

Our Quality Commitment, Your Compliance Reference

AVMED'S CARE MANAGEMENT and Healthy Living Programs

Our Care Management and Disease Management/Healthy Living programs are focused on delivering personalized health and wellness strategies that encompass and support our Members' lifestyles, goals, health and wellness needs.

Care Management Programs:

- Complex Care for Members who are experiencing a catastrophic medical or behavioral health/substance abuse event or diagnosis or who have multiple diagnoses requiring coordination and support
- Short-term Care for Members who could benefit from extra support following a health issue
- Transitional Care for Members who are discharged from a hospital and transitioning back home or to a skilled nursing facility
- High-risk Maternity
- Transplant

For more information on how our Care Management programs may be able to assist your patients or to make a referral by phone, please call AvMed's Care Management Department at **1-800-972-8633**.

Referrals can also be submitted to our secure e-mail at **CM@avmed.org**. For referrals via e-mail, please include: Member name, AvMed ID number and reason/diagnosis for the referral; as well as the best phone number to reach the Member.

AvMed's Disease Management/Healthy Living Program:

- Asthma
- CAD – coronary artery disease
- COPD – chronic obstructive pulmonary disease
- Diabetes
- Congestive heart failure

Healthy Living representatives are available to assist with your AvMed Members. Liaisons can provide you with information available to your patient. Just call AvMed's Healthy Living at **800-972-8633**.

CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

AvMed actively adopts and disseminates standards, guidelines, and related documents as a convenient reference for AvMed Network Practitioners. The documents contain the most current information related to clinical practice, and they are an essential resource for all health professionals who care for AvMed Members.

Guidelines are reviewed and if necessary, updated quarterly when new scientific evidence and national standards are published.

Visit AvMed's website to access the following clinical and preventive guidelines and standards and other related documents at **AvMed.org/Providers**:

- Clinical Guidelines
- Behavioral Health Clinical Guidelines
- Pediatric & Adult Preventive Care Recommendations
- Childhood, Adolescent and Adult Immunization Schedules
- Appointment and After-Hours Access Standards for PCPs and Specialists
- Medical Record Standards

For a paper copy of these clinical and preventive health guidelines, standards, recommendations or any other AvMed Physician reference, call the Provider Service Center at **1-800-452-8633** or e-mail your request to **Providers@AvMed.org**.

EVALUATION of New Technology

AvMed keeps pace with changes that provide Practitioners with new developments in technology through our Medical Technology Assessment Committee (MTAC). The technologies presented are comprised of medical and behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies for inclusion in benefit plans. The MTAC includes Board Certified Physicians with varied specialties. A new technology or a new development in technology is presented to the MTAC by unbiased Specialists who are experienced in the technology. Prior technology determinations are also revisited as the scientific evidence and/or the medical literature change. In addition, the MTAC is provided with information for review from appropriate government regulatory bodies, such as the FDA and CMS. Relevant scientific evidence from varied sources and professional organizations such as the American Medical Association and scientific journals, such as PubMed are also used to assist in making a determination on the technology.

The variables used to make a determination for approval include:

- A safe and efficient technology
- An improvement of health outcomes
- Potential benefits outweigh potential negative effects and
- The technology's comparison to those of established alternatives

The coverage guidelines can be found on AvMed's website located under About Us in the tool bar or under provider education in the Provider Portal. At any time, Practitioners may ask for consideration of a new technology. For these requests or any other question regarding medical technologies, please contact AvMed's Provider Service Center at **1-800-452-8633**.

ADVANCE DIRECTIVES

AvMed encourages its contracted Primary Care Physicians to offer and explain advance directives to all AvMed Members 18 years of age or older.

According to the AvMed Medical Record Standards, documentation that the Member has or has not executed an advance directive must be displayed in a prominent part of the Member's medical

record. A sticker may be utilized to indicate the Member's advance directive status.

The Member is not required to have an advance directive completed. In accordance with section 765.110, F.S., the Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive.

MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to:

- Considerate, courteous, and dignified treatment by all Participating Providers without regard to race, religion, gender, national origin, or disability and a reasonable response to a request for services, evaluation and/or referral for specialty care
- Receive information about AvMed, our products and services, our contracted Practitioners and Providers, and Members' rights and responsibilities
- Be informed of the health services covered and available to them or excluded from coverage, including a clear explanation of how to obtain services and applicable charges
- Access quality care, receive preventive health services and know the identity and professional status of individuals providing services to them
- The right to be treated with respect and dignity and a right to privacy
- Participate in making decisions about your healthcare with Practitioners or other Healthcare Professionals
- Participate in a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. To refuse medical treatment, including treatment considered experimental, and to be informed of the medical consequences of this decision
- Have available and reasonable access to service during regular hours and to after-hours and emergency coverage, information on how to obtain out-of-area coverage
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the Plan's Members' rights and responsibilities policies

Members have the responsibility to:

- Choose an AvMed participating Primary Care Physician and establish yourself with this physician*
- Become knowledgeable about your health plan coverage including covered benefits, limitations, exclusions and procedures regarding use of participating providers and referrals
- Take part in improving your health by maximizing healthy habits
- Supply information (to the extent possible) that the organization and its Practitioners and Providers need in order to provide care
- Participate in understanding your health problems and in developing mutually agreed-upon treatment goals, to the degree possible
- Follow any plans and instructions for care that you have agreed to with your Practitioners

- Keep appointments reliably, and promptly notify the Provider when unable to do so
 - Fulfill financial obligations for receiving care, as required by your health plan agreement, in a timely manner
 - Show consideration and respect to Providers and Provider Staff
- * Certain AvMed Plans do not require that you choose a Primary Care Physician. However, AvMed encourages all Members to establish a relationship with a Primary Care Physician, to help coordinate your care.

CONTINUITY & COORDINATION of Medical & Behavioral Health Care

Magellan, our statewide behavioral health care Provider, administers inpatient, outpatient, mental health and substance abuse services for AvMed Members. Care coordination for Behavioral Health or substance abuse treatment can easily be made by fax, telephone or email.

Magellan supports AvMed's CenteredCare approach by facilitating the effective coordination of care for all Members who require integrated care between medical and behavioral Specialists to address complex comorbidities, coexisting/co-occurring disorders, and/or a wide range of social problems that may impact the Members' ability to attain wellness.

You can contact Magellan Case Management at **1-800-741-5044** between 8:30am and 5pm for assistance with screening patients for co-occurring depression and substance abuse. Magellan also offers Case Management support for Members with complex behavioral health problems.

Magellan Case Management Programs assess, plan, implement, coordinate, and evaluate options and services to meet a Member's clinical and medical needs. Activities vary based on the specifics of the Member's needs. Magellan's case managers help create a personalized plan of care for every Member.

Referral to Magellan's Case Management program is strongly recommended for patients you suspect may be suffering from severe and persistent mental illness.

The following methods may be used to refer your patients to Magellan's Case Management programs:

- Phone: **1-800-424-4810**
- Fax: **1-888-656-5712**
- email: medicalcmreferrals@magellanhealth.com

Additional information and resources are available on Magellan's website at **MagellanHealth.com**.

ACCESS TO STAFF and Decision-Making Criteria

AvMed provides access to appropriate staff for Practitioners seeking information about the Utilization Management (UM) process, decision making criteria, and the authorization of care. Staff will identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues. Staff is available by phone Monday-Friday between the hours of 8:30-5:00 pm. Please contact **1-800-452-8633** for assistance. Fax after hours

communications to **1-800-339-3554**. On-call staff is available at **1-888-372-8633** to take calls regarding urgent or emergent authorization requests.

For assistance with information related to AvMed's decision making criteria, please call AvMed's Provider Service Center at **1-800-452-8633, option 3**. You may also access UM criteria on AvMed's web site at Avmed.org. Language assistance services and TTY services are available for Members who need them. Please call AvMed's Member Engagement Department toll-free at the number listed on the Member's AvMed ID card (TTY 711).

AUTHORIZATION PROCESS PROTECTED

by Strict Policies

AvMed has strict policies for Associates involved at all levels of the authorization process. Utilization Management decision-making is based on appropriateness of care and service, as well as Member benefit coverage. AvMed does not reward Physicians or other individuals for issuing denials of coverage or care. AvMed does not provide financial incentives to Utilization Management decision-makers for any type of utilization determinations resulting in barriers to care, service or under-utilization.

AvMed requires all Associates responsible for Utilization Management decisions to sign an AvMed Affirmation Statement Regarding Incentives form. By signing this form, Associates affirm that they do not receive incentives or rewards from any source for any type of utilization determination for AvMed Members.

MEDICAL RECORD

Requirements

In keeping with NCQA, national and state standards, AvMed requires Members' medical records be maintained in a current, detailed and organized manner for effective and confidential patient care and quality review. AvMed has established medical record standards to make communication, coordination and continuity of care easier, and to promote efficient and effective treatment. The standards are available as a reference for all Practitioners on AvMed's website at AvMed.org. Hard copies are available upon request.

AvMed's medical record standards ensure that Network Practitioners comply with standards. Policies and procedures address the following information:

- Confidentiality of medical records
- Medical record documentation standards
- An organized medical record-keeping system and standards for the availability of medical records
- Performance goals to assess the quality of medical record keeping AvMed's established policies and procedures for primary care medical records apply to the following:
- All services provided directly by a Practitioner who provides primary care services
- All ancillary services and diagnostic tests ordered by a Practitioner
- All diagnostic and therapeutic services for which a Member was referred by a Practitioner

Confidentiality of Medical Records

Physicians' offices and practice sites should have established confidentiality policies and procedures for patients' records and the release of records in accordance with HIPAA standards and practices. In general, the following standards and practices apply:

- Notifying patients of their privacy rights and how their information can be used
- Adopting and implementing privacy procedures for the practice
- Ensuring medical records are organized and stored securely granting access to authorized personnel only
- Providing periodic training for staff in Member information confidentiality

Organized medical record-keeping systems for availability of medical records:

- Each medical record must have HIPAA-compliant Member identification
- Medical records must be organized and stored in a secure manner allowing easy, prompt and efficient retrieval and granting access to authorized personnel only. AvMed assesses the quality of medical record keeping with established performance goals.

AvMed has established performance goals to assess the quality of medical record keeping. Documentation standards are assessed from samples of medical records, which may be utilized for HEDIS® studies, Ambulatory Medical Record Reviews (AMRRs) or other audits. Practitioners are scored on the elements noted above.

AvMed has implemented a method to improve medical record-keeping. A Practitioner with identified deficiencies in medical record-keeping will be sent a request for a corrective action plan to improve their medical record-keeping practices. You can ask for tools and aids to assist in the medical record-keeping process. AvMed appreciates your collaboration in our efforts to obtain an excellent NCQA accreditation for our medical record standards.

AvMed conducts an annual audit of Primary Care Physicians' (PCPs) medical records to fulfill federal and state requirements and to identify any areas for improvement.

In 2015, the average score of all medical records audited by AvMed was 98.82 percent, which exceeded the minimum criteria of 90 percent.

Standards on the Ambulatory Medical Record Review (AMRR) are derived from AvMed's policies on Medical Record Documentation Guidelines. These have been established from generally accepted standards required from various regulatory and accreditation agencies such as the National Committee for Quality Assurance (NCQA). To view these standards, visit AvMed.org/Providers.

PHARMACY MANAGEMENT

by Strict Policies

Providers:

AvMed Medicare Formularies are updated by the 1st of each month. Engage, Empower and Commercial Formularies are updated by the 1st of each quarter (Jan, Apr, Jul, Oct). Policies and procedures are updated by the 15th of each month following Pharmacy and Therapeutics (P&T) Committee meetings in March, June, September and December. All documents are located on AvMed's website at AvMed.org.

QUALITY PROGRAM

Operations

AvMed continually reviews, adopts and disseminates updated standards, guidelines and related documents (including Members' Rights & Responsibilities) for use by AvMed's Network Practitioners and Members. All resources contain current information related to clinical practice. They are provided as a convenient tool for all healthcare professionals who care for AvMed Members.

As a Physician or Care Provider, you have the ability to submit a Quality of Care complaint if you believe a mistake was made in the care rendered by another Physician or Care Provider. Please submit your complaint via email to the Provider Service Center at Providers@AvMed.org.

If you would like to participate more directly or would like more information about our Quality Improvement Program, including progress toward our goals, processes and outcomes, you may view or download this information. Visit AvMed.org, click on **Providers**, then **Tools**, **References** and finally, **Quality Improvement Program**.

If you would like a paper copy of our Quality Improvement Program summary or any other documents, email Providers@AvMed.org or call the Provider Service Center at **1-800-452-8633**.

PRIMARY CARE

Practitioner and Specialist

Appointment and After-Hours Accessibility Standards

Contractually, PCPs or a designee must be available to Members 24 hours a day. AvMed surveys Members to determine level of satisfaction with their PCPs including satisfaction with office staff, wait times, appointment accessibility, and more. PCPs may also be assessed annually to ensure their compliance with making appointments for Members within the recommended AvMed guidelines. When appropriate, results are calculated and forwarded to each PCP for review and action.

Initial Appointment

Type of Appointment	Criteria	Appointment Examples
Regular and Routine Care / Physical Exam	<ul style="list-style-type: none"> • Within 1 month (30 calendar days) 	<ul style="list-style-type: none"> • Yearly well female physical exam • Recheck for cholesterol • Stable diabetic follow-up
Behavioral Health	<ul style="list-style-type: none"> • Within 10 business days • Urgent Care within 48 hours • Care for non-life threatening emergency within 6 hours 	<ul style="list-style-type: none"> • Psychiatric Evaluation • Initial Diagnostic Evaluation • Priority / Urgent outpatient appointments received via CM Referral
Urgent	<ul style="list-style-type: none"> • Within 48 hours • Office to office interaction or Physician services intervention may be required 	<ul style="list-style-type: none"> • Broken extremities • Active GI bleed • Nausea / Vomiting • Palpitations

Follow-up Appointment

Type of Appointment	Criteria	Appointment Examples
Initiation of New Symptoms Increase in Active/Disabling Symptoms	<ul style="list-style-type: none"> • Within 2-3 days 	<ul style="list-style-type: none"> • Intractable pain • Progressive weakness
Behavioral Health	<ul style="list-style-type: none"> • Within 10 business days 	<ul style="list-style-type: none"> • Medication Management follow-up • Therapy visit • Psychiatric Testing

Wait Time in Office

The waiting time after arriving for an appointment does not exceed 15 minutes, unless the patient is notified of the delay.

After Hours

After Hours Telephone Access	<ul style="list-style-type: none"> • Be accessible by phone during all published hours of operations and be available to return after hour calls within 6 hours.
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