Therapy Provider Manual

Version 2020.1

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Overview

Alivi Therapy Network ("ATN" or "Network") is a comprehensive network of Physical, Occupational and Speech Therapists, formed to deliver quality health care services to those members insured through Managed Care health plans. This manual contains useful information regarding general billing guidelines and other related information. These guidelines may be updated from time to time to reflect any changes to the Network.

Definitions

Clean Claim:

A completed claim submitted in accordance to the set guidelines stated within this Provider Manual.

Copayment:

Means the amount required to be paid by Member to Provider as additional payments for Covered Services as are Medically Necessary. Copayments will vary in amount for Members, depending on benefit structure.

Corrected Claim:

A replacement of a previously submitted claim that shows changes including but not limited to corrections to charges, clinical or procedural codes, dates of service, and member information. A corrected claim must be submitted in the event of a rejection of an unclean claim or denial of a claim that was submitted inaccurately.

Unclean Claim:

A submitted incomplete claim that is not in accordance with set guidelines stated within this Provider Manual. Unclean claims are subject to rejection.

Contested Claim:

A claim under review for Utilization Management and/or Medical Necessity.

Utilization Management:

A process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.

Medical Necessity:

A medical service, supply, and/or setting which is required for diagnosis or treatment of sickness or injury that must be:

- Appropriate with regards to standards of good medical practice
- Not solely for convenience of the member
- The least costly of the alternative levels of service or supplies which are sufficient and available
- Not simply because of network provider has prescribed. Ordered, recommended or approved a service, supply, or setting.

Contacts

Alivi Therapy Network

3511 NW 91st Avenue
Miami, FL 33172

General Inquiries

Main Line : (786) 471-5767

Website : www.alivi.com

Email : info@alivi.com

Hours of Operations

Monday thru Friday
9:00 am to 5:00pm

Clearinghouse

Waystar

Payor ID : ATNET

Provider Relations Department

Provider Relations Fax Line : (305) 468-3930

Claims Department

Claims Fax Line : (305) 468-6538

Claims Email : claims@alivi.com

Claims Inquiry: : claimshelp@alivi.com

UM Department

UM Fax Line : (305) 675-2353

UM Portal: : aliviportal.alivi.com

Network Responsibilities

- Network agrees to comply with the protocols and guidelines set by each respective Health Plan.
- Network agrees to act in the best interests of the member, provider, and health plan.
- Network agrees to take appropriate steps to ensure highest level of quality medical care is available and provided to the member.
- Network agrees to ensure proper levels of accessibility to the member.
- Network agrees to take all necessary steps to ensure efficient, accurate, and timely reimbursement of services rendered by its providers.
- Network agrees to closely follow industry accepted reimbursement standards and protocols which include Flat Fee, Medicare and Medicaid Allowable Percentages.
- Network agrees to comply with all State, Federal, and Health Plan protocols and regulations.
- Network agrees to comply with HIPAA and HITECH guidelines to safeguard Protected Health Information.
- Network shall maintain a Provider Relations Department to act as a liaison between Member, Provider, and Health Plan to answer questions or address concerns regarding eligibility, contracting, benefits, and reimbursements.
- Network shall maintain a Claims Department to answer questions or address concerns regarding claim inventory, reimbursements, electronic payments, training, claim transmissions, and appropriateness of payments.
- Network shall maintain a Credentialing Department to assist Providers and Health Plans with certification of credentials, qualifications, practice history, and network adequacy standards. The Network is not delegated Credentialing services at this time.
- Network shall maintain a Compliance Department to comply and abide with State, Federal, and Health Plan protocols and regulations: such as corporate compliance, delegation oversight, HEDIS medical chart reviews, and fraud waste and abuse programs.
- Network shall maintain a Utilization Management Department to answer questions or address concerns regarding medical necessity, medical appropriateness, and post payment reviews.

Provider Responsibilities

- Provider shall be solely responsible to distribute this Provider Manual to its staff and/or billing company.
- Provider agrees to coordinate training and in-service the billing staff/billing company to ensure adherence to Network guidelines.
- Provider shall notify Network of any changes within their practice and/or billing company including but not limited to; additions/updates/terminations of its independent providers and/or practice locations.
- Provider and all associated healthcare providers and facilities must meet all credentialing and re-credentialing requirements as may be established by the health plan and ATN.
- Provider agrees that Network will not be held responsible for any claims which are denied or unpaid because of the office staff and/or billing company's failure to adhere to Network guidelines set forth in this Provider Manual.
- Provider shall verify eligibility, benefits, and financial responsibility of the Member prior to rendering care. Eligibility can be verified by accessing the Health Plan website.
- Provider shall obtain an approval for procedures requiring prior authorization.
- Provider shall submit an electronic clean claim for all services rendered within sixty 60 days of the date of service and shall be accompanied by all required documentation, including Third Party Liability and Coordination of Benefits details, and/or authorizations in accordance with this Provider Manual. Failure to submit all claims data may impact a provider's compensation under their ATN agreement and is grounds for cause termination under the Agreement.
- Provider shall NOT refer the Member to a Non-Network Provider under any circumstance. The Health Plan is solely responsible for all Member related issues.
- Provider shall NOT balance bill any Member for denied services or any other service included in the Member's Health Plan covered benefits as per Federal/State Guidelines.
- Provider shall comply with all applicable State and Federal regulations regarding the confidentiality of patient records. Records should only be released if the appropriate documentation is signed by the patient. Medical records must be legible and signed by the rendering therapist. Stamp signatures are not acceptable.
- Provider agrees that all therapists employed by and/or associated with provider, including covering therapists, must meet all credentialing and re-credentialing requirements as may be established by Health Plan and ATN.
- Provider agrees to notify ATN when employing new therapists so that they may be credentialed. Newly employed therapist may not render services to Health Plan members until they have been fully credentialed.
- Provider agrees that all facility locations associated with provider shall meet credentialing and re-credentialing requirements as may be established by Health Plan and ATN.
- Provider agrees to notify ATN prior to opening a new facility or when relocating an existing facility so that Health Plan and ATN can credential the new location. Providers may not render services to Health Plan members until the location has been fully credentialed.

Prior Authorization Guidelines

Initial Evaluation & Treatment Request

- All therapy procedures including initial evaluation requires prior authorization. Therapist are expected to confirm member eligibility and benefits prior to submitting a prior authorization request.

- For a Prior Authorization request, the following must be submitted via Fax to the UM Department or ATN web portal
  - A clear copy of the signed prescription from the referring physician
  - Completed Prior Authorization Form (attached hereto)
  - Initial Evaluation with the following items clearly documented.
  - Plan of Care
  - Frequency of Services
  - Diagnosis
  - Procedure Codes
  - Member Demographics
  - Reason for Referral
  - Assessment
  - Service Start Date

Reevaluation Request

- For a Prior Authorization request, the following must be submitted via Fax to the UM Department or via the ATN web portal
- A clear copy of the signed prescription from the referring physician
- Completed Prior Authorization Form (attached hereto)
- Reevaluation with the following items clearly documented.
  - Plan of Care
  - Frequency of Services
  - Diagnosis
  - Procedure Codes
  - Member Demographics
  - Reason for Reevaluation
  - Assessment
  - Service Start Date

Authorization Reconsideration Guidelines

- Request for authorization reconsideration must be received within thirty (30) calendar days from the determination date.
- If a Prior Authorization is denied a request for reconsideration may be submitted by doing the following.
  - Authorization Reconsideration Form
  - Copy of Original Request and Supporting Documentation
  - Written Statement from the Provider with Medical Necessity
- The network will provide a response within 30 days from the date of receipt.
- An Expedited request may be submitted If the normal processing time frame jeopardizes the life or health of the member or the member's ability to regain maximum function, an expedited request may be submitted. Additional medical records or other documentation may be requested to justify the request. Decisions on expedited responded will be provided within 72 hours of receipt of the request.

Extension of Authorizations

- Request for authorization extensions will be authorized if the member has missed visits. In these cases, the authorization time period will be extended. No additional until will be provided.
- If further therapy is required after the authorization period has expired, the provider may request another authorization by repeating the submission process.

Claim Submission Guidelines

- All claims must be received within sixty (60) calendar days from the date of service. Adjudication of claims shall be made within the prompt reimbursement guidelines set forth by State and Federal regulations.
- All ATN claims must be submitted electronically through your Clearing house to Payor ID: ATNET. Provider must ensure compliance with Network's 837 Companion Guide prior to submitting claims for reimbursement.
- All claims must be submitted with the rendering or supervising provider NPI number (Type 1), Group NPI Number (Type 2), Location of Service, and the Tax ID number used during contracting.
- Claims requiring corrections, replacements, or voids must be submitted via EDI with the correct claim frequency code and reference the original Claim ID.

Claim Reconsideration Guidelines

- Request for claim reconsideration must be received within sixty (60) calendar days of the date of the original Explanation of Payment (EOP).
- For a claim to be considered for review, the following must be submitted:
  - A completed Claim Reconsideration Form (One form per individual claim).
  - A copy of the corresponding EOP page that clearly identifies the claim that is to be reviewed.
  - A copy of the original CMS1500 Claim.
  - All supporting documentation needed to justify medical necessity.
- All claims submitted for review must be sent to the attention of the Claims Department via Fax or Email.
- Claims submitted after sixty (60) calendar days from date of service will be considered untimely. Claims that have been denied for untimely submission will not be subject to further review.

Contested Claims Guidelines

- The network may request further documentation to establish medical necessity and appropriateness. In such cases, written notification will be sent to the provider.
- Provider must submit additional requested documentation within thirty (30) days of receipt of request or case will be subject to potential denial.
- The network will review all submitted documentation and provide a response with the final determination within sixty (60) days.

Billing Guidelines

Physical Therapy & Occupational Therapy

- All Services will require prior authorization. (See Prior Authorization Guidelines)
- Physical Therapy Services cannot be billed separately from Occupational therapy services for therapies provided to the same patient on the same day.
- One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed.

Speech Therapy

- All Services will require prior authorization. (See Prior Authorization Guidelines)
- Services that are provided by a speech therapist and a physical Therapist or an occupational therapist may overlap. However, speech therapy being provided as part of an occupational plan of care will be considered a duplication of services.

Coordination of Benefits & Third-Party Liability

- The provider is required to notify ATN of any third-party liability, subrogation, or secondary payer information.
- ATN is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. Medicare Advantage Organizations are allowed four provisions in which Medicare is considered a secondary payer.
  - Employer group health plans (EGHP) and large group health plans (LGHP)
  - Liability insurance plans
  - No-fault insurance plans
  - Workers' Compensation plans (WC)

Services not covered by the Network

- Services rendered in an in-patient environment
- Services rendered at a patient's residence
- Therapy or treatment provided to prevent or slow deterioration
- Long-term rehabilitation services when significant improvement is not expected
- Experimental Procedures
- Durable Medical Equipment
- Work Hardening and Functional Capacity Testing
- Cardiac and Pulmonary Rehabilitation

Medicare Advantage Program Requirements

To the extent that any Alivi Client offers Therapy services to Medicare beneficiaries, the Centers for Medicare and Medicaid Services ("CMS") and associated laws, rules and regulations regarding the Medicare Advantage ("MA") Program require that the Client provide for compliance of contracted network providers and their respective employees with certain MA program requirements including, without limitation, inclusion of certain mandatory provisions in MA provider participation agreements and/or associated documents including agreements between Alivi and subcontracted providers, as applicable. A list of some of these requirements can be found in the CMS Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Additionally, revisions to certain applicable regulations can be found in 74 Fed. Reg. 1494 (January 12, 2009) (amending 42 C.F.R. Parts 422 and 423). As such and in addition to the terms and conditions in the Agreement between Alivi and Provider, Provider agrees to the following terms and conditions to the extent applicable to therapy services rendered to Medicare beneficiaries enrolled in MA health benefit plans. Provider will maintain full participation status in the federal Medicare program and shall ensure that any employee, contractor and/or subcontractor of Provider is not excluded from providing services to Medicare beneficiaries under the Medicare program. In the event of a conflict between the contract between Alivi and Provider related to services rendered to Medicare beneficiaries and applicable provisions of this Medicare Advantage Program Provider Requirements Addendum ("Addendum"), this Addendum shall control.

I. Definitions. For purposes of this Addendum the following additional terms shall have the meaning set out below:

1. **"Covered Services"** means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Medicare beneficiary's MA Plan.
   a. Covered Services means the benefits covered under the applicable Medicare Advantage PLAN and for which Alivi and/or PLAN has the obligation to pay, as described and set forth in the applicable Evidence of Coverage, including any endorsements and passengers thereto.
   b. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
      i. serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
      ii. serious impairment to bodily functions; or
      iii. serious dysfunction of any bodily organ or part.
   c. Emergency Services means Covered Services which are either inpatient or outpatient services that are:
      i. furnished by a provider qualified to furnish emergency services; and
      ii. needed to evaluate or stabilize an Emergency Medical Condition.

2. "**Dual Eligible Member**" means a Medicare beneficiary who is also entitled to medical assistance under a state plan under Title XIX ("Medicaid") of the Social Security Act (the "Act").

3. "**First Tier Entity**" means Alivi.

4. "**Health Plan**" means the entity that offers the MA health benefit plans with which Medicare beneficiaries participate.

5. "**MA Plan**" means the one or more MA health benefit plans offered or administered by Health Plan(s) for Medicare beneficiaries and under which Provider renders services to Medicare beneficiaries.

6. "**Medicare Advantage Program or MA Program**" means the federal Medicare managed care program for Medicare Advantage (formerly known as Medicare Choice) products run and administered by CMS, or CMS' successor.

7. "**Medicare Contract**" means Health Plan's contract(s) with CMS to arrange for the provision of health care services to certain persons enrolled in an MA Plan who are eligible for Medicare under Title XVIII of the Social Security Act.

8. "**State**" means the state in which Provider provides the Covered Services.

9. "**State Medicaid Plan**" the State's plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

10. "**Medicare beneficiary**" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with Health Plan.

II. Additional MA Program Obligations and Requirements. Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries.

1. **Audits; Access to and Record Retention.**
Provider shall permit audit, evaluation and inspection directly by Health Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to services provided to Medicare beneficiaries), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from

the end of the calendar year in which expiration or termination of the agreement under which Provider renders services to Medicare beneficiaries occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to:

a. up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault;

b. completion of any audit should that date be later than the time frame(s) indicated above;

c. if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or

d. such greater period of time as provided for by law.

Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare beneficiaries to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities:

a. to provide Health Plan and/or CMS with timely access to records, information and data necessary for:

   i. Health Plan to meet its obligations under its Medicare Contract(s); and/or

   ii. CMS to administer and evaluate the MA program; and

b. to submit all reports and clinical information required by Health Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v)]

2. Privacy and Accuracy of Records.

In accordance with the CMS Managed Care Manual and the regulations cited below, Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or Medicare Contract requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation:

a. HIPAA and the rules and regulations promulgated thereunder;

b. 42 C.F.R. § 422.504(a)(13); and

c. 42 C.F.R. § 422.118; (d) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS.

Provider also agrees to release such information only in accordance with applicable state and/or federal law, including pursuant to valid court orders or subpoenas.

3. Hold Harmless of Medicare Beneficiaries. Provider hereby agrees:

a. that in no event including, but not limited to, non-payment by Health Plan or First Tier Entity, Health

Plan's determination that services were not Medically Necessary, Health Plan's or First Tier Entity's insolvency, or breach of the agreement between Provider and First Tier Entity that is the subject hereof or the agreement between First Tier Entity and Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare beneficiary for amounts that are the legal obligation of Health Plan and/or First Tier Entity; and

b. that Medicare beneficiaries shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision

   i. shall be construed for the benefit of Medicare beneficiaries;

   ii. shall survive the termination of the agreements between Provider and First Tier Entity and First Tier Entity and Health Plan regardless of the cause giving rise to such termination; and

   iii. supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare beneficiaries, or persons acting on behalf of a Medicare beneficiary. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i)]

4. Hold Harmless of Dual Eligible Members.

With respect to those Medicare beneficiaries who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill CMS, Medicare or Medicare beneficiaries the balance of ("balance-bill"), and that such Medicare beneficiaries are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept First Tier Entity's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii).]

5. Accordance with Health Plan's Contractual Obligations.

Provider agrees that any services provided to Medicare beneficiaries shall be consistent with and comply with the requirements of the Medicare Contract. [42 C.F.R. § 422.504(i)(3)(iii).]

6. Prompt Payment of Claims.

First Tier Entity will process and pay or deny claims for Covered Services within the timeframe set forth in the agreement between Provider and First Tier Entity. [42 C.F.R. § 422.520(b).]

7. Delegation of Provider Selection.

As applicable, Provider understands that if selection of providers who render services to Medicare beneficiaries has been delegated to First Tier Entity by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted

arrangements to the extent applicable to Medicare beneficiaries enrolled with Health Plan. [42 C.F.R.§ 422.504(i)(5).]

8. Compliance with Health Plan's Policies and Procedures.

Provider shall comply with all policies and procedures of Health Plan to the extent applicable to the services rendered by Provider. Such policies may include written standards for the following:

a. Timeliness of access to care and member services;

b. Policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and

c. Health Plan's compliance program which encourages effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R.§ 422.112; 42 C.F.R. § 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

9. Delegation (Accountability) Provisions.

Provider agrees that to the extent Health Plan, in Health Plan's sole discretion, elects to delegate any administrative activities or functions to First Tier Entity, the following shall apply:

10. Reporting Responsibilities.

The Health Plan and First Tier Entity will agree in writing to a clear statement of such delegated activities and reporting responsibilities relative thereto. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(i)]

11. Revocation.

In the event CMS or Health Plan determines that First Tier Entity does not satisfactorily perform the delegated activities and any plan of correction, any and all of the delegated activities may be revoked upon notice by the Health Plan to First Tier Entity. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R.§ 422.504(i)(4)(ii)]

12. Monitoring.

Any delegated activities will be monitored by the Health Plan on an ongoing basis and formally reviewed by the Health Plan at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R.§ 422.504(i)(4)(iii)]

13. Credentialing.

The credentials of medical professionals, if any, affiliated with Provider and/or First Tier Entity will either be reviewed by Health Plan or, in the event Health Plan has delegated credentialing to First Tier Entity, First Tier Entity's credentialing process will be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. §

422.504(i)(4)(iv)]

14. No Assignment of Responsibility.

Provider understands that Provider and/or First Tier Entity may not delegate, transfer or assign any of Provider's or First Tier Entity's obligations with respect to Medicare beneficiaries or any delegation agreement between Health Plan and Provider and/or First Tier Entity without Health Plan's prior written consent.

15. Compliance with Laws and Regulations.

Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and with all other applicable state and federal laws, rules and regulations, as may be amended from time to time including, without limitation:

a. laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b) of the Act);

b. applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time;

c. Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules found at 45 C.F.R. parts 160, 162, and 164; and

d. laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, and to the extent applicable, Provider agrees to maintain full participation status in the federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.204(b)(4) and 42 C.F.R. § 422.752(a)(8)]

e. Compliance. Provider shall comply with all policies and procedures of Alivi including, without limitation, written standards for the following:

   i. timeliness of access to care and Member services;

   ii. policies and procedures that allow for individual medical necessity determinations;

   iii. provider consideration of Medicare Advantage Member input into Provider's proposed treatment plan; and

   iv. PLAN's compliance program, which encourages effective communication between Provider and PLAN's' compliance officer and participation by Provider and its Professional Staff in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS

f. Non-Compliance. If performance of a Provider causes non-compliance with state or federal regulatory agencies, Provider shall hold harmless and indemnify Alivi for payment of fines as a result of non-compliance. In addition, Provider agrees to be financially responsible for payment of such

fines and shall make payment to Alivi with thirty (30) days' notice. If Provider fails to make payment within timeframe, Alivi, at its discretion, may deduct any amounts owed from Provider reimbursement or payments owed.

16. Accountability.

Provider hereby acknowledges and agrees that Health Plan oversees the provision of services by Provider to Medicare beneficiaries and that Health Plan shall be accountable under the Medicare Contract for such services regardless of any delegation of administrative activities or functions to Provider or First Tier Entity. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii)]

17. Benefit Continuation.

Upon termination of Provider's status as a participating provider with Health Plan (unless such termination was related to safety or other concerns), Provider will continue to provide health care benefits/services to Medicare beneficiaries in a manner that ensures medically appropriate continuity of care and for the time period required by applicable law. Specifically, for Medicare beneficiaries who are hospitalized on the date of such termination, services will be provided through the applicable Medicare beneficiary's date of discharge. In accordance with the requirements of PLAN's accrediting bodies and applicable laws, rules and regulations, Provider will continue to provide Covered Services to Medicare Advantage Members after the termination of this Agreement, whether by virtue of insolvency or cessation of operations of Alivi, or otherwise:

a. for those Medicare Advantage Members who are confined in or admitted to an inpatient facility on the date of termination, until discharge;

b. for all Medicare Advantage Members, through the date for which payments have been made by CMS under the Medicare Advantage Contract; and

c. for those Medicare Advantage Members undergoing active treatment of chronic or acute medical conditions as of the date of termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required.

The terms and conditions in the Agreement shall apply to such post- termination Covered Services, and Alivi will pay Provider for such post-termination Covered Services the compensation set out in the applicable Compensation Addendum to the Agreement (excluding administrative fees, potential bonus or shared risk arrangements, if any) or Provider billed charges or the applicable CMS Medicare fee schedule, whichever is less. [42 C.F.R. § 422.504(g)(2)]. The parties acknowledge the provisions set for in this paragraph K are not applicable to NET services.

18. Conscience Protection and Medicare Advantage Member Advice.

Nothing in this Agreement will prohibit or otherwise restrict Provider or Provider's Professional Staff, acting within the lawful scope of his, her, or it's field or practice, from advising, or advocating on behalf of a Medicare Advantage Member about:

a. The Medicare Advantage Member's health status, medical care, or treatment options, including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

b. The risk, benefits, and consequences of treatment and no treatment; or

c. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

19. Confidentiality and Accuracy of Medicare Advantage Member Records.

For any medical records or other health and enrollment information maintained with respect to Medicare Advantage Members, Provider shall:

a. Safeguard the privacy of any information that identifies a particular Medicare Advantage Member and generally comply with all obligations under HIPAA. Information from, or copies of, records may be released only to authorized individuals. Provider shall ensure that unauthorized individuals cannot gain access to or alter such records. Medical records must be released only in accordance with federal or state laws, court orders, or subpoenas;

b. Maintain all such records and information in an accurate and timely manner;

c. Allow timely access by Medicare Advantage Members to the records and information that pertain to them; and

d. Abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and Medicare Advantage Member information.

20. Federal Funds.

Because PLAN under its Medicare Advantage Contract receives federal payments, Provider acknowledges and understands that the PLAN is subject to certain laws that are applicable to individuals and entities receiving federal funds, and that payments received from CMS under the Medicare Advantage Contract are, in whole or in part, federal funds.

21. Non-Discrimination.

Neither Provider nor any of Provider's Professional Staff shall discriminate against any Medicare Advantage Member on the basis of race, color, religion, sex, national origin, age, health status, participation in any government program (including Medicare), source of payment, membership in a health maintenance organization, marital status or physical or mental handicap, nor shall Provider knowingly contract with any person or entity which discriminates against any Medicare Advantage Member on any such basis.

22. Incentive Plans. The parties agree:

a. that nothing contained in the Agreement nor any payment made by ALIVI to Provider is a financial incentive or inducement to reduce, limit or withhold services to Medicare Advantage Members; and

b. that any incentive plans between Alivi and Provider and/or between Provider and other providers shall follow applicable state and federal laws, rules and regulations and in accordance with the Medicare Advantage Contract.

Upon request, Provider agrees to disclose to Alivi the terms and conditions of any "physician incentive

plan" as defined by CMS and/or any state or federal law, rule or regulation. Within thirty (30) days or such lesser period of time required for ALIVI to comply with all applicable state or federal laws, Provider shall disclose to Alivi, upon request by Alivi, execution of this Agreement or creation of a relevant incentive Alivi, all of the terms and conditions of any payment arrangement with respect to its staff, employees or contractors that constitutes a "physician incentive", as defined by CMS and/or any other federal law or regulation. Provider agrees to cooperate with Alivi to make certain that any stop-loss coverage required by law in relation to any physician incentive Alivi's offered by Alivi or Provider is made available. Provider agrees that compensation received from Alivi shall be adjusted by the cost of any stop-loss coverage which Alivi may be required by law to provide.

23. Delegation.

In the event PLAN and/or Alivi, elects to delegate any administrative provisions or functions to Provider, Provider acknowledge and agrees that:

a. Provider may not delegate any of Provider's obligations under the Agreement, this Addendum or any other document without Alivi's written consent;

b. Provider must demonstrate Provider's ability to perform such delegated duty to ALIVI's satisfaction;

c. Provider and Alivi must set down in writing

   i. the specific functions delegated;

   ii. the reporting obligations of Provider pursuant to Alivi's policies and procedures or the Medicare Advantage Contract;

   iii. the scope of Alivi's oversight and supervisory functions under the agreement of delegation; and

   iv. any corrective action measures, including the termination or suspension of the delegated functions if Alivi or CMS determines that such delegated activities have not been adequately performed.

Services of any delegates or subcontractors will be subject to monitoring by Alivi on an ongoing basis. Alivi retains the right to approve, suspend or terminate the subcontract or delegation.

24. Other

Provider shall document the existence of an advance directive in a prominent place in all applicable Medicare Advantage Member patient records in compliance with the Patient Self-Determination Act (P.L. 101-508), as amended and to the extent applicable, and other applicable laws. Provider shall provide Covered Services to Medicare Advantage Members in a manner consistent with professionally recognized standards of health care. To assist PLAN in fulfilling its duty to provide written notice of the termination of Provider within fifteen (15) working days to all Medicare Advantage Members who are patients seen on a regular basis by Provider, Provider shall provide to Alivi and/or PLAN a list of such Medicare Advantage Members specific to Provider within fifteen (15) days. Provider shall arrange for the provision of or make available Covered Services to Medicare Advantage Members on a twenty-four (24) hour basis. Provider shall arrange telephone coverage after regular office hours and arrange for appropriate instructions as to how and where to obtain such Covered Services from others in the event Provider is unavailable, in order to assure that the life or safety of a Medicare Advantage Member will

not be jeopardized. Provider acknowledge and agree that Alivi shall oversee the provision of Covered Services to Medicare Advantage Members under the Agreement and shall be accountable and bear ultimate responsibility under the Medicare Advantage Contract for the provision of such Covered Services, regardless of the provisions of the Agreement or the delegation of duties or the delegation of any administrative functions under the Agreement; provided that the foregoing shall no limit or restrict Provider's obligations under the Agreement, including any delegation of duties thereunder. Alivi and/or PLAN shall monitor Provider's performance on an ongoing basis.

Fraud, Waste and Abuse Policy

Federal law requires that entities such as Alivi and its subsidiaries receive at least $5 million in annual payments under a State Medicaid program, establish written policies for its employees, contractors and agents that furnish detailed information regarding the federal and state False Claims Acts, the administrative remedies available under the acts, other protection under the acts, and the Company's procedures for detecting fraud, waste and abuse.

Alivi's policy is to provide detailed information to all employees, contractors and agents about federal and state False Claims Acts and the Company's policies and procedures to detect and prevent fraud, waste and abuse. The information in this policy forms part of its employee manual, its provider manual, and is distributed to all contractors and agents as required by the Deficit Reduction Act of 2005.

Federal False Claims Act

The federal False Claims Act, among other things, applies to the submission of claims by healthcare providers for payment by Medicare, Medicaid and other federal and state healthcare programs. The False Claims Act is the federal government's primary civil remedy for improper or fraudulent claims. It applies to all federal programs, from military procurement contracts to welfare benefits to healthcare benefits.

The False Claims Act prohibits, among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval.
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information.

Enforcement

The United States Attorney General may bring civil actions for violations of the False Claims Act. As with most other civil actions, the government must establish its case by presenting a preponderance of the evidence rather than meeting the higher burden of proof that applies in criminal cases. The False Claims Act allows private individuals to bring "qui tam" actions for violations of the False Claims Act.

Employee Protection

If any employee has knowledge or information that any such activity may have taken place, the employee should notify his or her supervisor or other management official. Providers must have a system in place for reporting potential violations, and such information may be reported anonymously. Federal and state law as well as Alivi policy prohibit any retaliation or retribution against any person who reports suspected violations of these laws to law enforcement officials or who file lawsuits on behalf of the government. Anyone who believes that he or she has been the subject to any such retaliation or retribution should also report this to their supervisor or other appropriate person, as provider by their employer's policy covering such matters.

Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986 ("PFCRA") authorizes federal agencies such as the Department of Health and Human Services to investigate and assess penalties for the submission of false claims to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. For example, a person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim that the person knows or has reason to know:

- is false, fictitious, or fraudulent;
- includes or is supported by any written statement that:
- omits a material fact;
- is false, fictitious, or fraudulent as a result of such omission; and
- include such material fact; or
- is for payment for the provision of property or services which the person has not provided as claimed.

If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further investigate or may refer the matter to the Department of Justice for proceedings under the False Claims Act. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint regarding the false claim. A hearing following the detailed due process procedures set forth in the regulations implementing the PFCRA would be held.

State False Claims Acts

Several states have enacted False Claims Acts that are similar in substance and procedure to the Federal laws described, above. At present, these States include AR, CA, DE, DC, FL, GA, HI, IN, IL, LA, MA, MI, MN, MO, MT, NH, NJ, NM, NY, NV, OK, RI, TN, TX, VA, and WI. In addition, the municipalities of Chicago and New York City have enacted False Claims Acts that are similar in substance and procedure to the Federal laws described above.

Fraud, Waste and Abuse / Company Detection

Alivi has numerous policies and procedures for detecting fraud, waste and abuse. Some of our more important procedures are (1) the gate keeping protocol performed during the reservation process; (2) the detailed verification process for each invoice submitted by providers; (3) recertification of standing orders, (4) sampling patient attendance records with health care facilities; (5) background check requirement for providers; (6) field monitor activities; and (7) requirement of preauthorization and job number. Alivi takes seriously any allegation of fraud, waste or abuse, and appropriately investigates any such allegation. Providers are required to report suspected cases of fraud, waste, abuse or other impropriety. Providers must cooperate in any investigations initiated by Alivi or any government agency, as required by law.

Prior Authorization Request Form

Fax Completed Requests To: (305) 675.2353

Please check type of request	
☐	Routine (Non-urgent services)
☐	Expedited* (Required within 72 hours)
☐	Submission of additional clinical information

*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as standard/non-urgent.

Member Name					
Member ID					
DOB					
Health Plan					
☐	Initial Evaluation	☐	Re-evaluation		
☐	Physical Therapy	☐	Occupational Therapy	☐	Speech Therapy
☐	Chiropractic	☐	Podiatry		

Facility/Provider/Service Information

Referring Provider	
Date	
Phone	
Fax	

Rendering Provider	
Date	
Phone	
Fax	
Contact at Requesting Provider's office	

Diagnosis Code & Description

Diagnosis Code & Description					
CPT/HCPC/J Code & Description*					
Number of visits requested		DOS from	/ /	to	/ /

Please send clinical notes and any supporting documentation copy of insurance card (front and back).

Authorization Reconsideration Request

Please use this form to submit a request for reconsideration of an action we have taken related to an authorization for services. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation (see list of examples on following page) to:

Alivi UM Department
3511 Northwest 91st Avenue
Doral, FL 33172
Phone : 786-300-4331
Fax : 305-675-2353
Business Hours : 8 A.M to 5 P.M, Monday through Friday

You may also fax the completed form and all documentation to: 1-866-387-2968

Reconsideration Request Date		Has the service been provided?	☐ Yes. ☐ No
Is this an Expedited Request? (See next page for definition of Expedited Request)			☐ Yes. ☐ No
Provider Information			
Name		National Provider ID (NPI)	
Address		City	
Phone #	Fax #	Contact Person	
Patient Information			
Name		Date of Birth	Member ID #
Service Information			
Date(s) of Service	Place of Service		
Reason for Denial (from EOB or Notice of Action Letter)			
☐ Medical Necessity	☐ Lack of Information	☐ Untimely Filing	
☐ Exceeds Authorization	☐ Claim not Billed as Authorized	☐ Out of Network	
☐ Benefits Exhausted	☐ Lack of Prior Authorization	☐ Invalid Code	
☐ Not a Covered Benefit	☐ Other		
Reason for Request			

Authorization Reconsideration Request (Cont.)

Important Information

Timeframes

Request for reconsideration of authorizations must be received within thirty (30) calendar days of the date of determination date. Your request will be processed once all necessary documentation is received.

Documentation

Please provide all medical information necessary to support the request for reconsideration. Examples include the following:

- Documentation of procedures, such as:
  - Plan of care
  - Medical records
  - Referring Physician Script
- Physical, Occupational and/or Speech Therapy progress notes, evaluations, summaries
- Radiology reports and/or referring MD script
- Documentation of timely filing, such as billing notes, fax confirmation, or certified and signed mail card

Expedited Request

You may also request that we expedite the request process if you believe that the standard 30-calendar day timeframe could jeopardize the life or health of the member of the member's ability to regain maximum function. Additional medical records or other documentation may be requested to justify the request. If your request is approved, we will complete our review and a decision will be made within 72 hours of receipt of the request and you will immediately be notified of the results.

Claim Reconsideration Request

Please use this form to submit a request for reconsideration of an action we have taken related to a claim for services. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation (see list of examples on following page) to:

Alivi Claims Department
3511 Northwest 91st Avenue
Doral, FL 33172

You may also fax the completed form and all documentation to: 305-468-6538 or ClaimsHelp@Alivi.com

Request Date		Has the service been provided?	☐ Yes. ☐ No

Provider Information		
Name		National Provider ID (NPI)
Address		City
Phone #	Fax #	Contact Person

Patient Information		
Name	Date of Birth	Member ID #

Service Information	
Date(s) of Service	Place of Service

Reason for Denial (from EOP or Notice of Action Letter)		
☐ Medical Necessity	☐ Lack of Information	☐ Untimely Filing
☐ Exceeds Authorization	☐ Claim not Billed as Authorized	☐ Out of Network
☐ Benefits Exhausted	☐ Lack of Prior Authorization	☐ Invalid Code
☐ Not a Covered Benefit	☐ Other	

Reason for Reconsideration

Important Information

Timeframes

Claims submitted for reconsideration must be received within sixty (60) calendar days of the date of the original Explanation of Payment (EOP). Your request will be processed once all necessary documentation is received.

Documentation

Please provide all medical information necessary to support the request. Examples include the following:

- Documentation of procedures, such as:
  - Medical records
- Documentation of timely filing, such as billing notes, fax confirmation, or certified and signed mail card