

AvMed Health Plans' Processes for Utilization Management, Authorization, and Referrals for Healthcare Services

In accordance with Section 641.54(3), (4) and (5), Florida Statutes, and Title 42, Part 422.111(c)(2), Code of Federal Regulations, following are the descriptions of AvMed's processes for health care services authorization and referral, and for making determinations regarding "medically necessary"

Health Care Services Determinations and Utilization

Decisions regarding health care services utilization, authorizations, and medical necessity are conducted under the scope of AvMed's Utilization Management (UM) Program. The goal of AvMed's UM Program is to direct and monitor the delivery of health care services in the most appropriate setting and to ensure that AvMed's members receive high quality care.

The AvMed UM Program has several components, which include prior authorization, concurrent review, discharge planning, care management, disease management, and quality improvement. Through these processes, AvMed's UM Program coordinates with physicians and health care entities to provide the medically necessary services and treatments for AvMed members.

AvMed Health Plans' Medical Department uses nationally recognized guidelines and resources to guide clinical determinations. Reviews for medical determinations, including requests for referrals, continuation of services, facility admissions, continued stay reviews, and discharge planning are evaluated using criteria and/or guidelines based on *reasonable medical evidence*. Reviews consider the individual Member's benefits, the participating status of the provider, the location of the service, and review of criteria related to the specific service requested. Evidence based criteria are applied when a medical necessity determination is required.

A panel of Board Certified Physicians, ranging from Cardiology to Obstetrics, reviews atypical requests. Certain utilization review and care management functions are delegated to integrated delivery systems, independent practice associations or other provider groups. Delegated Providers utilize criteria consistent with AvMed's standards and guidelines.

Only an AvMed Medical Director may make medical necessity or clinical appropriateness determinations that result in a denial. Other designated healthcare staff may make benefit coverage determinations.

The Authorization Process

AvMed's authorization process is designed to achieve and sustain high quality, coordinated, efficient and cost-effective care for AvMed Members. The process also allows AvMed to identify and enroll Members in pre-planned discharge planning, and specialized programs such as Disease and Case Management. When requests are submitted for authorization, requesting providers and AvMed's Members can expect AvMed's Benefit Coordination Team to provide consistent application of internal procedures and guidelines, nationally recognized criteria and administration of benefit coverage guidelines.

Primary Care Physicians and Specialists are encouraged to utilize AvMed's Link Line and Web authorization module tools to obtain select automated authorizations and to check Member benefits and eligibility. If AvMed's automated tools cannot process the requested service, AvMed accepts fax and telephonic requests for authorization.

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Services Requiring Authorization

If provided by in-network physicians, the services listed below require authorization by AvMed and may be requested telephonically, if emergent, or by using AvMed's automated authorization tools for select services.

- Inpatient Hospitalization (Acute, Observation, Skilled Nursing, Mental Health and Rehabilitation admissions)+
- Outpatient Complex Radiological Procedures (CT, MRI, MRA, PET Scans, and CT-Angiography)*+
- Outpatient Surgical Procedures, including Cardiac Catheterizations and PTCA procedures*+
- Outpatient Drug Infusions/Injections*+
- In-Office Drug Administration*+
- Home Health Care*+
- Dialysis Care+
- Transplant Care+
- Non-Participating Provider Services+
- Certain In-Office Drug Administration:
 - Procrit, Epogen, Neulasta, Aranesep, IVIG delivered by infusion, Remicade, Alefacept, and Synagis+

- * These services are exempt from the authorization requirements for the Choice Product and when POS Members utilize their out-of-network benefits.
- + These services are exempt from the authorization requirements when PPO Members utilize their out-of-network benefits.

Services Not Requiring Authorization

Most Products offerings recognize the Primary Care Physician as the "Care Coordinator". All *simple* referrals/consultations to an in-network Specialist must be arranged through the Member's Primary Care Physician.

For all AvMed Products, simple referrals/consultations to participating specialists do not require a formal *authorization* from AvMed; however, a professional referral from the Primary Care Physician to the Specialist is *required* and supports the expectation that the PCP will continue to play an integral role with our Members by coordinating their medical care with specialists and other healthcare providers.

Members are afforded direct access for the following:

- Annual GYN visit
- Medically necessary follow-up care detected at the annual GYN visit
- Visits to participating podiatrists (does not include routine foot care)
- Visits to participating dermatologists - up to 5 visits per calendar year
- Visits to participating chiropractors (for acute symptoms)
- Routine eye exams for dependents through age 17, Medicare Members and for Members with supplemental benefits
- Emergency care**

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**If a Member needs to be admitted to an inpatient facility on an emergency/urgent basis, either from the physician's office or an emergency room, call AvMed's 24-hour emergency line at (888) ER-AVMED (1-888-372-8633).

Access to UM Staff

UM staff are available via telephone for Members and Providers seeking information about the UM Process and the authorization of care. There is designated staff available at the local plan to receive communication during normal business hours.

AvMed Health Plans' Processes for reviewing Requests for Experimental or Investigational Medical Treatments

Experimental and/or investigational procedures are excluded from coverage. A drug, treatment, device, surgery, or procedure may be determined to be experimental and/or investigational if any of the following applies:

- the Food and Drug Administration (FDA) has not granted the approval for general use; or
- there are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- there is no consensus among practicing physicians that the drug, treatment, therapy, procedure, or device is not the standard treatment, therapy, procedure, or device utilized by practicing physicians in treating other patients with the same or similar condition; or
- such drug, treatment, procedure, or device is the subject of an ongoing Phase I or Phase II clinical investigation or experimental or research or of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

AvMed Health Plans' professional healthcare staff utilizes standardized, nationally accepted written clinical criteria and/or guidelines in its Utilization Management Program when making decisions regarding requested healthcare services;

Cases that do not meet currently established treatment status and may be considered as experimental and/or investigational are reviewed on a case-by-case basis by AvMed Health Plans' professional staff;

AvMed Health Plans' Process for Determining Medical Necessity

“Medically necessary” as defined by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Explanation of Coverage:

“Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of a Member/patient or his/her doctor”; and

in AvMed’s Commercial Group Medical and Hospital Services Contract:

“the use of any appropriate medical treatment, service, equipment, and/or supply as provided by a Hospital, skilled nursing facility, Physician, or other provider which is necessary for the diagnosis, care, and/or treatment of a Member’s illness or injury, and which is:

- Consistent with the symptom, diagnosis, and treatment of the Member’s condition;
- The most appropriate level of supply and/or service for the diagnosis and treatment of the Member’s condition;
- In accordance with standards of acceptable community practice;
- Not primarily intended for the personal comfort or convenience of the Member, the Member’s family, the Physician, or other health care provider;
- Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Member’s condition;
- Prescribed, directed, authorized, and/or rendered by a participating or authorized provider, except in the case of an emergency; and
- Not experimental or investigational

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