AvMed Network NEWSBRIEF

Spring Issue
April 2016

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AvMed

A quarterly publication for AvMed Providers and Staff

OUR COMMITMENT TO YOU

Spring is a time of new growth and at AvMed we are growing in leaps and bounds. We have expanded our products, programs, technology, and our Membership as well. In order to keep you up to date and informed of relevant programs and material, AvMed will host a quarterly series of topical Provider webinars. Look for details coming soon when you log on to **AvMed.org**.

In addition to other information, this issue of Network NewsBrief features a number of articles designed to be helpful physician resources: Have questions about AvMed's referral process? See Physician-to-Physician Referral FAQ on page 5. Need a better understanding of HEDIS and how to close gaps in care? See page 6. How can you help prepare your patients for CAHPS? Read the article on page 7.

As always we also provide you with news you need to know, authorization information and 411, a directory of AvMed numbers frequently used by Providers.

Should you have any questions, suggestions or concerns feel free to call AvMed's Provider Service Center at **1-800-452-8633** or email us at **Providers@AvMed.org**. We want to hear from you.

Best wishes for a bountiful season.

Sincerely,

Susan Knapp Pinnas
Senior Vice President
Provider Strategy & Alliances

NEWS YOU NEED TO KNOW

For complete details on all the current news you need to know and to download forms, please visit our website at **AvMed.org**.

UPDATED FORMS & WEB LINKS:

- Visit our redesigned website!
- Referral Exceptions Matrix
- Referral Guidelines

INTEGRATED HOME CARE SERVICES:

New local fax number:
786-655-5055

Toll free remains the same:
1-844-215-4265

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: 1-800-452-3847

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ADMINISTRATIVE UPDATES

PRIORITIZING PRIOR AUTHORIZATION REQUESTS

AvMed's prior authorization process groups requests into four categories: routine, urgent, emergent and stat/expedited/urgent. Each request is processed as quickly as possible within the below listed time frames. In order to meet the quoted turnaround times, however, it is critical that all proper documentation accompany the initial pre-authorization request. Please note, resubmitting a request for approval will not expedite the process, it may slow it down.

An Authorization Request Form can be found online at **AvMed.org/Providers**.

- Please complete the form in its entirety so we have all the information required to provide a timely response.
- Be sure to include clinical history and any previous pertinent treatment and supporting test results.

ROUTINE REQUESTS

Routine requests are for care needed within a 2-4 week time frame. Most referral requests are routine unless the patient needs care in less than 72 hours.

Please submit routine requests via fax to 1-800-552-8633 a minimum of 10-15 days prior to the anticipated date of service.

URGENT REQUESTS

Urgent requests are for medically necessary care ordered to be performed within 72 hours or less, after the Physician has seen and evaluated the Member.

Please call the Clinical Coordination Department at 1-800-816-5465 for same day urgent authorizations.

EMERGENT REQUESTS

Emergent requests are for medically necessary care ordered to be performed within 24 hours or less after the Doctor has seen and evaluated the Member.

Please call 1-800-816-5465 to speak with a Nurse Reviewer.

STAT/Expedited/Urgent requests must be supported by acute symptoms of sufficient severity such that, the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of the patient, including pregnant women or her fetus.
- Serious impairment to bodily functions or serious dysfunction to any organ or body part.

GOVERNMENT MANDATED DEMOGRAPHIC UPDATES

CMS implemented a new policy effective January 1, 2016 requiring health plans to validate the accuracy of participating Provider information listed in all Provider directories on a quarterly basis.

AvMed will be contacting you each quarter to confirm the following information:

- Physical Address
- Phone Number
- Continued Acceptance of new patients

Please help us with the validation process. Simply log on to **AvMed.org** and verify your directory demographic information under **My Profile**, where you can make changes if necessary.

Should you have any questions, contact AvMed's Provider Service Center at **1-800-452-8633**, option 3.

We look forward to working together to keep your information accurate and up to date.

MEDICATION UPDATES

AvMed has realigned our formulary to make medication more accessible to both Medicare and Commercial Plan Members. In addition to re-evaluating in which tier each medication belongs and what copayments apply, we removed high cost brands that have lower cost generic alternatives.

In order to promote easier access, we made certain frequently needed medications are available for 90 day refills, including: statins, COPD medications, diabetes medications and antidepressants.

As of January 1, 2016 CVS Caremark is our specialty drug pharmacy benefit manager, but Members may also drop off and pick up most specialty prescriptions at local retail pharmacies. AvMed will incorporate medication adherence into your Care Opportunity Reports as well so you can begin monitoring your patient's prescription usage.

PHYSICIAN-TO-PHYSICIAN REFERRAL FAQS

Primary Care Physicians (PCPs) play a critical role in the health of our Medicare Members and are in the best position to coordinate their healthcare needs. AvMed's Physician-to-Physician referral program enables Primary Care Physicians (PCPs) to provide referrals for Medicare Members to most specialty care services. The referral system was designed for PCPs to create referrals and Specialists to verify them. A referral does not require AvMed's approval. The program was established to promote better communication and coordination between treating Physicians.

Q: Where can I find information regarding AvMed's referral program?
A: Details regarding Avmed's Physician-to-Physician referral program can be found on AvMed's Provider Portal at **AvMed.org**. Navigate to the **Providers** section and then refer to the **Medicare Referral** tab. Log in is not necessary for access to this information.

Q: Do referrals need to be approved by AvMed?
A: No, if a Primary Care Physician determines a Member needs to see a Specialist, they may create an online referral. AvMed will not deny a referral created or approved by a Participating AvMed PCP in the physician-to-physician referral process.

Q: Can a Specialist view a referral in the system the same day it is entered by a PCP?
A: A referral is available in the system one business day after creation. The PCP, however, can approve a same day referral if coordinated with the Specialist.

Q: How long do I have to input a retro referral?
A: A Specialist may request and a PCP may put in a retro referral for up to 5 days from the date of service.

Q: Will the PCP diagnosis on a referral determine service level and reimbursement?
A: The diagnosis code on a referral is a suggestion from the PCP. Specialist diagnosis and level of service will determine reimbursement.

Q: Can I modify an already created referral?
A: No you cannot modify an already created referral.

Q: What happens if a Member arrives for an appointment and no referral was created in the portal?
A: If you are a Participating Specialty Provider, we ask that you honor 100% of all scheduled appointments. AvMed will allow Specialists to contact the Member's PCP up to five business days after the date of service to request a retro-referral in the system. This will ensure time to secure a referral and avoid claim payment delays.

Q: What if my patient will need extended visits with a Specialist?
A: Each referral is approved for up to nine visits during a 90 day period. If a Member has exhausted the maximum amount of visits and requires more, a new referral can be created to accommodate the need for additional visits.

Q: Do I need to follow the same referral procedure for hospitalizations?
A: The physician-to-physician referral process does not include hospitalizations. Our guidelines for hospitalizations have not changed.

FORMULARY UPDATE

To view the latest formulary list, copay levels and other pertinent pharmacy information visit **AvMed.org**.

HEDIS® & YOU

What is HEDIS?

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of quality metrics used by more than 90 percent of America's health plans to measure performance on important dimensions of care such as:

- Effectiveness of Care
- Access to Care
- Member Satisfaction with the health plan and doctors

HEDIS ALSO:

- Ensures health plans are offering quality preventive care and service to Members
- Allows for a true comparison of the performance of health plans by consumers and employers
- Identifies noncompliant Members to ensure they receive necessary screenings and treatment

HEDIS MEASURES INCLUDE:

- Preventive Care:
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Cervical Cancer Screening
  - Flu Vaccination
  - Pneumonia Vaccination
  - Childhood and Adolescent Immunizations
- Chronic and Acute Care Measures:
  - Comprehensive Diabetes Care (HbA1c, Eye exam, Nephropathy Screening, BP control)
  - Controlling BP for Hypertensive Members
  - DMARD Therapy for Rheumatoid Arthritis
  - Osteoporosis Management in Women with Fractures
  - Pharmacotherapy Management for COPD Exacerbation

VALUE TO YOUR PATIENTS, OUR MEMBERS

- Ensures Members receive optimal preventive and chronic care

VALUE TO YOU, OUR PROVIDERS

HEDIS can help you

- Identify Members with gaps in care and ensure they receive necessary screenings and treatment
- Proactively manage patient care
- Effectively monitor patient health
- Prevent complications
- Identify issues with patient care
- Determine how you compare with other AvMed Providers
- Determine how you compare with the national average
- Save you time
- Potentially reduce healthcare costs

HEDIS RESOURCES AVAILABLE TO PROVIDERS AT AVMED.ORG

- Care Opportunity Report
- A summary of Provider performance on select HEDIS Quality Measures
- Includes HEDIS/Stars measures the Provider is in a position to impact
- Care Opportunity Report consisting of two sections:
  - Provider Summary
  - Member Detail
- Care Opportunity Report Provider Response Form
  - document to submit with missing data elements
- HEDIS Measure Provider Matrix
  - provides tips to improve the capture of required data elements
- HEDIS Encounter Coding Guide
  - includes ICD-10 coding tips
- Quality Stars Measure Reminder

WHAT YOU CAN DO

- Check your individual patients' gaps in care prior to their scheduled appointments
- Encourage your patients to schedule missing screenings and/or comply with necessary treatment listed as a gap in care
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant Members listed on your full Care Opportunity Report
- Submit administrative claims or Supplemental Data to AvMed

Get copies of any of the documents referenced above plus Clinical Guidelines, Screenings and Recommendations, and referral information by logging on to **AvMed.org/Providers** or by calling AvMed's Provider Service Center at **1-800-452-8633**.

CODING & RISK ADJUSTMENT

Risk Adjustment is an important topic for both AvMed and our Providers. Appropriate revenue payments to AvMed allow us to reimburse our Providers for their valuable services. Risk Adjustment provides a mechanism to pay more to those health plans who have on average higher risk Members and less to health plans with lower risk Members. AvMed needs coding and documentation accuracy from our Providers to insure that our Membership's risk is accurately reflected. Medicare Members have been risk adjusted for some time and recently Risk Adjustment has been applied to some Commercial Members as well. There is variation between the Commercial and Medicare risk adjustment models, however, the key for our Providers is to document the health conditions of our Members thoroughly in the medical record and submit claims that are complete and consistent with that documentation.

Hierarchical Condition Categories (HCCs) are the basis for reimbursement for Medicare Advantage plans (Medicare Part C) and Commercial Risk Adjusted plans as well. These models allow the identification of individuals with serious or chronic illness and assign a risk factor score to each Member based upon a combination of the individual's health conditions and demographic details. The individual's health conditions are identified via ICD 10 diagnoses that are submitted by Providers on claims and clinical documentation. CMS uses this data for Medicare advantage to prospectively estimate predicted costs for enrolled Members during the next year of coverage; while Commercial Members are risk adjusted using data from the same calendar year via the HHS-HCC model. HCCs must be recertified annually for CMS to reimburse the plan and ideally every six months.

Accurate Risk Adjustment is critical to the success of Risk Adjusted products and Providers play a vital role in this process. Beyond receiving appropriate revenue for our Members, which is critical, proper risk adjustment and stratification of your AvMed Members ensure those with higher complexity (i.e., one or more co-morbid or co-morbid conditions) are identified and placed on the appropriate Care Management, Disease Management, and Quality Improvement tracks, which will lead to better clinical outcomes for your Patients and our Members. ■

PREPARING FOR CAHPS

Each year CMS conducts the Consumer Assessment of Health Plan Survey (CAHPS) of Medicare Members to assess the Member's experiences with health plans, Providers and their ability to maintain and/or improve the Members' physical and mental health.

The CAHPS survey focuses on how patients perceive key aspects of their care to assess patient experience. The survey asks patients questions such as how often they experienced critical aspects of healthcare, including communication with their doctors, understanding medication instruction and coordination of care with other Providers or services. It also asks questions about Provider accessibility, such as whether the patient was able to receive the care needed as soon as they thought they needed it, whether they were offered timely appointments (as soon as they thought they needed them) at their doctor's office and whether they saw "the person they came to see" [at the doctor's office] within 15 minutes of the appointment time.

CAHPS survey scores affect STARS ratings and ultimately all of our bottom lines. We strive to do everything possible to help reinforce the Member's perception of the Provider/patient experience. Accordingly we recommend the following for Primary Care Practices:

- Make every effort to be flexible in scheduling urgent and non-urgent appointments.
- See patients promptly based on the scheduled appointment time.
- Do not double book/over book appointment slots.
- Have a process in place to address the instances where the Member is not seen in 15 minutes- Communication is Key!
- Ask your patients about their visit with your office. Assure them how important their experience is to you, and that you are constantly working to provide the best service possible.
- Offer an alternative Participating Provider in the practice if the requested Physician does not have appointment availability that is convenient for the Member. ■

AvMed
9400 S. Dadeland Blvd.
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** or call the Provider Service Center at **1-800-452-8633**, Monday-Friday, 8:30 am-5 pm, excluding holidays.

You may write us at:
AvMed
Public Relations Department
9400 S. Dadeland Boulevard
Miami, FL 33156

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AVMED'S WEBSITE: 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 at 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).

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)

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