stay
  - Name of hospital
  - Other health coverage
  - Pertinent clinical information
  - Plan of treatment
  
- Concurrent review is performed on all admissions. During the member's hospitalization, the VIVA HEALTH coordinator will contact the hospital to obtain additional medical information. If the member's condition warrants further hospitalization, contact a VIVA HEALTH coordinator 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 and/or "never events."

**ALL NON-EMERGENCY HOSPITAL INPATIENT OR OBSERVATION  
ADMISSIONS MUST BE PRIOR AUTHORIZED.**



## ***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 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.
- 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 or 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. If a member uses one of these centers the member should contact VIVA HEALTH following the visit.

### **WILL THE EMERGENCY ROOM TREATMENT BE COVERED BY VIVA HEALTH?**

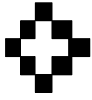
Emergency medical care, including hospital emergency room services and emergency ambulance services will be covered twenty-four (24) hours per day, seven (7) days per week, if provided by an appropriate health professional whether in or out of the Service Area if the following conditions exist: (a) the 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.

There is 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.

### **Important Reminders about Emergency Services:**

- The ER or the PCP should notify VIVA HEALTH'S UM Nurse the next day of the ER treatment and request an authorization number. If the patient is admitted, the ER visit becomes part of the Inpatient Admission Review and no ER authorization is necessary.
- ER authorization during the PCP's regular office hours is undesirable for conditions that are treatable by the PCP.



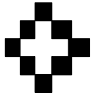
# **AMBULATORY SURGICAL AUTHORIZATION GUIDELINES**

Ambulatory Surgery includes those surgical procedures that are performed in freestanding surgical facilities or outpatient departments of hospitals. All such surgeries require prior authorization and must be performed in VIVA HEALTH contracted facilities.

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:

<b>IF YOU ARE REQUESTING THESE SERVICES:</b>	<b>UNDER THESE CPT CODES:</b>	<b>VIVA HEALTH WILL NEED THIS INFORMATION TO EVALUATE YOUR REQUEST:</b>
<u>Auditory (Ear)</u> Otoplasty	69300	A letter of Medical Necessity and photographs
<u>Breast</u> Mastectomy for gynecomastia	19140	<ul style="list-style-type: none"> <li>• A letter of Medical Necessity, including height and weight, photographs, and symptoms.</li> </ul>
Breast reduction	19318	<ul style="list-style-type: none"> <li>• Requires a letter of Medical Necessity and frontal and lateral view photographs, weight/height, and medical complications.</li> </ul>
Breast reconstruction	19340-19350	<ul style="list-style-type: none"> <li>• Excluded except when required after mastectomy surgery. <b>Covered only as related to reconstruction due to malignancy.</b> Requires a letter of Medical Necessity.</li> </ul>
<u>Eye and Ocular</u> Blepharoplasty Canthopexy Repair of blepharoptosis Repair Ectropion/Entropion Excision, repair, reconstruction of eyelids Plastic repair canaliculi	15820-15823 21280, 21282 67901-67911 67914-67924 67950-67975  68700	<ul style="list-style-type: none"> <li>• A letter of Medical Necessity, photographs and results of a visual field exam.</li> </ul>
<u>Integumentary (Skin)</u> Tissue expander insertion, replacement, or removal  Scar revision  Tracheostomy scar revision	11960-11971  15786, 15787  31830	<ul style="list-style-type: none"> <li>• A letter of Medical Necessity, the patient's history, and photographs</li> <li>• A photograph of the lesion, along with measurements, and a description of the impairment involved</li> </ul>
<u>Respiratory (Nose)</u> Rhinoplasty  Submucous resection Septoplasty	30460-30462  30130-30140 30520, 30620-30630	<ul style="list-style-type: none"> <li>• <b>Limited to cleft lip/palate or reconstruction due to accident or illness.</b> Requires a letter of Medical Necessity and photographs from a surgeon.</li> </ul>

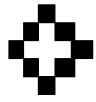
**In- office surgical procedures do not require prior authorization. The specialist must obtain a referral from the PCP if the member's plan requires a PCP referral.**



## ***AMBULATORY SURGICAL PROCEDURES THAT ARE NOT COVERED***

Non-covered Ambulatory Surgical Procedures include, but are not limited to, the following:

<b>NON-COVERED PROCEDURE</b>
<u>Auditory (Ear)</u> Ear Piercing
<u>Breast</u> Removal/replacement of breast implants except when required for post mastectomy reconstruction. Breast augmentation Correction of inverted nipple
<u>Eye and Ocular</u> Radial Keratotomy
<u>Integumentary (Skin)</u> Cervicoplasty Chemical peel Dermabrasion Electrolysis Excessive fat removal (lipectomy) Hair transplant Injection of sclerosing solutions Rhytidectomy Salabrasion Subcutaneous injections of filling material Keloid removal
<u>Reproduction</u> Penile implants Intersex surgery Reversal of voluntary sterilization
<u>Respiratory (Nose)</u> Excision for rhinophyma



## **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-9 diagnostic codes
- CPT-4 procedure codes with modifiers, 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 HCPC 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 one hundred and eighty days of date of service.*

### **Claims should be submitted to:**

#### for Employer Group Members

VIVA Health Claims  
P.O. Box 55926  
Birmingham, Alabama 35255-5926

#### for Medicare Advantage Plan Members

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

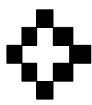
Claims filed to VIVA HEALTH as a secondary carrier must be billed as paper claims with the primary carrier's Explanation of Payment attached. If VIVA HEALTH identifies a another primary insurance carrier after paying a claim as the primary carrier, VIVA HEALTH may reverse its payment and request that the claim be filed with the primary carrier.

**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 by the Medical Management Department 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 Medical Director as needed to determine medical necessity. The Medical Director is responsible for deciding claims issues related to medical necessity with input from other physicians, as needed/ required.



## ***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 *PLUS* 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.

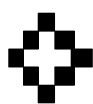


## ***ELECTRONIC CLAIM FILING***

VIVA HEALTH has contracted with Emdeon On-line 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.

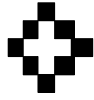
Providers interested in conducting electronic claims transactions directly with VIVA HEALTH, should view the HIPAA "EDI Enrollment Form and Trading Partner Agreement" on our web site at <http://vivaprovider.com/Resources/Forms.aspx> to find out what is required to conduct electronic transactions with VIVA HEALTH. All electronic transactions must be conducted using the Health Insurance Portability and Accountability Act (HIPAA) standard transaction (if applicable). Providers contracted with a clearinghouse should be advised that VIVA HEALTH does not pay any fees assessed by the clearinghouse; all such fees are the provider's responsibility.



## ***UNIQUE BILLING SITUATIONS***

Provider Reimbursement Methodologies	Unique billing situations and provider reimbursement methodologies may exist or develop. VIVA HEALTH will calculate covered expenses following evaluation and validation of all provider billings in accordance with the methodologies in the most recent edition of CPT or as reported by generally recognized professional organizations or publications. Expenses not covered due to provider reimbursement methodologies are indicated in the “Provider Adjustment/Provider Discount” fields in the EOB. These are not to be balance billed to the VIVA HEALTH member. Please refer billing questions to Customer Service at 1-800-294-7780. Some of the more common provider reimbursement methodologies are described below and on the following pages. Provider must use the appropriate modifiers. Please note that this is not a complete listing.
Office Visits On The Same Day As Surgery	Bill for office visits on the same day as surgery in the following instances only: <ul style="list-style-type: none"><li>• for a new patient</li><li>• an initial consultation or emergency</li><li>• if the visit is determined to be in connection with a condition unrelated to the surgery/diagnostic procedure</li></ul>
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: <ul style="list-style-type: none"><li>• 100% of the fee schedule for the highest value procedure</li><li>• 50% of the fee schedule for the second highest value procedure</li><li>• 25% of the fee schedule for third highest value procedure</li><li>• 10% for the fourth and fifth highest value procedures</li></ul> <p>This guideline applies to all VIVA HEALTH and VIVA MEDICARE <i>PLUS</i> products</p>
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 on-line. 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	<p>Every anesthesia code should be submitted with a payment modifier. Anesthesia codes 00100-01999 will be rejected if a modifier is not included. The accepted payment modifiers include:</p> <ul style="list-style-type: none"> <li>• AA Anesthesia service performed personally by anesthesiologist</li> <li>• AD Medically supervised by a physician for more than four concurrent procedures</li> <li>• QK Medical direction of 2-4 concurrent anesthesia procedures involving qualified individuals</li> <li>• QX Anesthetist service with medical direction of a physician currently payable only for VIVA MEDICARE <i>PLUS</i></li> <li>• QY Medical direction of one CRNA by an anesthesiologist</li> <li>• QZ Anesthetist service without medical direction of a physician currently payable only for VIVA MEDICARE <i>PLUS</i></li> </ul>
Maternity Care	Maternity care is included under the global maternity code (CPT Code 59400 or 59510). A copay will be charged at the first office visit. You may not bill for each office visit for routine maternity care; these visits will be included in the payment for your global maternity bill. If global maternity services include VBAC (vaginal birth after C-section) or complicated delivery, please add the modifier 22 to 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.



## ***APPEALING CLAIMS***

### **CLAIMS ISSUES**

Providers may inquire about a claim denial or other concerns regarding payment by calling our Provider Customer Service Department at 205-558-7474 in Birmingham or toll free 1-800-294-7780. Requests to process or reprocess claims, or make additional payments, must be received within 180 days of the original check date or, in the case of claim denial, original date of the Explanation of Payment. If the issue is not resolved after speaking with our Provider Customer Service Department, a written appeal may be forwarded to VIVA HEALTH for review. Please include information and documentation relevant to the appeal. Appeals will generally be reviewed within 45 days of receipt. A final decision will be forwarded to the provider and is not subject to further appeal.

Appeals should be sent to:

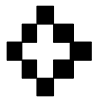
**VIVA HEALTH  
ATTENTION: PROVIDER APPEALS  
1222 14th Avenue South  
Birmingham, AL 35205**

Appeals may also be faxed to the attention of Provider Appeals at 205-449-7542. Providers with secure e-mail delivery, to protect Patient Health Information (PHI), may also e-mail appeals to [vivaproviderservices@uabmc.edu](mailto:vivaproviderservices@uabmc.edu). However, it is recommended that appeals with large amounts of documentation, such as medical records, NOT be faxed or e-mailed.



## ***FEE SCHEDULE CHANGES***

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



## ***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 PLUS* 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 PLUS* 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 MEDICAL MANAGEMENT***

The Medical Management Department is comprised of specially trained individuals including registered nurses and referral coordinators. The staff is overseen by the physician Medical Director who ensures that appropriate utilization, quality controls and departmental procedures are followed by interacting with the medical management staff regarding its day to day activities.

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 registered nurse, 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 nurse will speak with the attending MD or the case will be referred to the Medical Director 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 Nurse will authorize an extended length of stay based on meeting guidelines or refer the case to the Medical Director 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 and 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 Nurse 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 Nurse 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. Providers may appeal decisions by following the provider appeals procedure in this manual.

### **Physician Sanctioning**

When a participating physician repeatedly fails to comply with medical management requirements, physician sanctioning provides a method for penalty. Medical Management compiles reports for the Medical Director and the Utilization Management/Quality Improvement Committee, as needed, to review and apply sanctions if appropriate.

### **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 Medical Director as needed to determine medical necessity. The Medical Director 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 are available on the VIVA HEALTH website at [www.vivaprovider.com](http://www.vivaprovider.com).

**Updating and Establishing  
Medical Policy**

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

**PCP/Specialist  
Appointment Times**

Members should be able to obtain appointments for needed care within a reasonable amount of time: Emergency: immediately; Urgent: same or following day; Non-urgent: within one week; Routine: within 30 days; Preventive: within 45 days.



## ***VIVA HEALTH'S QUALITY IMPROVEMENT PROGRAM***

The primary focus of the QI activity centers on VIVA HEALTH ensuring that members receive quality health care. The purpose of the Quality Improvement Program (QIP) is to establish, implement and maintain an effective program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems.

The QIP is a dynamic, organized, peer based and integral part of health care delivery and administrative practice. The Program provides feedback to providers and health plan administration that can be utilized to promote appropriate changes and thereby improve or maintain quality of care.

QI review activities encompass all aspects of VIVA HEALTH administration such as availability, accessibility, effectiveness, coordination, continuity and delivery of medical care. QI activities include all demographic groups, health care places of service and types of service. All contracted providers are required to participate in the QIP by contract.

The following is a list of the important aspects of care and service that are reviewed:

- Continual quality monitors such as readmission, post-op complications, infection and deaths are used to identify potential quality of care/service issues.
- Focused studies provide opportunities for improvement within the inpatient and outpatient care settings.
- Provider surveys and provider profiling are utilized periodically for evaluating the services provided by our participating providers on an on-going basis. The survey identifies opportunities for improvement in the various services offered.
- Collection and reporting of HEDIS data for VIVA MEDICARE *PLUS* members.

**Program Structure**

A. Governing Body

Ultimate accountability for the Quality Improvement Program is to the Board of Directors. The Quality Improvement Plan is reviewed and approved annually by the UM/QI Committee and the Board of Directors.

## B. Utilization Management/Quality Improvement Committee

This Committee is comprised of a range of participating Primary Care Physicians and Specialists. The Medical Director and the Medical Management and Quality Improvement staffs provide support to the Committee. The Medical Director sits as chairman of the Committee.

The Committee is responsible for monitoring and evaluating the medical care rendered by VIVA HEALTH providers as well as the administrative services provided by our staff to VIVA HEALTH providers and members. The Committee meets at least quarterly. 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.

The ultimate responsibility for the UM/QI Committee and the Quality Improvement Program itself rests with the Board of Directors. The UM/QI minutes become a permanent part of the Board minutes. These minutes include key discussion points, decisions made, rationale, planned actions, responsible person(s) and follow up. Minutes are confidential.

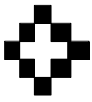
All potential problems with clinical care and services identified are reported to the Medical Director for review. If the Medical Director determines that a quality of care issue exists, the issue is referred to the UM/QI Committee for review. The committee makes recommendations for follow up and problem resolution. Follow up performed by Quality Improvement staff is reported back to the Committee for documentation of resolution or the need for further action.

## C. Specialty and Subspecialty Committees

VIVA HEALTH is committed to the concept of Peer Review. Issues which are particular to a medical specialty will generally be reviewed and judged by physicians within that specialty.

## D. Medical Director

The Medical Director is directly involved in Quality Improvement activities. The Medical Director oversees the medical decision-making process at VIVA HEALTH and is responsible for program implementation.



# **VIVA HEALTH'S COMPLAINT PROCEDURE FOR EMPLOYER GROUP MEMBERS**

*(See VIVA MEDICARE PLUS Provider Manual 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  
Post Office Box 55926  
Birmingham, Alabama 35255-5926**

A provider may act on behalf of the Member in the Formal Complaint process if the provider certifies in

writing to VIVA HEALTH that the Member is unable to act on 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 Formal Complaint.

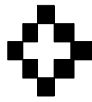
The Formal Complaint Committee reviews all Formal Complaints. The Member or any other party of interest may provide pertinent data to the Formal Complaint Committee in person or in writing. The Formal Complaint Committee issues its decision within 30 days of the receipt date of the Formal Complaint (for a member employed by an employer subject to ERISA, this timeframe is shortened to 15 days on pre-service claims only). The Member is given written notification regarding the Formal Complaint Committee's decision within 5 working days of the decision being made. In the case of an adverse outcome (in whole or in part) Members of plans offered under VIVA HEALTH, Inc.'s HMO license have a right to a Third Level Review by the State Health Officer or the Alabama Insurance Commissioner.

- 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 Level Review by the State Health Officer or the Alabama Insurance Commissioner.

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.



# **VIVA HEALTH'S PROVIDER CREDENTIALING/RE-CREDENTIALING AND PROVIDER SANCTIONING**

## **Credentialing**

Credentialing is the initial process through which VIVA HEALTH collects, reviews, and verifies specific criteria and prerequisites in order to determine eligibility for participation with VIVA HEALTH. Once the data has been collected and verified, it is presented to the VIVA HEALTH Credentialing Committee.

VIVA HEALTH's Credentialing Committee makes decisions based on the qualifications, training, and experience of the provider, as well as the welfare and needs of VIVA HEALTH's 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.

The Credentialing Committee's decisions are taken before the VIVA HEALTH Board of Directors or its designated subcommittee for final approval. After Board approval, notification of the Credentialing Committee's decision will be made in writing to the provider. If the decision is favorable, a welcome letter will be mailed to the provider. If the decision is unfavorable, a notice including the reason for the unfavorable decision will be forwarded to the provider and the provider may appeal the decision according to the appeals procedure outlined in this Provider Manual.

## **Mid-cycle Verifications**

Between the time a participating provider is credentialed and recredentialed, VIVA HEALTH continues to verify certain qualifications including state medical license and controlled substance certificate, the existence of required malpractice coverage, Medicare/Office of Inspector General (OIG) sanctions and a current DEA permit (when required). In accordance with the 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.

## **Recredentialing**

All providers participating with VIVA HEALTH must be recredentialed every three years at a minimum. If concerns arise, recredentialing may be initiated at any time. VIVA HEALTH requires the provider to complete a recredentialing application and reviews, revises and re-verifies all appropriate provider information during recredentialing. The provider's information will be taken before the VIVA HEALTH Credentialing Committee for decision and then forwarded on to the VIVA HEALTH Board of Directors for final approval in order to continue as a participating provider.

## **Provider Sanctioning**

If the 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, a 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;

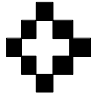
- Immediate suspension from participation with VIVA HEALTH; or
- Immediate termination of the participating provider contract.

If the corrective action results in a suspension, the facts and circumstances of the suspension shall be reviewed by the Credentialing Committee or the UM/QI Committee within seven (7) days thereof, and the reviewing committee shall determine the ultimate action to be taken in the matter. The provider has a right to appeal any continuation of a suspension beyond thirty (30) days in accordance with the Provider Appeals Process described below.

### **CREDENTIALING/RE-CREDENTIALING DENIALS**

Providers who are sanctioned, limited, suspended or terminated from participation shall be notified in writing and given thirty (30) days to appeal. This notice will include information on the appeal process. The provider may appeal the decision through a written request for an appeal and the basis therefore. VIVA HEALTH will notify other parties of the action as required by law, regulation or as recommended by regulatory authorities or legal counsel.

Upon receipt of the written request for appeal, VIVA HEALTH will appoint a panel of physicians to review the appeal. The panel will meet within thirty (30) days of receipt of the provider's request for appeal. The provider will have the opportunity to submit information the provider considers relevant to the decision, to be represented by counsel, to have a record made of the proceedings, to call witnesses, and to submit a written statement.



# ***PROVIDER APPEAL PROCESS***

## **CLAIMS AND SERVICE DENIALS**

Providers may inquire about a claim or service denial or other concerns regarding payment by calling our Provider Customer Service Department at (205) 558-7474 in Birmingham or toll free 1-800-294-7780. Requests to process or reprocess claims, or make additional payments, must be received within 180 days of the original check date or, in the case of claim denial, original date of the Explanation of Payment.

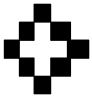
Providers may also check on the status of an authorization or referral request by calling our Medical Management Department at (205) 558-7475 or 933-1201 or 1-800-294-7780 or on-line with VIVA HEALTH's *e-Power*, described on page 4.

If the issue is not resolved after speaking with our Provider Customer Service or Medical Management Departments, an appeal in writing may be forwarded to VIVA HEALTH for review. Please include all information and documentation relevant to the appeal. Appeals will generally be reviewed within 45 days of receipt. A final decision will be forwarded to the provider and is not subject to further appeal.

Appeals should be sent to:

**VIVA HEALTH  
ATTENTION: PROVIDER APPEALS  
1222 14th Avenue South  
Birmingham, AL 35205**

Appeals may also be faxed to the attention of Provider Appeals at 205-449-7542. Providers with secure e-mail delivery, to protect Patient Health Information (PHI), may also e-mail appeals to [vivaproviderservices@uabmc.edu](mailto:vivaproviderservices@uabmc.edu). However, it is recommended that appeals with large amounts of documentation, such as medical records, NOT be faxed or e-mailed.



# ***CLINICAL PRACTICE AND PREVENTATIVE 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 judgement 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 Guidelines:**

### **Standards of Medical Care for Patients with Diabetes Mellitus**

This standard can be reviewed by visiting:

- <http://care.diabetesjournals.org>

### **ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult**

This standard can be reviewed by visiting:

- <http://www.acc.org/qualityandscience/clinical/statements.htm>

### **Guidelines for Pediatric Preventive Care Recommendations**

This standard can be reviewed by visiting:

- American Academy of Pediatrics  
[www.aap.org](http://www.aap.org)

### **Guidelines for Adult Preventive Care Recommendations**

This standard can be reviewed by visiting:

- U.S. Preventive Services Task Force  
<http://www.ahrq.gov/clinic>
- American Cancer Society

<http://www.cancer.org>

- American College of Obstetrics and Gynecology

<http://www.acog.org/>

- American College of Physicians

<http://www.acponline.org/>

- American Academy of Family Physicians

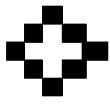
<http://www.aafp.org>

**[Guidelines for the Evaluation and Management of Chronic Obstructive Lung Disease](#)**

[This standard can be reviewed by visiting:](#)

- [www.goldcopd.org](http://www.goldcopd.org)

If you do not have access to the Internet or if you have trouble viewing the above websites, a copy of the above standards can be obtained by contacting your Provider Services Representative.



## ***VIVA HEALTH Pharmacy Information***

VIVA HEALTH currently works with Caremark<sup>®</sup>, a pharmacy benefit Management Company, to administer the prescription drug program for its plans that include drug benefits. Note that some employers have carved prescription drug benefits out to another vendor.

### **1. Pharmacy RX Benefit Information**

VIVA HEALTH typically has 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. Our Medicare Part D drug benefit is described in the VIVA MEDICARE *PLUS* Provider Manual. Here are a few tips to remember on how 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 be responsible for the total cost of the brand drug.
- 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.
- Keep a copy of the most current VIVA HEALTH Custom Drug List and prior authorization list in your office for reference. The current lists are available at <http://vivaprovider.com/Resources/Default.aspx>
- When requesting a prior authorization for Part B drugs, **always** include the HCPC 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, <http://vivaprovider.com/Resources/AuthList.aspx>, 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. Remember PPI use after 8 weeks requires a prior authorization. Please call VIVA HEALTH Medical Management at 933-1201 for prior authorization information.

### 3. VIVA HEALTH Custom/Preferred Drug List

The VIVA HEALTH Custom Drug List changes periodically. When a drug becomes available in the generic form or over the counter, it is automatically removed from the Custom Drug List. 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 list visit our website at [www.vivaprovider.com](http://www.vivaprovider.com). You can contact VIVA HEALTH's customer service department at 205-558-7474 to get a current listing mailed to you.

### 4. CTS for Biological, Biotechnical, and Injectable Drugs

VIVA HEALTH works with Caremark Therapeutic Services (CTS) to distribute covered self-administered injectable biological and biotechnical drugs to our members. CTS provides services to individuals with various chronic or genetic disorders such as Crohn's Disease, Cystic Fibrosis, Hemophilia, Hepatitis C, Immune Disorder, Multiple Sclerosis, Rheumatoid Arthritis and to members who require growth hormones or drugs for RSV Prevention. If you have a member that needs to be enrolled, please call CTS directly at 1-800-237-2767. Once CTS has received 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. Caremark's Automatic Prescription Formulary Letters

Caremark and VIVA HEALTH have an automated program in place to help manage pharmacy costs. If you write a prescription for a brand drug that isn't on the VIVA HEALTH Custom Drug List, Caremark will automatically send a letter to your office asking if you would consider changing the member's prescription in the future. This change would result in lower copays for the member and would lower overall pharmacy costs. Using the Custom Drug List is one of the tools VIVA HEALTH has implemented to help control increasing pharmacy expense. We appreciate your cooperation with this program as we continue to look for ways to offset pharmacy cost increases.

### 6. VIVA HEALTH Half-tab Programs

VIVA HEALTH has a half-tab for the drugs Celexa, and Zoloft. An example of this program is when a patient is taking one 50mg tablet of a particular medication per day, or 30 pills per month. The half-tab program will provide 15 pills of 100mg strength. These pills are scored, or perforated, so that the patient can break them in half with ease. The patient breaks the pill in half and takes 50mg per day. For several medications the cost of 50mg tablets is almost the same as 100mg tablets. By utilizing the higher dosage, and splitting the pre-scored pills, it is possible to lower the cost of therapy significantly. For more information please call VIVA HEALTH Customer Service at (205) 558-7474 or (800) 294-7780.

Non-Covered Dosing Regimen	Covered Dosing Regimen
Zoloft 25mg .....1 tablet/day	Zoloft 50mg .....1/2 tablet/day
Zoloft 25mg.....2 tablets/day	Zoloft 100mg....1/2 tablet/day
Zoloft 25mg.....3 tablets/day	Zoloft 50mg.....1 and 1/2 tablets/day
Zoloft 25mg.....4 tablets/day	Zoloft 100mg.....1 tablet/day
Zoloft 50mg.....1 tablet/day	Zoloft 100mg.....1/2 tablet/day
Zoloft 50mg.....3 tablets/day	Zoloft 100mg.....1 and 1/2 tablets/day
Celexa 20mg.....1 tablet/day	Celexa 40mg....1/2 tablet/day
Celexa 20mg.....2 tablets/day	Celexa 40mg....1 tablet/day
Celexa 20mg.....3 tablets/day	Celexa 40mg....1 and 1/2 tablets/day

## **7. VIVA HEALTH Proper Dosing Programs**

VIVA Health has a half-tab program for Celexa, Paxil and Zoloft. VIVA Health has a proper dosing program for Lescol, Lipitor, Lovastatin, Mevacor, Pravachol, Pravastatin, Somvastatin and Zocor. Call VIVA Health Customer Service at 558-7474 or 1-800-294-7780 for details.

## **8. RX Rider**

Member's 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.

## VIVA Health Drugs Requiring Prior Authorization List as of January 2010

*(This List Does Not Apply to VIVA Medicare Plus Members)*

This is a list of prescription drugs that either require prior authorization or are excluded from coverage. **This is not an all-inclusive list. It is provided strictly as a guide and may change periodically.** Please call VIVA Health Medical Management at 933-1201 in Birmingham or 1-800-294-7780 if you have questions regarding a particular drug.

Pharmaceuticals
Accutane
Adderall (amphetamine), Adderall XR (amphetamine ER), Ritalin (methylin), Concerta, Focalin, Strattera, Metadate, Provigil, Nuvigil and Vyvanse
Arava
Axid
<b>COX II's:</b> Celebrex
Desoxyn
Dexedrine
Dextrostat
Diflucan/Fluconazole 150mg <b>(QL)</b>
<b>Hypnotic/Sedatives-(QLC):</b> Ambien/Ambien CR(zolpidem), Lunesta, Sonata (zaleplon), Restoril (temazepam), Rozerem
Lamisil (terbinafine), Sporanox (itraconazole)
Lovenox, Arixtra-Auth required if use exceeds 14 days
<b>NSAIDS:</b> Arthrotec, Naprelan, Ponstel
<i>Proscar</i>
<b>Proton Pump Inhibitors-</b> Prevacid, Kapidex, Nexium, Aciphex, Protonix (pantoprazole) <b>*Auth required after initial 8 weeks*</b>
Retin-A, Avita, Vesanoid, Renova, Tazorac
Stadol NS
<b>Triptans-(QL):</b> Amerge, Axert, Frova, sumatriptan, Maxalt, Replax, Treximet & Zomig
Wellbutrin/Wellbutrin SR, Bupropion, Budeprion SR
Zofran

Exclusions
OTC and OTC Equivalents
Anorexiant Drugs/Weight Loss/Gain
Depigmenting Drugs
ED Drugs
Hair Loss Drugs
All Infertility Drugs
Smoking Cessation Drugs
All RX vitamins except Prenatal & Flouride Combos

\* Not required to come from Caremark Specialty and auth required for greater than 14 day utilization.

\*\* FDA standard recommended quantity limits on some narcotics. Prior Authorization is required when limits are Exceeded.

***(QL) Authorization only required if standard quantity limits are exceeded.***

**All of the unclassified Drug codes (such as J3490, J3590, J8999, and J9999) require a prior authorization. When requesting a prior authorization for an unclassified drug please submit the NDC#, Drug name, and Dosage.**

Injectible and Biological Drugs	
Adagen	Lupron
	Neulasta
ACTH	Neupogen
Aldurazyme	Neumega
Aloxi	Nexavar
Amevive	Orencia
Aralast	Pegasys
Aranesp	Peg-Intron
Aredia	Procrit
Arixtra*	
Avonex	Proleukin
Betaseron	Pulmozyme
Botox	Raptiva
Ceredase	Rebetol
Copaxone	Rebetron
Copegus	Rebif
Enbrel	Remicade
Epogen	Remodulin
Euflexxa	Revlimid
Fabrazyme	Respigam
Factor VIII	Revatio
Flolan	Supartz
Fludara	Sutent
Forteo	Synagis
Fragmin	Synvisc
Gamimmune	Temodar
Growth Hormones	Tev-Tropin
Hemophilia Injectibles	Thalomid
Hepatitis A Vaccine	Thryogen
Humira	TOBI
Hyalgan	Tracleer
Increlex	Trelstar
Intron A	Ventavis
Iressa	Vivaglobulin
IGIV	Xeloda
Kineret	Xolair
Leukine	Zoladex
Lovenox*	Zometa
Letairis	

***(QLC) Short-term use medications with 15-day quantity limits per copay. Mail-order not available.***

**VIVA Medicare Plus RX Part D Drugs Requiring Prior Authorization or Quantity Limit  
Summary List as of January 2010**

*(This List Does Not Apply to VIVA Commercial Group Plan Members)*

**This is a list of prescription drugs that either require prior authorization, have quantity limits or are excluded from coverage. This is not an all-inclusive list. It is provided strictly as a guide and may change periodically. With the uncertainty of Part D vs. Part B coverage, most Biological, Biotechnicals and Speciality medications require prior authorizations. Please call VIVA Health Medical Management at 205-933-1201 or 1-800-294-7780 if you have questions regarding a particular drug.**

**Pharmaceuticals**

Flunisolide, Rhinocort Aqua, fluticasone spray (QL)  
 Atrovent, ipratropium soln, Spiriva (QL)  
 Nasacort AQ, Nasonex, Pulmicort, Qvar, Serevent,  
 Symbicort, terbutaline sulfate, Xopenex (QL)  
 Advair, Asmanex, Astelin, Astepro, Azmacort, Flovent HFA,  
 Albuterol, Combivent, Foradil, Maxair, Proair, Proventil,  
 cromolyn soln, Intal (QL)  
 Alinia (QL)  
 Concerta, dextroamphetamine, methylphenidate, Methylin, Metadate CD, Ritalin LA & Strattera  
 Androderm, Androgel, oxandrolone, Testim  
 Avinza, Dilaudid, endocet, fentanyl, hydromorphone, Kadian, methadone, morphine, Opana, oxycodone, Oxycontin, & roxicet (QL)  
 Celebrex  
 Frova, Maxalt, Migranal, Migranal, Relpax, sumatriptan,  
 Zomig (QL)  
 gabapentin, Lyrica & Neurontin (QL)  
  
 itraconazole, terbinafine  
 Nexium, omeprazole, pantoprazole, lansoprazole, Kapidex, Zegrid (QL) \*  
  
 dronabinol, Emend (QL)  
 Provigil  
 Regranex  
 avita, Differin, Retin-A Micro, tretinoin  
 Chantix  
 Lidoderm  
 Revatio  
 zolpidem, Lunesta, zaleplon (QL)\*

**Part D Biological, Biotechnical, & Specialty Drugs\*\***

**\*\*some of these medications can be covered by Part D or Part B, depending on their diagnosis or setting. Please contact VIVA Health Medical Management for more information.**

acetylcysteine	hepatamine	Remicade
albuterol sulfate	Hepatasol	Renamin
Afinitor	Humira	Revatio
Aminess	Increlex	Revlimid
Aminosyn	Infergen	ribapak
Aranesp	intralipid	ribaspHERE
chorionic gonadotropin	ipratropium bromide	ribavirin
Clinimix	Nephramine	Rituxan
clinisol	Neulasta	Saizen
Cimzia	Neupogen	Sandostatin
colistimethate sodium	Norditropin	Somatuline
cromolyn sodium	novamine	Somavert
cyclophosphamide tabs	octreotide acetate	Tev-Tropin
Decavac	ondansetron	Tetanus Toxoid Absorbed tetanus/diphtheria toxoids
diphtheria/tetanus toxoid	Pegasys	Thalomid
dronabinol	Peg-Intron	Tobi
Emend	Premasol	Travasol
Enbrel	Procalamine	Trophamine
Engerix-B	Procrit	Ventavis
Forteo	Prosol	Xenazine
Freamine	Pulmicort	Xolair
Gammagard	Pulmozyme	Xopenex
Gamunex	Rebetol	
granisetron	Recombivax HB	
granisol	Regranex	

(QL) Quantity limits exist for the drug, exception request required.

(QL) \* QL Post limit criteria required if quantity limit is to be exceeded.

**VIVA Medicare Plus RX Part D Drugs Requiring Prior Authorization or Quantity Limit  
Summary List as of January 2010, Continued**  
*(This List Does Not Apply to VIVA Commercial Group Plan Members)*

<b>Exclusions</b>
Anorexiant Drugs/Weight Loss/Gain
Infertility
Cosmetic Drugs
Hair Loss/Growth Drugs
Cough and Cold
Benzodiazepines (Valium, Xanax, etc.)
Barbituates (Seconal, Butisol, etc.)
OTC
All RX vitamins except Prenatal & Fluoride
Combos
Erectile Dysfunction Drugs
<b>Step Therapy</b>
Elidel
Protopic

<b>Common Part B Biological, Biotechnical &amp; Specialty Drugs</b>	
Lipids & AAs for Infusions	Nutropin AQ
Nebulizer Solutions for DME	Humatrope
Hepatitis B Vaccines	Epogen
Lupron (IM)	Genotropin
Synvisc	Gamunex 10%
Zometa	
Avastin, Lucentis	
Eloxatin	
Seasonal Influenza Vaccine	
<b>Immunosuppressants for Medicare Transplants:</b>	
Azasan, azathioprine, Cellcept, cyclosporine, gengraf, Neoral, Prograf, Rapamune, Sandimmune & mycophenolate mofetil	
<b>Oral Anti-cancer Drugs:</b>	
Xeloda, Eulexin, Zoladex, Etoposide, Temodar, Iressa, Cyclophosamide	

**All unclassified drug codes (such as J3490, J3590, J8999 and J9999) require prior authorization. When requesting authorization for an unclassified drug please submit the NDC#, Drug Name, and Dosage.**