

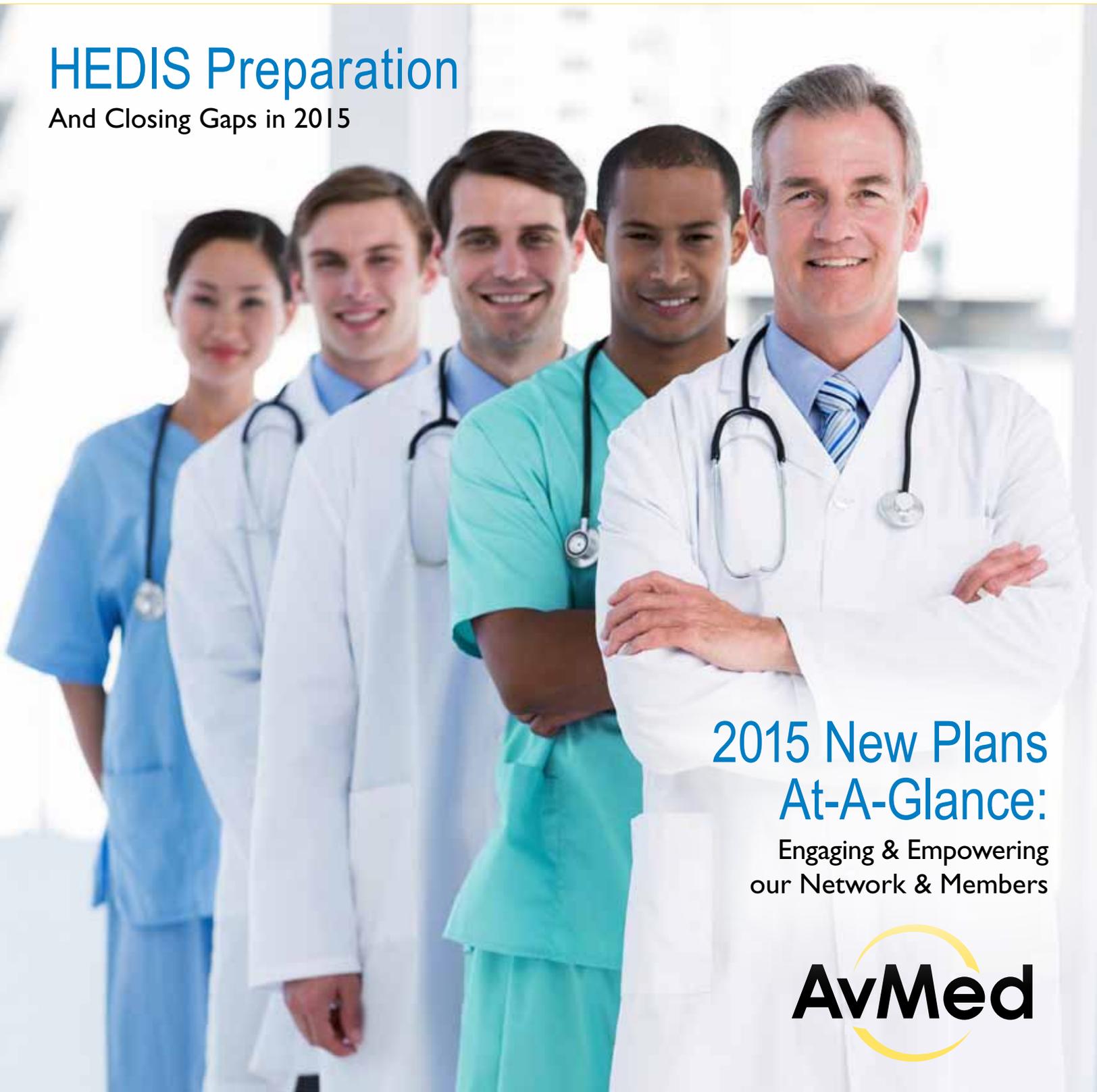
# AvMed Network NEWSBRIEF



A quarterly publication for AvMed Providers

Winter Issue - January 2015

## HEDIS Preparation And Closing Gaps in 2015



## 2015 New Plans At-A-Glance:

Engaging & Empowering  
our Network & Members





## Our Commitment to You

Happy New Year! We are starting the new year “engaging” and “empowering” our Members and provider network alike with new plans designed to offer maximum choice and flexibility. This issue of the Network NewsBrief features an overview of our new plans on page 6.

Also included are two full pages of Administrative Updates (pages 4-5). These pages contain information to assist with the daily operation of your practice. If you have suggestions or details you would like included in Administrative Updates, please forward them to [communications@avmed.org](mailto:communications@avmed.org).

Every year at about the same time, AvMed enlists the help of auditors to assist with collecting information from our physician partners’ offices to help us close out gaps in care prior to our annual NCQA review. Please refer to pages 8 and 9 for articles on preparing for these audits and assisting with closing the gaps.

Don’t miss our new section, Notes from an AvMed Medical Director. We promise you’ll be able to read them!

And in 2015, we will continue to feature our Provider Profile on page 15. In every issue of the Network NewsBrief, we highlight an outstanding provider partner. Look for your name or nominate a colleague you believe deserves recognition in future issues.

As always, should you have any questions, suggestions or concerns, please call AvMed’s Provider Service Center at **1-800-452-8633** or email us at [providers@avmed.org](mailto:providers@avmed.org). We want to hear from you.

Thank you for helping our members live healthier.

Susan Knapp Pinnas  
Senior Vice President  
Provider Strategy & Alliances

## NEWS YOU NEED TO KNOW

For complete details on all the most current news you need to know and to download forms, please visit our website at [www.avmed.org/providers/tools/references](http://www.avmed.org/providers/tools/references).

### Forms, etc.

- Emdeon EFT/ERA Enrollment
- Notice of Medicare Non-Coverage
- Ophthalmology CPT Codes
- Updated Referral Guidelines

All forms can be found online at [www.avmed.org/providers/tools/references](http://www.avmed.org/providers/tools/references).

### Submit New Claims to:

**P.O. Box 569000**  
**Miami, FL 33256**

### Claims Correspondence, Reviews and Appeals to:

**P.O. Box 569004**  
**Miami, FL 33256**  
**Fax: 1-800-452-8633**

**Note:** When returning forms to AvMed, please do not staple them together.

If you have members with specific language needs, please call AvMed Member Service Department at the number listed on the member ID cards.

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## Commercial & Medicare

### FLU ALERT

A new very virulent strain of flu is causing severe and widespread illness. The flu vaccine can help to prevent or lessen severity of symptoms. Early treatment with anti-viral medication is very important in treating severe cases.

Please be sure to evaluate and treat patients reporting flu symptoms as early as possible.

For more information, visit <http://www.cdc.gov/flu/>.



### OH MY ACHING BACK!

Low back pain is the fifth most common reason for all physician visits in the United States. Many patients have self-limited episodes of acute low back pain and many improve rapidly in the first month.

For patients with acute low back pain it is recommended that providers:

- Do not obtain imaging or other diagnostic tests in the first month following the diagnosis unless there is evidence of severe or progressive neurological deficits.
- Provide patients with evidence based information on low back pain such as expected course and self-care options.

#### Helpful Hints for Your Practice

- Provide patients with low back

pain evidence-based information about their expected course, advise patients to remain active, and provide information about effective self-care options.

- Assess severity of baseline pain and functional deficits and discuss potential benefits and risks before initiating therapy.
- Do not routinely obtain imaging or other diagnostic tests in patients with non-specific low back pain.
- Conduct a focused history and physical examination to help place patients with low back pain into one of three broad categories: non-specific low back pain, back pain potentially associated with radiculopathy, or spinal stenosis or back pain potentially associated

with another specific spinal cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain.



## Commercial & Medicare

### ANTIBIOTICS: AVOID THEM WHEN POSSIBLE

Misuse and overuse of antibiotics lead to antibiotic drug resistance. Each year in the United States:

- At least 2 million people become infected with antibiotic resistant bacteria.
- At least 23,000 people die as a result of antibiotic resistant infections.
- Antibiotics are most often inappropriately prescribed for adults with acute bronchitis.
- The vast majority of acute bronchitis cases — more than 90 percent — have a nonbacterial cause.

#### Helpful Hints for Your Practice

- For patients who request a prescription, use the CDC's Viral Rx Pad to prescribe over-the-counter treatment appropriate for acute bronchitis. The Viral Rx Pad is available on the CDC's website.
- Provide patients with information on:
  - The dangers of misusing and overusing antibiotics
  - How antibiotic resistance happens
  - Recommend symptomatic therapy for viral illnesses

For more information, visit our website at [www.avmed.org/hedishighlight](http://www.avmed.org/hedishighlight).



### QUALITY RESOURCES

AvMed is actively involved in the adoption and dissemination of standards, guidelines and related documents (including Members' Rights & Responsibilities) for use by AvMed's network practitioners and members. These documents contain current information related to clinical practice. They are a convenient and important resource 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](mailto: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. Go to [www.avmed.org](http://www.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](mailto:providers@avmed.org) OR call the Provider Service Center at 1-800-452-8633

## 2015 New Plans At-A-Glance

AvMed introduced two new plans for 2015 designed to “engage” and “empower” our Members and provider network alike.

AvMed Engage and Empower are available in South Florida (in Miami-Dade, Broward and Palm Beach counties), Orlando (in Lake-partial, Orange, Osceola, and Seminole counties), Jacksonville (in Baker, Clay, Duval, Nassau and St. Johns counties), Gainesville (in Alachua, Bradford, Columbia, Marion, Suwannee and Union counties) and Tampa (in Hillsborough, Pasco, Pinellas and Polk counties). For plan details, visit [www.avmed.org](http://www.avmed.org) or call the AvMed Provider Service Center at **1-800-452-8633**.

AvMed Engage, an HMO product, provides high-quality healthcare at an affordable price. It positions the Primary Care Physician (PCP) at the center of the member's healthcare universe. Engage Members select a PCP to become an advocate and an advisor as you work together to embrace better health. We've built a special network of highly-respected health systems that have committed to delivering the high-quality healthcare experience our Members deserve.

### AvMed Engage Highlights:

- HMO (closed-network) plans with a high-quality provider network of carefully selected physicians and facilities. Enables the PCP to become our Member's trusted advocate at the center of his/her healthcare experience.
- Members may choose from several plans with varying deductibles and low co-pays.
- PCP selection required, physician-to-physician referrals required later in 2015.
- Features AvMed CenteredCare, which leverages the PCP's unique vantage point to coordinate all aspects of our Members' care. CenteredCare is founded in the strength of the member-physician relationship and its ability to build bridges to an entire care team, hand picked by (and for) the member from within our provider partner network.
- No benefits outside of provider partner network.



**Embrace better health.**

AvMed Empower, a Point-of-Service (POS) product, adds the flexibility and comfort of choice, along with cost incentives for making smart healthcare decisions. Through a tiered benefit design, Empower Members who are willing to pay a little more can access the full AvMed provider network, along with out-of-network options. For Members who prefer cost savings, Empower truly delivers. Empower reserves its lowest benefit cost tier as an incentive for selecting from a special network of highly qualified hospitals and physicians.

### AvMed Empower Highlights:

- POS plans with coverage across the entire AvMed network, as well as out-of-network options.
- Tiered cost structure with lowest cost tier reserved for AvMed's provider partners.
- Plans offer members the comfort of flexibility plus cost incentives to make smart health choices.
- PCP selection encouraged, but NOT required.
- One free PCP visit per calendar year (no out-of-pocket patient cost).

Verify benefits through our Provider Portal ([www.avmed.org](http://www.avmed.org)), our Provider Service Center (**1-800-452-8633**) or verify member participation by checking for “ENGAGE” or “EMPOWER” on the front of the Member ID Card.

Remember, you'll always find the most complete, current listing of participating physician, hospital and ancillary providers in Engage, Empower and other AvMed plans in our online provider directory at [www.avmed.org](http://www.avmed.org).

# 2015 Primary Care Practitioner and Specialist Appointment and After-Hours Accessibility Standards

PCPs may be assessed annually to ensure their compliance with making appointments for Members within the recommended AvMed guidelines. Additionally, contractually, you or a designee must be available to Members 24 hours a day. AvMed surveys Members to determine level of satisfaction with their PCPs. This includes satisfaction with office staff, waiting times, appointment accessibility, etc. 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"> <li>• Within one month (30 calendar days)</li> </ul>	<ul style="list-style-type: none"> <li>• Yearly well female physical exam</li> <li>• Recheck for cholesterol</li> <li>• Stable diabetic follow up</li> </ul>
Urgent	<ul style="list-style-type: none"> <li>• Within 48 hours</li> <li>• Office to office interaction or physician services intervention may be required</li> </ul>	<ul style="list-style-type: none"> <li>• Broken extremities</li> <li>• Active GI bleed</li> <li>• Nausea/vomiting</li> <li>• Palpitations</li> </ul>

## FOLLOW-UP APPOINTMENT

Type of Symptoms	Criteria	Appointment Examples
<ul style="list-style-type: none"> <li>• Initiation of New Symptoms</li> <li>• Increase in Active/Disabling Symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Within 2-3 days</li> </ul>	<ul style="list-style-type: none"> <li>• Intractable pain</li> <li>• Progressive weakness</li> </ul>

## WAIT TIME IN OFFICE

The waiting time after arriving for an appointment does not exceed 30 minutes, unless the patient is notified of the delay.

## AFTER HOURS

After Hours Telephone Access	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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## 2015 HEDIS Preparation

Thank you in advance for your anticipated involvement in the data collection for Healthcare Effectiveness Data and Information Set (HEDIS). This nationally recognized quality improvement initiative designed by the National Committee for Quality Assurance (NCQA) examines medical records samples to measure quality. The program is meant to monitor the performance of managed care organizations and is not a physician review.

**Our HEDIS 2015 medical record review partner, General Dynamics Information Technology (GDIT), is authorized to act on behalf of AvMed to review charts from physicians' offices.** GDIT may contact your office via phone or written correspondence between January and May 2015. Every effort will be made to minimize disruptions in patient care activities.

### TIPS FOR A SMOOTH HEDIS REVIEW:

- Be as flexible as possible when scheduling appointments with reviewers in your office.
- Clarify date/time of appointment, name of reviewer and health plan presented.
- Identify patients and pull their medical charts prior to the reviewer's arrival.
- If you have multiple office locations, arrange for all medical charts to be available at one location.
- Designate an area where reviewer can sit and work, and provide an electrical outlet so the reviewer can plug in their laptop.
- Allow any charts needed for auditing purposes to be photocopied or scanned.
- Mail or fax requested copies of charts in a timely manner as NCQA has aggressive reporting deadlines. GDIT offers multiple options for retrieving or receiving records for providers with EMR (electronic medical records).
- Access your preference when the GDIT reviewer calls to schedule an appointment.

### Remote Access:

- GDIT will provide a member list and you can provide GDIT with remote access to the system with access only to the members specified in the list.

### Secure Flash Drive:

- An on-site reviewer can load medical record data on a secure flash drive.

### OR

- GDIT will send a flash drive and member list. Your office can then load the data onto the flash drive and return to GDIT, postage pre-paid.

### CD:

- GDIT will send a disc and member list. Your office can then load the data onto the flash drive and return to GDIT, postage pre-paid.

### On-Site:

- Abstractor will visit and print records and then scan and destroy paper records.

### FTP:

- You can post the records to GDIT's secure FTP.

AvMed is aware of your concerns regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In particular, you may question whether a specific authorization is required from a patient prior to releasing a copy of the medical record. **For the purposes of a HEDIS review, no specific authorization is required from your patient prior to releasing a copy of the medical record.** Under the HIPAA regulations, the form you obtain from the patient permitting you to bill AvMed is satisfactory. Specifically, HIPAA regulations section 164.506 indicates the routine form you obtain is sufficient for disclosures to carry out health care operations. Section 164.501 defines health care operations to include quality assessment and improvement activities such as HEDIS.

**In addition, participating provider and network agreements, as well as the member's application for coverage with AvMed provide for release of the medical record information to AvMed or its designee for quality improvement efforts at no charge.** Your assistance in the data collection process for HEDIS is extremely important to its success. If you have any questions, please call **1-410-832-8300**. Once again, thank you for your cooperation.

## Close HEDIS Gaps During an Office Visit

HEDIS measures are used to gauge the quality of care health plan members are receiving. The following chart provides specific information on services needed and how you can help close member gaps in care for some measures during any regular office visit. For information on how to address additional HEDIS measures, please refer to the HEDIS Matrix, available on AvMed's provider portal.

In some cases a gap may be closed by submitting medical record documentation indicating a member has already received relevant services within the correct time frame or has a condition that excludes the member from a measure. Any medical record submitted to close a HEDIS Gap in Care should be faxed to AvMed Corporate Quality Improvement at **1-800-331-3843**.

Measure	How to Close Gap	Measure	How to Close Gap
Adult BMI Assessment (ABA)	<p>Document member's weight and BMI at least once every year.</p> <p>Include appropriate diagnosis code on claim for every office visit to indicate weight was measured and BMI was documented: V85.0 – V85.5.</p>	Colorectal Cancer Screening (COL)	<p>Refer members age 50-75 for a colonoscopy. Schedule the member's colonoscopy for them to increase the likelihood the member will have it done.</p> <p>If member refuses colonoscopy, order a fecal occult blood test on an annual basis.</p> <p>If member had a total colectomy or history of colorectal cancer, document so in the medical record and submit record to AvMed upon request.</p>
Breast Cancer Screening (BCS)	<p>Order annual mammography for female members age 40-74. Schedule the member's mammography for them to increase the likelihood the member will have it done.</p> <p>If member had bilateral mastectomy or two unilateral mastectomies, document so in the medical record and submit record to AvMed.</p>	Glaucoma Screening (GSO)	<p>Refer all members age 65 and older to an eye care specialist (optometrist or ophthalmologist) for an eye exam annually. Schedule member's eye exam for them to increase the likelihood the member will have it done.</p>
Cervical Cancer Screening (CCS)	<p>Female members age 21-64 should have a pap test at least once every three years. Members age 30-64 may have a pap test/HPV co-testing every 5 years.</p> <p>Schedule member's pap test for them to increase likelihood the member will have it done.</p> <p>If member had a complete hysterectomy with no residual cervix, document so in the medical record and submit record to AvMed upon request.</p>	Comprehensive Diabetes Care (CDC)	<p>Order at least one LDL-C, HbA1c and urine microalbumin screening annually for diabetic members. Include appropriate CPT codes on claims to indicate member's most recent results and relevant conditions:</p> <ul style="list-style-type: none"> <li>• HbA1c: 3044F - 3046F</li> <li>• LDL-C: 3048F - 3050F</li> <li>• Microalbumin: 3060F, 3061F,</li> <li>• Evidence of nephropathy: 3062F, 3066F</li> <li>• ACE/ARB therapy: 4009F</li> </ul>
Chlamydia Screening in Women (CHL)	<p>Consider routine chlamydia screening using a urine sample for all sexually active female members age 16-24.</p> <p>Screen at least once a year during any visit (sick or well visit).</p> <p>Take the opportunity to counsel and educate all members, including adolescents, on STDs.</p>		<p>Be sure to order a follow-up screening if the most recent LDL-C result is <math>\geq 100</math> mg/dl or the most recent HbA1c is <math>\geq 9\%</math>.</p> <p>Refer members to an eye care specialist (optometrist or ophthalmologist) for a retinal/dilated eye exam annually. Schedule member's eye exam for them to increase likelihood the member will have it done.</p>

\* The rates reported are based on HEDIS 2013 that evaluated data collected during calendar year 2012

## Medical Director and UM Assistance When Can the Medical Director Assist?

### **Utilization Management Adverse Determinations:**

**Medical Directors** are available to speak with a treating practitioner to discuss UM adverse determinations issued by AvMed. Physicians may request a reconsideration of the decision via a Peer-to-Peer appointment or submit additional information within 14 days from the date the denial was issued by calling **1-800-346-0231 extension 40513** or faxing **1-352-337-8555**. **Note:** For Medicare Part D denials, CMS regulations require prescribing providers to file a Member Appeal.

**For Facilities:** If you have received an adverse determination **AND** the member is still in-house, please call the regional UM department to provide additional information for reconsideration. The Statewide UM fax number is **1-904-858-1359**. If the member is discharged, please refer to the Claims Appeal process below.

**Note:** The [Pre-Cert] Medical Director is unable to perform the reconsideration process for contractually excluded (“*Not a Covered Benefit*”) determinations. Please follow the Member Appeal process below or as outlined in the adverse determination letter.

### **Adverse Determinations issued by AvMed’s**

**Delegated Entities:** Please refer to the denial fax cover sheet and/or adverse determination letter for contact information. The Delegate will perform a reconsideration (e.g., “Peer-to-Peer” or accept additional information/clinicals) *within 14 days of the date the denial was issued*. Several of AvMed’s delegated entities (ICORE, NIA) will attempt to contact the requesting physician’s office prior to rendering a decision in order to avoid adverse determinations, reconsiderations, and appeals.

**Note:** NCH does not perform reconsiderations. Requesting providers may submit a new request including additional clinicals not previously submitted or file a Member Appeal.

### **Member Appeal:**

**Standard, non-urgent requests** for appeal of adverse determination made more than 14 days from the date the denial was issued should be submitted in writing by the requesting provider and sent by fax to **1-352-337-8794**.

**URGENT Appeals** (processed by AvMed within 72 hours due to decline in Member’s health): Requesting physician may call AvMed Member Service (refer to the Member’s ID card for specific 800#) or call **1-800-882-8633** for Commercial or **1-800-782-8633** for Medicare Member Service. If the request does not meet AvMed’s Urgent Appeal criteria, you will be notified of Standard Appeal process.

Both the standard and urgent member appeals processes can be found outlined in the adverse determination letter.

### **Claims Appeals (post-service / post-discharge):**

Please submit a formal letter of appeal detailing your dispute including clinical documentation to:

AvMed Claims Service Department  
Appeal Unit, P.O. Box 569004  
Miami, FL 33256

For claims appeal status, call **1-800-452-8633 x2**.

Copies of adverse determination letters may be obtained from AvMed Member Service or by contacting the delegated entity who issued the letter.

### **Authorization Information:**

Providing the clinical documentation required to support medical necessity helps reduce review time and requests for additional information. It also minimizes adverse determinations and the need for appeals. We encourage providers to review coverage guidelines on AvMed’s website to assist with clinical requirements prior to submitting an authorization request.

## A NOTE FROM OUR MEDICAL DIRECTOR: MICHAEL SHEEHAN, M.D.

### Submitting Authorization Requests:

**STANDARD MEDICAL requests:** fax AvMed at **1-800-552-8633** or the delegated entity (when indicated). **Reminder:** Determinations of standard requests submitted to AvMed or our delegates may take up to 14 days to render.

**URGENT MEDICAL requests:** call AvMed's Clinical Coordination Department at **1-800-816-5465** "authorizations" option (you will need your 6 digit provider ID #) or call the delegated entity (when indicated).

**All PHARMACY requests:** fax a completed Medication Exception Request (MER) form to the AvMed Clinical Pharmacy Department at **1-877-535-1391**. The MER form can be located on AvMed's website at **www.avmed.org**. Click on **Providers**, then **Tools**, and finally, **Forms**. Then, select the appropriate MER form (Commercial or Medicare).

**AvMed adopted the Florida Statutes & NCQA definition of Urgent Care:** Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in serious jeopardy to the life or health of the member or the Member's ability to regain maximum function.

**Note:** An Authorization Form submitted with insufficient time to allow 14 days to perform review before Date of Service does not constitute an urgent request.

For AvMed Authorization Status, call the Link Line at **1-800-816-5465**.

For provider assistance, call AvMed's Provider Service Center at **1-800-452-8633** option 3. For Network Contracting & Service issues, please contact the regional AvMed Plan Office for assistance. The Medical Director is not able to assist in these areas.

### Genetic Testing

Genomic medicine offers significant opportunities to improve patient care through the integration of genetic information into healthcare decision-making. New genetic tests are coming to market almost daily, and the field now extends far beyond the traditional diagnosis of Mendelian genetic disorders. Patients and their providers can use genetic information to better understand health risks, choose the most effective therapies, and pursue prevention strategies for common diseases.

These are exciting new tests with lots of promise for our Members. However, they all require prior authorization and should only be used sparingly and in a targeted fashion with clear clinical benefit that changes management of the patient, with some consideration of reasonable cost given disease state.

### General Coverage Guidance

Individuals may be considered for genetic testing when the following conditions are met:

*Technical and clinical validity:* The test must be accurate, sensitive and specific, based on sufficient, quality scientific evidence to support the claims of the test.

*Clinical utility:* Healthcare providers can use the test results to provide significantly better medical care for the individual.

*Reasonable use:* The usefulness of the test is not significantly offset by negative factors, such as expense, clinical risk, or social or ethical challenges.

#### Limits:

- Testing will be considered only for the number of genes or tests necessary to establish status. A tiered approach to testing, with reflex to more detailed testing and/or different genes, will be required when clinically possible.
- All testing requires prior authorization, even if being performed by a participating laboratory.

## Fraud, Waste, Abuse and Compliance Training for Medicare Advantage Providers

AvMed Medicare contracted providers are required to complete Fraud, Waste, and Abuse and Compliance training on an annual basis. Training can be completed through AvMed, another health plan or through CMS directly, but an attestation is required to be submitted to AvMed each year.

To make compliance as easy as possible, AvMed has posted the training and attestation of completion on our website. Simply follow these steps to locate the training modules:

- Go to **www.avmed.org**.
- Select the **Doctors, Hospitals, and Facilities** option on the toolbar at the left side of the home page below the **Providers** section.
- Locate and review the Anti-Fraud and Compliance training presentations.
- Click on the link to attest that you and your staff have completed the training.
- If your practice or organization has already completed training, simply complete the information in the online attestation.
- Each training session takes about 10 – 15 minutes to complete, and a certificate of completion can be generated following completion of the courses.

Providers may also submit a paper attestation covering all providers in the practice or in the same corporation. This is a convenient option for multi-specialty groups and large organizations. It is required that providers keep records of participation as they would for any other staff training. CMS and/or health plans may request additional information to substantiate statements made in attestations.

Remember, providers must attest that they and their staff have complied with this requirement, and have completed required training. Physicians within a group practice,

facilities, and ancillary providers (e.g., hospitals, durable medical equipment suppliers, pharmacists, etc.) as well as the staff within each organization must complete the training.



## New Pharmacy Benefit Manager: **CVS Caremark**

With its current Pharmacy Benefit Manager (PBM) contract up for renewal this year, AvMed decided to explore other partner options in an effort to best manage pricing and deliver an enhanced service experience to its Members. CVS Caremark has been chosen to do just that and, in 2015, it will help AvMed manage all pharmacy claims services and become AvMed's Mail Order Pharmacy vendor. Its designation, however, does not preclude Members from utilizing the services of other participating pharmacies in the AvMed network. AvMed's goal is to solidify a seamless transition so that Members will not experience any disruption in service. Steps have already been taken to notify network pharmacies of the PBM change. Medco Mail prescriptions will transfer to CVS Caremark on January 1. AvMed will continue to process authorization requests.



## Pharmacy Management Policies & Procedures

All AvMed Formularies are updated on our website by the fifth of each month.

Coverage guidelines, prior authorization criteria, policies and procedures are updated on our website by the 15<sup>th</sup> of each month following P&T Committee meetings on March 15, June 15, September 15, and December 15.

## Formulary Update

### Medications Added to the Formulary:

- Adempas (riociguat) for pulmonary hypertension
- Aerospan (flunisolide) for asthma
- Anoro Ellipta (umeclidinium/vilanterol) for COPD
- Aptiom (eslicarbazepine) for partial seizures
- Duavee (conjugated estrogens/bazedoxifene)
- Farxiga (dapagliflozin) for diabetes
- Nexium 24HR 20mg OTC (esomeprazole) for gastroesophageal reflux (GERD)
- Otezla (apremilast) for psoriatic arthritis
- Orenitram (treprostenil) for pulmonary hypertension
- Tanzeum (albiglutide) for diabetes
- Velphoro (sucroferric oxyhydroxide) for hyperphosphatemia
- Zontivity (vorapaxar) for stroke/heart attack prevention
- Zykadia (ceritinib) for non-small cell lung cancer (NSCLC)

### New Generics:

- adapalene (Differin Gel 0.3%) for acne
- azelastine (Astepro) for allergic rhinitis
- budesonide (Rhinocort Aqua) for allergic rhinitis
- diclofenac 1.5% solution (Pennsaid) for osteoarthritis
- hydromorphone ER (Exalgo) for chronic severe pain
- risedronate (Actonel) for osteoporosis
- valsartan (Diovan) for hypertension/heart failure

### Prior Authorization Additions:

- Aptiom
- Orenitram
- Otezla

**See latest formulary list on our website for co-pay levels and other pertinent pharmacy benefit information.**

# HIGH-TECH HEALTH

## SAVE TIME AND MONEY ELECTRONIC CLAIMS SUBMISSION & REAL-TIME ELIGIBILITY VERIFICATION

Submitting claims and eligibility verification requests electronically to AvMed is referred to as Electronic Data Interchange (EDI).

Prevent the hassle of multiple downloads and get data from all EOPs on one easy to view page. **Just log in and click "Download to EDI 835"** to instantly view all data from checks tied to your Provider ID.

When you utilize EDI, there will be no more hanging on the telephone! You will receive real-time instant information.

If your clearinghouse is not listed below, please contact them to prearrange submitting EDI to AvMed.

### Availity LLC\*

**1-800-282-4548** [www.availity.com](http://www.availity.com)

### Capario

**1-800-586-6870** [www.capario.com](http://www.capario.com)

### eHDL

**1-954-331-6500** [www.ehdl.com](http://www.ehdl.com)

### Emdeon

**1-877-363-3666** [www.emdeon.com](http://www.emdeon.com)

### OptumInsight\*

**1-800-341-6141** [www.enshealth.com](http://www.enshealth.com)

### RelayHealth\*

**1-866-735-2963** [www.relayhealth.com](http://www.relayhealth.com)

\* Real time eligibility available on AvMed's website

## ICD-10 UPDATE

On April 1, 2014, President Obama signed a bill postponing the transition to the International Classification of Diseases, 10th Revision (ICD-10) set of diagnostic codes for a year or longer.

Mandatory compliance will not be in effect any sooner than October 1, 2015.

Revised CMS ICD-10 compliance guidelines have not yet been published. AvMed will adhere to all guidelines published by CMS.

Due to the fluidity of the ICD10 implementation, we recommend using the following helpful resources for information and updates on ICD10:

### CMS

[http://www.cms.gov/medicare/coding/icd10/provider resources.html](http://www.cms.gov/medicare/coding/icd10/provider%20resources.html)

### WHO

<http://apps.who.int/classifications/apps/icd/icd10training/>

ICD-10 Inquiries may be sent to [icd10provider@avmed.org](mailto:icd10provider@avmed.org).

## IVR UPDATE

- 1 Call **1-800-816-5465**
- 2 Enter Your Provider Tax ID or NPI #
- 3 24/7 Access to:
  - Authorizations
  - Member Eligibility
  - Claim Status

Providers no longer need their Provider ID and PIN # to log in to AvMed's automated Link Line. Just call and enter your provider Tax ID or NPI# to access instant authorizations, member eligibility, and claim status.

## FEATURED NETWORK PROVIDER:

**Dr. Felix E. Guzman**

AvMed's provider network consists of more than 35,000 individual providers, group practices, hospitals, and facilities throughout the state of Florida. The network consistently earns high ratings among satisfied members and physicians alike. AvMed salutes the dedication of each and every one of our valued network partners.

**Name:**

Felix E. Guzman, M.D.

**Physician Type:**

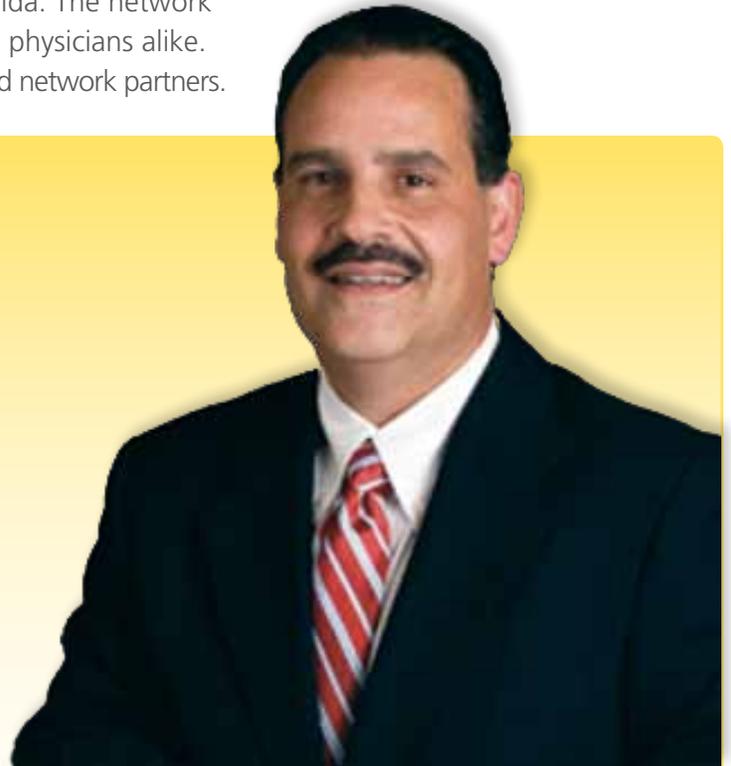
Internal Medicine

**Practice:**12600 SW 120th Street  
Miami, FL**AvMed Provider Since:**

2001

**Panel Size:**

450+ Members



Dr. Felix Guzman, a PCP, practices internal medicine in Miami. Both his patients and AvMed staff rave about the excellent service he and his staff provide.

**Q:** What do you think differentiates AvMed from other health plans?

**A:** AvMed offers a wide selection of specialists and hospitals.

**Q:** What do you currently consider the greatest challenge in medicine or to your area of practice?

**A:** Uncoordinated care among providers and facilities results in high use and expensive hospital services.

**Q:** Tell us something that most patients don't know about you.

**A:** I am a huge Miami Heat fan. Go Heat Nation!



9400 S. Dadeland Blvd.  
Suite 409  
Miami, FL 33156



## We welcome your feedback.

We are committed to having the best provider network available and encourage you to give us your feedback and suggestions. Let us know about your experiences with quality improvement studies, practice guidelines or any other AvMed practice or interaction.

We are always looking for more efficient, effective and above all, quality-driven ways to service our providers, practitioners and members.

If you would like to participate more directly in our Quality Improvement Program or would like information about the program, including progress toward our goals, email us at [providers@avmed.org](mailto:providers@avmed.org) or call the Provider Service Center at **1-800-452-8633**, Monday-Friday, 8:30 a.m. - 5:00 p.m., excluding holidays.

### You may write us at:

AvMed  
Public Relations Department  
9400 S. Dadeland Boulevard  
Miami, FL 33156

## 411

### AVMED'S WEBSITE: [www.avmed.org](http://www.avmed.org)

#### ONLINE PROVIDER SERVICES:

Claims Inquiry, Member Eligibility, Referral Inquiry, Provider Directory, Physician Reference Guide, Clinical Guidelines, Preferred Drug List

Please note our email address:

**providers@avmed.org**

Use our centralized toll-free number to reach several key departments within AvMed.

#### PROVIDER SERVICE CENTER

**1-800-452-8633**

- AvMed Link Line, press one (1)  
Use this option to verify member eligibility and limited benefit information, or confirm and request authorizations
- Claims Service Department, press two (2) Use this option to verify status of claims payment, reviews and appeals.
- Provider Service Center, press three (3)  
Use this option for questions about policies and procedures, to report or

request a change in your panel status, address/phone, covering physicians, hospital privileges, tax ID and licensure, or any other service issue.

- Clinical Pharmacy Management, press four (4)

Your office will still be able to utilize AvMed's:

#### PRE-AUTHORIZATION LINK LINE

**1-800-816-5465**

#### AUDIT SERVICES AND INVESTIGATIONS UNIT

**1-877-286-3889**

(To refer suspect issues, anonymously if preferred)

#### CARE MANAGEMENT

**1-800-972-8633**

#### CLINICAL COORDINATION

**1-888-372-8633**

(For authorizations that originate in the ER or direct admits from the doctor's office)