PHYSICIAN AND FACILITY REFERENCE GUIDE

AvMed

PHYSICIAN'S REFERENCE GUIDE CONTENTS

CHAPTER 1 CONTENTS
PHYSICIAN RESPONSIBILITIES

This section covers Physician responsibilities you need to know when treating AvMed Members.

AVMED'S ETHICAL BUSINESS CONDUCT CODE

Purpose

It is AvMed's policy that all Directors, Officers and Employees conduct business affairs and relationships with honesty, integrity and high ethical standards. AvMed's Board of Directors has adopted this Ethical Business Conduct Code in an effort to provide uniform standards of appropriate conduct for all Employees and Associates.

Introduction

AvMed's ability to function as a respected member of the business community rests solely on the trust and confidence that our Members, Clients, Providers, Regulators and other Customers have in our organization. That confidence is earned, on a daily basis, when we conduct business with integrity and have a culture that encourages the highest ethical standards. AvMed has established and adopted the following professional standards as a component of its Corporate Compliance Program to reflect the requirements of federal, state and local laws and regulations. These standards, as outlined in this document, are officially known as AvMed's Ethical Business Conduct Code ("Code"). The Board of Directors has designated the Compliance Officer as the individual within the organization responsible for overall implementation and operation of the Corporate Compliance Program.

All Employees of AvMed, as well as its Agents and Vendors, are required to adhere to the standards set forth in the Code. All Employees are responsible for ensuring their behavior and activities are consistent with the Code. AvMed has prepared the Code to help Employees understand what is expected of them in the workplace and as representatives of the organization. These standards apply to everyone, at every level of the organization. Employees are asked to confirm, in writing, receipt of the Code and an understanding of its content. In addition, there are a number of more detailed and specific procedures covering particular departments or compliance subjects published in Policies and Procedures manuals of SFHC and its Affiliates. Those specific procedures shall be communicated to personnel who are particularly affected by them and who must comply with them in the normal course of business. If you have any questions about the Code, please contact the Chief Compliance Officer or his or her designee.

STANDARDS OF CONDUCT

Legal Compliance

AvMed will strive to ensure that all activity by or on behalf of the organization is in compliance with applicable federal, state and local laws and regulations. The following standards are intended to provide guidance to Covered Persons that shall assist them in their obligation to comply with these laws and regulations. These standards are neither exclusive nor complete.

1. AvMed is diligent in its efforts to provide frequent and comprehensive updates to Covered Persons addressing recent legislative or regulatory changes that may impact the operations of SFHC and its Affiliates. Covered Persons are expected to stay abreast of any changes that may impact their departmental operations and to make adjustments as necessary to be in compliance with new or revised legislation.
2. AvMed expects its employees, Agents and Vendors to refrain from any conduct that may violate state and federal fraud, waste and abuse laws. These laws prohibit, at a minimum:
    a. Direct, indirect or disguised payments in exchange for the referral of patients.
    b. The submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than that actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and
    c. Making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

3. All employees and associates are required to comply with all applicable laws and regulations, whether or not they have been specifically addressed by a written policy in this or any other policy manual. SFHC and its Affiliates shall vigorously enforce compliance and shall take corrective action, including termination and legal action as appropriate.

4. Avmed will ensure that its reporting to external agencies, associations, and the public is timely, accurate, honest, and reasonably complete.

Antitrust

While AvMed Employees are encouraged to actively participate in local, state and national organizations, and forums to advocate for efficient and effective healthcare for all citizens, it is the policy of AvMed to conduct all of its activities in full compliance with federal and state antitrust laws. Accordingly, in the course of outside meetings and other industry activities, it is important that AvMed Employees refrain from agreeing to, or even discussing, or exchanging information regarding any competitively sensitive matter with any person who is a representative, employee, officer or director of any competitor. Such competitively sensitive matters include, but are not limited to:

1. Prices or premiums charged for managed care or insurance products or for hospice, healthcare, or senior living services
2. Any increase, decrease or discount in prices for managed care or insurance products or for hospice, healthcare, or senior living services
3. What constitutes a fair price
4. Allocation of customers, enrollees, sales territories, sales of any product or contracts with Providers
5. Refusal to deal with any customer, provider or payor or class or group of coustomers, providers, or payors
6. What products or services will be offered to enrollees
7. Other competitively sensitive information, such as information about market share, profits, margins, costs, reimbursement levels or methodologies for reimbursing Providers, or terms of coverage

These same standards of conduct are to be observed at all informal or social discussions at the sites of any public or private meetings or gatherings.

Confidentiality

AvMed and its Employees are in possession of and have access to a wealth of confidential, sensitive and proprietary information. The inappropriate release of such information could be detrimental to AvMed, as well as its Members, Clients, Providers and/or Vendors. Every AvMed Employee has an obligation to actively protect and safeguard confidential, sensitive and proprietary information in a manner designed to prevent its unauthorized disclosure.

1. AvMed Employees have an obligation to maintain the confidentiality of Member information in accordance with all applicable laws and regulations, including, but not limited to, the HIPAA privacy and security standards. Employees are reminded that information requiring protection exists in many formats, such as paper, electronic, audio and video. All copies, formats and versions of Member information must be maintained in accordance with applicable laws and AvMed policies and procedures. AvMed assigns Employee access to confidential information through a role-based security approach to ensure that only those staff whose jobs require it and who have a legitimate need to know, have the ability to access confidential Member data. Employees must not share passwords or other system access rights with any other Employee(s) or person(s). Employees are instructed to always make sure that any access or use of confidential data is carried out using only the minimum amount necessary. Additionally, Employees shall refrain from revealing any personal or confidential information unless supported by legitimate business or Member care purposes. If the disclosure of information is so supported, Employees shall use or disclose on a need-to-know basis, only the minimum amount necessary to accomplish the task. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriate release of information, Employees should seek assistance from a supervisor, the Compliance Department or other appropriate staff within the AvMed Legal Department.

2. Information, ideas and intellectual property assets of AvMed are important to its success. Information pertaining to competitive position, business strategy, payment and reimbursement information, and information relating to negotiations with third parties or other Employees should be protected and shared only with those individuals having a need to know in order to perform their job responsibilities.
3. Salary, benefit and other personal information relating to Employees shall be treated as confidential. Personnel files, payroll information, disciplinary matters and similar information shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.
4. Employees will exercise due care to prevent the unauthorized release or sharing of information.

Conflict of Interest

"Conflicts of interest" may arise when personal or financial relationships or interests interfere, or have the potential to interfere, with professional roles, responsibilities or judgment. A conflict of interest occurs when there is a divergence between an individual's private interests and his or her professional obligations to AvMed, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. A conflict of interest depends on the situation, and not on the character or actions of the individual. Directors, Officers and Employees owe a duty of loyalty to AvMed; and therefore, all individuals are expected to regulate their activities so as to avoid actual impropriety or the appearance thereof, which might arise from the influence of those activities on business decisions made on behalf of AvMed.

The following situations, while not inclusive, might create a conflict of interest:

- Ownership in or employment by any outside organization that does business with AvMed
- Conduct of any business not on behalf of AvMed with any Vendor, Supplier, Contractor or Agency
- Representation of AvMed by any of the above individuals in any transaction in which he or she has a substantial personal interest
- Disclosure or use of confidential, special or inside information of or about AvMed particularly for personal profit or advantage
- Competition with AvMed, directly or indirectly, in the purchase, sale or ownership of property or property rights and interests
- The receipt of any gifts, gratuities, or the acceptance of entertainment or travel benefits from any company with which AvMed has or is considering business dealings

In order to better ensure that AvMed staff do not engage in or appear to be at risk for conflicts of interest, the points below should be followed at all times.

- Personal gifts from Vendors, Suppliers, Contractors, Agencies or industry Representatives may not be accepted by any AvMed Employee.
- Compensation and/or travel expense coverage or reimbursement may not be accepted for simply attending or participating in an industry meeting, activity or conference. Special guidance: If the Employee is an active part (presenter, coordinator, organizer, etc.) of a conference or industry meeting and the sponsoring organization is expected to offer reimbursement for time or expenses, instruct sponsoring organization to submit any payments directly to AvMed. Checks should be made out to "AvMed." AvMed will then issue any reimbursements due to the Employee.

Additionally, AvMed Directors, Officers or Employees may not perform work or render services for any competitor of AvMed or for any organization with which AvMed does business, outside of the normal course of his or her employment, without prior approval from their department Director and/or the Director of the Human Resources Department. Please contact the Human Resources Department or a Member of the Compliance Department for further guidance on this requirement.

The preferred method for dealing with conflict, both real and perceived, is disclosure. Employees are required to complete a Conflict of Interest Certification to disclose any situation or relationship that might constitute a conflict of interest. The Compliance Officer or a Designated Member of the Legal Department staff will review all disclosures, and will submit them to the Chief Executive Officer and/or the Audit Committee as necessary.

Political Activities

As an organization, political activities must be conducted in accordance with applicable laws. Accordingly, Employees, Officers and Members of the Board should not use company assets to engage in political activities without prior review and approval from the Legal or Compliance Department.

AvMed is a Section 501(c)(4) social welfare organization, and may engage in some political activities, so long as that is not its primary activity. Notwithstanding AvMed's ability to engage in political activities, AvMed funds may not be used to make any political contribution related to a federal election (whether to a candidate, political party or political action committee) since it is against the law. AvMed is permitted by law to use its funds to support the administration of the America's Health Insurance Plans Political Action Committee (AHIP PAC). Any use of AvMed funds for the AHIP PAC or any state or local political activity must be processed through the Legal Department.

Personal political activity is totally voluntary, and you should make contributions to candidates or campaigns only if you freely choose to do so. You should not bundle contributions; violate any provision of federal, state or local campaign finance laws; or otherwise suggest that AvMed endorses your political activity.

Government Contracts

Remember that the government is a unique customer. While we always conduct our business with the highest degree of integrity and honesty, there are unique rules applicable to government contractors.

When we act as a government contractor, we have a special obligation to the government (along with the public at large) to ensure that we perform with the highest degree of integrity. Accordingly, we must all be committed to compliance not only to the letter, but also the spirit of the laws and regulations that apply to our government contracting business.

Although all of the standards discussed in the Code are applicable whether the customer is the government or a private entity, particular statutes and regulations apply to government business dealings. For example, under Title 18 of the United States Code, it is a crime to knowingly make a false statement or claim for payment to the government. If you submit falsified data to the government, you have committed a crime. This is true even if you are not doing so in an attempt to obtain payment. Both you and the company could be subject to large penalties, fines and criminal prosecution for your violation. In addition, both you, as an individual, and our company, as an organization, could be prohibited, through suspension and debarment or exclusion, from working on government projects in the future.

Relationships With Elected Officials

Special restrictions may apply to recruiting former government personnel and the activities of former government employees retained as Employees or Consultants. Approval must be obtained from the Legal or Compliance Department before even mentioning possible employment to a current government employee and before retaining any former government employee. Specific procedures dealing with such relationships have been approved by the SantaFe HealthCare Board of Directors and are applicable to all SantaFe Affiliates and Employees.

Equal Employment Opportunities/Commitment Against Sexual Harassment/Workplace Safety

At AvMed, we value diversity in our workforce. We are committed to providing equal opportunities to applicants and employees. We seek to develop and maintain a highly qualified, culturally diverse workforce that is able to meet the cultural and linguistic needs of our diverse Members, Clients and Customers. AvMed complies with legal requirements to and are committed to fairness and equitable treatment of all Employees, including but not limited to the following:

1. Ensuring decisions regarding employees Selection and placement of any Employee is based on that Employee's qualifications, without regard to race, color, religion, national origin, gender, age, citizenship status, disability, sexual orientation, or status as a disabled or non-disabled veteran or any other category protected by law.
2. Establishing compensation based on the employee's contribution and performance to AvMed, and independent of considerations related to any protected category creating a safe and healthy work environment for all employees.

Protection of Assets

All Employees shall strive to preserve and protect all assets of AvMed through prudent and effective use of its resources and assets.

1. All Employees are expected to refrain from utilizing company assets for personal gain or enjoyment. Employees are prohibited from the unauthorized use or removal of AvMed's equipment, supplies, materials or services. Employees must obtain the approval of the department supervisor or management prior to engaging in any activity on company time that will result in compensation to the Employee or the use of AvMed's equipment, supplies, materials or services for personal or nonwork-related purposes.
2. Employees are required to comply with all internal control standards to ensure the appropriate use and protection of assets. All financial records and reports, accounting records, research reports, expense accounts, time sheets and other documentation must accurately and clearly represent the relevant facts of a transaction.

REPORTING VIOLATIONS

Illegal acts or improper conduct may subject AvMed to severe civil or criminal penalties, including large fines or sanctions and being barred from certain types of business. It is, therefore, very important that any illegal or unethical activity or violation of the Code be reported promptly.

1. Any AvMed Director, Officer or Employee who believes a violation of the Code or any other illegal activity has occurred, shall promptly report the violation in person, by phone or in writing to one of the following:
   a. The Compliance Officer or another Member of the Compliance staff
   b. The Internal Auditor
   c. The appropriate department head, supervisor or manager
2. It is a violation of the Code not to report a violation or other illegal/unethical activity. If an Employee has questions about particular acts or conduct, one of the individuals listed above may be contacted for guidance.
3. It is AvMed's policy to promptly and thoroughly investigate all reports of illegal/unethical activity or violations of the Code. AvMed personnel are required to cooperate with investigations. It is a violation of the Code for any Employee to prevent, hinder or delay discovery or full investigation of this nature.
4. AvMed personnel may report such activity or a violation anonymously. AvMed will take reasonable precautions to maintain the confidentiality of individuals who report such activity and of those involved in the alleged improper activity.

5. No reprimands or disciplinary action will be taken or permitted against personnel for good faith reporting of or cooperating in the investigation of activities or violations of this Code.
6. Personnel who violate the Code or commit illegal/unethical acts are subject to discipline up to and including dismissal. Personnel who report their own misconduct, however, will have self-reporting taken into account in determining the appropriate disciplinary action.

ADMINISTRATION AND APPLICATION OF ETHICAL BUSINESS CONDUCT CODE

AvMed expects each person to whom the Code applies to abide by the standards set forth herein and to conduct the business and affairs of AvMed in a manner consistent with these principles.

Failure to abide by the Code may result in disciplinary action. To determine the appropriate disciplinary action for a violation of the Code or a failure to report such a violation, the Corporate Compliance Officer and Members of Senior Management may take into account the following factors:

1. The nature of the violation and the ramifications to AvMed, its Clients and Stakeholders
2. Whether the Employee's involvement was direct or indirect
3. Whether the violation was willful or unintentional
4. Whether the violation represented an isolated occurrence or a pattern of conduct
5. Whether the Employee withheld relevant or material information and the degree to which the Employee cooperated with the investigation
6. Any action previously imposed for similar violations and/or the Employee's past violations
7. Whether the violation constituted a fraudulent act (intentional deception)

Nothing in the Code is intended to nor shall it be construed to provide any additional employment or contract rights to Employees or other persons. While AvMed will generally attempt to communicate changes concurrent with or prior to the implementation of such changes, AvMed reserves the right to modify, amend or alter the Ethical Business Conduct Code without notice to any person or Employee.

AVMED COMPLIANCE HOT LINE

To request information about the AvMed Corporate Compliance Program or to report possible misconduct, please contact a Member of the Compliance staff. The Compliance Hot Line is available 24 hours per day by calling toll-free **1-877-AVM-DUTY** (1-877-286-3889). Alternatively, the Compliance staff may be contacted by mail at the following address:

AvMed Compliance Program
AvMed
P.O. Box 569004
Miami, FL 33256-9887

What We Ask of You

As Provider, you are the Member's personal physician and first contact point within his or her healthcare delivery system. As such, there are several responsibilities you should assume:

GENERAL RESPONSIBILITIES:

- Use AvMed's participating hospitals and facilities and appropriate referrals.
- Use AvMed's participating Providers for laboratory, pathology, radiology, pharmacy and other services.
- Coordinate appropriate referrals to participating specialists and other participating Providers.
- Allow the Member/patient to visit a participating chiropractor, dermatologist or podiatrist without a referral (under no circumstances should a Member be denied access to a chiropractor, dermatologist or podiatrist).
- Coordinate all radiological tests, laboratory tests or surgery requested by the chiropractor, dermatologist or podiatrist with participating Providers.
- Comply with AvMed's Quality Management and Benefit Coordination programs, as well as its policies and procedures.
- Bill AvMed for all covered services, coding those services in accordance with ICD-10 guidelines.
- Submit encounter data on all services performed (applies to capitated Physicians).
- Treat all Members equally and without discrimination, regardless of a Member's race, sex, religion, place of residence or health status.
- Agree to observe, protect and promote the rights of AvMed Members. A copy of AvMed's Members' Rights and Responsibilities can be found in this chapter.
- Agree to maintain the privacy of AvMed Member's protected health information. A copy of AvMed's Notice of Privacy Practices can be found on AvMed's website at **AvMed.org**.
- Support and encourage participation in any AvMed program, such as Disease Management, Smoking Cessation, etc., encouraging Members to improve their healthcare status or manage a chronic condition.
- Respond promptly to requests from AvMed for any information required from the PCP or specialist to support Medicare coverage determinations, appeals and/or grievances.
- Schedule routine office visits for all Medicare Members for preventive, maintenance, acute and chronic care.

WE EXPECT EACH PRIMARY CARE PHYSICIAN TO:

Avmed provider are expected to see AvMed Members within 15 minutes of thier scheduled appointment time; If something comes up and the Member is not seen within 15 minutes, the Avmed provider and/or their staff should apologize and explain the delay.

- Provide care or arrange appropriate backup coverage with an AvMed Participating Physician, 24 hours a day, 7 days a week. Your backup Physician's office must be within 25 minutes, non-rush-hour travel time, from your office.
- Agree to accept a minimum of 50 to 100 new patients during the first year of the contract. AvMed Members should be accepted and integrated into your practice with the same treatment as any new patient.
- Be accessible by phone during all published hours of operation and keep an after-hours answering service. You should respond to urgent or emergency care telephone calls within 30 minutes of the call and to other calls within one hour.
- Have a flexible appointment schedule to respond to the severity of patients' illnesses. You should have a minimum of 20 hours of regularly scheduled office hours for patient treatment every week. We expect that you will see no more than an average of five adult patients or six pediatric patients per hour.
- Provide appointment scheduling within plan standards for all types of visits. See Chapter 8 for Appointment Accessibility Standards.

Note: We require on-call coverage with a Participating Physician. If coverage is with a non-participating physician, you are financially responsible for the care of your Members by an on-call partner. (Waivers may be issued under certain circumstances.)

WHEN A MEMBER CALLS TO SCHEDULE AN APPOINTMENT

When scheduling an appointment for a Member, your office should verify eligibility in any of the following ways:

- By checking your monthly eligibility list
- By accessing our website at **AvMed.org**
- By calling AvMed's Provider Service Center **1-800-452-8633**
- Through the use of Availity **1-800-AVAILITY** or Change Healthcare **1-800-845-6592**

Verifying eligibility will ensure the Member is assigned to you. Members should always present their identification card (ID) when seeking medical treatment. Each covered family member receives a personal ID card (see sample ID cards in Chapter 5. If a new Member does not have an ID card, he or she may either present a copy of his or her enrollment form as proof of membership, or your office can use the Verification Form (sample found in this chapter). Members are able to print a temporary membership ID card from our website (sample found in this chapter). If a Member has lost his or her card, you may refer the Member to the Member Engagement Department or you can access the Provider Portal on our website at **AvMed.org** to verify eligibility. To access the Provider Portal on our website, click on **Providers**, enter your username and password, then choose **Member Eligibility.**

You may access the Provider Portal on AvMed's website to search by Member ID number and Member's name (date of birth required). Additionally, you have the option of searching for a Member in your panel by Member's last name.

All data on our website is refreshed on a daily basis in order to provide your office with the most current information available. The Member Eligibility section provides basic benefit and copayment information as well as some Member detail, including the following:

Member's Details:

- Member Name
- Member Number (first three digits are secured)
- Group/Division
- Group Name
- PCP Name
- PCP Phone Number
- Currently Eligible or Known Effective/Termination Date
- Deductible (when applicable)

Copayments:

- PCP
- Specialist
- Preferred Generic Drug
- Preferred Brand Drug
- Non-Preferred Brand or Generic
- Emergency
- Hospital
- Member Coinsurance (when applicable)

The Provider Portal is one of the many services offered on our website. Login requires a predetermined username and password, which can be provided to you by AvMed have not yet received it. Please contact the Provider Service Center at **1-800-452-8633** or send an e-mail to **Providers@AvMed.org.**

AVMED VERIFICATION FORM

AVMED VERIFICATION FORM

Dear AvMed Patient:
Our records show you are not on our AvMed eligibility list. You will receive services today with the understanding that you may be billed and held financially responsible in the unlikely event that your coverage is not effective for one of the following reasons:

- Your membership has lapsed
- The services are not a covered benefit
- You have selected a different Primary Care Physician this month
- Your enrollment application is still being processed, has not been received or cannot be verified by AvMed.

I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY TO DOCTOR _____.
I HEREBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGEMENT OF THIS UNDERSTANDING. I AUTHORIZE AVMED TO DESIGNATE THIS PHYSICIAN AS MY PRIMARY CARE PHYSICIAN AS OF TODAY'S DATE.

_____ _____
Patient's Signature/Date Office Staff Signature/Date

_____ _____
Patient's Name (Please Print) Employer/Group Name (If Applicable)

_____ _____
AvMed ID Number AvMed Provider Number
(If not sure, use *Subscriber's SS#)
*SUBSCRIBER IS THE PERSON WHO WORKS FOR THE EMPLOYER WHO OFFERS AVMED COVERAGE**.**

TO PHYSICIAN'S OFFICE: AvMed members who are required to select a PCP and are not on your eligibility list should sign this form. Mail or fax forms to AvMed so that your eligibility listing can be updated.

Mail: AvMed Health Plans
Attn: Member Services
P.O. Box 569008
Miami, FL 33256

Fax: (352) 337-8612

WHEN TO CALL THE PROVIDER SERVICE CENTER

As a valued Physician in AvMed's Network, we want to make sure you receive all the support you need. The Provider Service Center is your primary link to AvMed. You may contact the Provider Service Center weekdays, 8:30 am-5:00 pm at **1-800-452-8633**.

Call AvMed's Provider Service Center whenever you:

- Have questions about procedures or policies
- Need forms or literature
- Need to arrange an orientation meeting for the Physicians and/or staff members in your office who want to arrange for an on-site visit
- Need to report changes* in your status, such as:
  - Address
  - Phone number
  - Fax number
  - Hours
  - Covering Physicians
  - Hospital privileges
  - Physicians in your group
  - Services you provide
  - Restricting or opening your patient panel
- Need to address any problems or changes* in your professional status, such as:
  - Corrective actions taken by regulatory authorities
  - Credentials
  - Professional liability insurance
  - Tax ID number
  - Board certification
  - Licensure
- Want to request a change in your panel status:
  - Open Panel: Physicians will accept new AvMed Members.
  - Established Panel: Physicians will accept established Members from another insurance plan and/or self-pay patient joining AvMed. Member Engagement will verify with your office that the Member is established before the assignment is made.
  - Closed Panel: Physicians cannot accept any new AvMed Members even if the Member is established with the Physician on another insurance plan or a self-pay policy. The only allowable exception is a Member returning to the Physician after receiving obstetrical care during pregnancy.

Note: A Closed Panel status may exclude your name from all Member Directories. Physicians must submit written notice 90 days in advance of any change that restricts patient access (i.e., Established or Closed).

*Please mail or fax your written notification to:

AvMed
AvMed Health Plans Provider Service Center
3470 NW 82nd Avenue Ste 1100
Doral, FL 33256
Fax: 305-671-6149 (local)
Fax: 1-877-231-7695 (toll-free)
To update provider demographic information online login to AvMed.org and choose My Profile.

Each area is assigned an AvMed Network Representative. It is his or her responsibility to introduce you to AvMed and to troubleshoot problems, explain changes, offer assistance, visit you and your staff, and generally make your participation as rewarding as possible. Do not hesitate to rely on your AvMed Network Representative, or the Provider Service Center, to assist or direct you appropriately.

AVMED'S MEDICAL DEPARTMENT

AvMed's Medical Department has Care Management programs that are health- and wellness-focused and designed to assist AvMed Members in reaching optimal health goals while dealing with extensive medical conditions. Various conditions include CHF, asthma, cancer, high-risk pregnancy, diabetes and complex case management.

All Care Management programs are FREE and are among the values of being an AvMed Member.

Benefit Coordination decisions are made on the appropriateness of care and service. AvMed Medical Directors are available to discuss medical necessity issues (including denials) regarding their patients with practitioners. Please contact our Medical Department with any questions.

BASIC AGREEMENT REFERENCE POINTS

It is important for you to be aware of what we require and offer you. Here are a few basic agreement highlights for your reference.

Notifying Us of Changes:

Please notify us in writing at least 60 days prior to office relocation or a change in tax ID number, and at least 90 days before closing your practice to new patients.

Billing Members:

Do not bill, charge or otherwise seek payment from Members (other than copayments, coinsurance and deductibles) for services covered by AvMed. Billing Members for covered services is prohibited by federal and state statutes and is noted as such in your AvMed contract.

Release of Records:

The medical record is to be treated as confidential in accordance with state and federal laws and regulations. In most instances, the information in the medical record cannot be disclosed unless the Member has given prior consent evidenced by a patient's Medical Record Release Form. The release on the Member's enrollment form authorizes AvMed to inspect the Member's medical records. AvMed may require a copy of the medical records from time to time for Quality Improvement and Utilization Review activities endorsed by AvMed, including state and federal regulatory agencies.

Renewals/Terminations/Continuing Service

Your continued participation is subject to the terms of your AvMed agreement. Some, though not all, automatically renew each year on the anniversary date. Please consult the agreement for clarification. In addition, either you or AvMed may terminate your participation without prejudice or specified cause, subject to the terms of your agreement. In serious circumstances, such as suspension of your license, AvMed may terminate the agreement immediately.

NOTICE OF CONSUMER ASSISTANCE

Pursuant to Florida Statute Section 641.511(8), Providers must post a Consumer Assistance notice that is prominently displayed in the reception area of the office and clearly noticeable by all patients. The Consumer Assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration Program and the Florida Department of Financial Services (DFS). The consumer notice must also clearly state that the address and toll-free number of AvMed's Grievance Department shall be provided upon request. A model of what the notice should look like is on the next page.

Important Notice

We are required by law to post a Consumer Assistance notice of addresses and telephone numbers for the following:

Agency for Health Care Administration
2727 Mahan Drive, Building 1, Room 343
Tallahassee, FL 32308
1-888-419-3456
DOH.State.FL.US

Subscriber Assistance Panel
2727 Mahan Drive, Mail Stop 26
Tallahassee, FL 32308
1-888-419-3456
1-850-412-4502
1-850-413-0900 Fax
SAP@AHCA.MyFlorida.com

Department of Financial Services –
Florida Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-4288
1-877-MY-FL-CFO (1-877-693-5236)
TDD line: 1-800-640-0886
MyFloridACFO.com/Consumers/NeedOurHelp.htm

Department of Health
Division of Medical Quality Assurance,
Consumer Services Unit
4052 Bald Cypress Way Bin C-75
Tallahassee, FL 32399-3275
850-245-4339
DOH.State.FL.US

The address and telephone number of AvMed's Grievance Department is available upon request.

IN-OFFICE LABORATORY GUIDELINES

The tests below are on the approved Physician in-office lab list and will be considered routine. No chief complaint or sick diagnosis is required to receive payment.

82270	BLOOD, OCCULT ,BY PEROXIDASE ACTIVITY (EG, GUAIAC),QUALITATIVE;FECES,
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL
87210	SMEAR, PRIMARY SOURCE WITH INTERPRETATION ; WET MOUNT FOR INFECTIOUS
87220	TISSUE EXAMINATION BY KOH SLIDE OF SAMPLES FROM SKIN, HAIR, OR NAILS

The tests listed below are payable when services are rendered in the Physician's office and only when the Member is treated for a chief complaint or sick diagnosis. If the visit is a well or preventive medicine visit, please send all specimens to your local AvMed-contracted laboratory Provider.

81000	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE,
81001	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE,
81002	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE,
81003	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE,
81015	URINALYSIS; MICROSCOPIC ONLY
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82247	BILIRUBIN, TOTAL
82375	CARBOXYHEMOGLOBIN; QUANTITATIVE
82465	CHOLESTEROL, SERUM OR WHOLE BLOOD, TOTAL
82803	GASES, BLOOD, ANY COMBINATION OF PH, PCO2, PO2, CO2,, HCO3
82805	GASES, BLOOD, ANY COMBINATION OF PH, PCO2, PO2, CO2, HCO3
82947	GLUCOSE; QUANTITATIVE , BLOOD (EXCEPT REAGENT STRIP)
82948	GLUCOSE; BLOOD, REAGENT STRIP
82962	GLUCOSE, BLOOD BY GLUCOSE MONITORING DEVICE(S) CLEARED BY THE FDA
83051	HEMOGLOBIN; PLASMA
85004	BLOOD COUNT, AUTO MATED DIFERENTIAL WBC COUNT
85007	BLOOD COUNT; BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL
85013	BLOOD COUNT; SPUN MICROHEMATO CRIT
85014	BLOOD COUNT; HEMATO CRIT (HCT)
85018	BLOOD COUNT; HEMOGLOBIN (HGB)
85025	BLOOD COUNT; COMPLETE (CBC), AUTO MATED (HGB, HCT, RBC, WBC AND PLATELET
85610	PROTHROMBIN TIME;
85651	SEDIMENTATION RATE , ERYTHROCYTE; NON-AUTO MATED
86003	ALLERGEN SPECIFIC IGE; QUANTITATIVE OR SEMI-QUANTITATIVE, EACH ALLERGEN
86308	ETEROPHILE ANTIBODIES; SCRENING
87081	CULTURE , PRESUMPTIVE, PATHOGENI C ORGANISMS, SCRENING
87086	CULTURE , BACTERIAL; QUANTITATIVE COLONLY COUNTY, URINE
87430	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASAY TECHNIQUE
87880	INFECTIOUS AGENT DETECTION BY IMMUNOASAY WITH DIRECT OPTICAL

All lab work statewide should be sent to Quest Diagnostics. Consolidated Laboratory is an alternative option for Jacksonville area Members only.

For medically necessary lab tests that are not available from a participating lab, Please call the Provider Service Center at **1-800-452-8633** for more information

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 changes. 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
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.

The Pharmacy and Therapeutics (P&T) Committee is responsible for the evaluation and assessment of pharmaceuticals. The recommendations of the P&T Committee are included in specific AvMed publications and are posted on the AvMed website annually.

The Medical Technology Assessment Program (MTAP) and Committee (MTAC)
AvMed has a formal mechanism in place as required by NCQA, the Medical Technology Assessment Program (MTAP) and Committee (MTAC). The purpose is to evaluate and address the new developments in technology and the new applications of existing technology for possible coverage and inclusion in the Member's benefit plan, including:

- Medical care procedures
- Behavioral healthcare procedures
- Pharmaceuticals
- Devices

The Pharmacy and Therapeutics (P&T) Committee is responsible for the evaluation and assessment of pharmaceuticals. The recommendations of the P&T Committee are included in specific AvMed publications and are posted on the AvMed website annually.

AVMED COMMUNICATIONS THAT MEMBERS AND PROVIDERS WILL RECEIVE

- **EMBRACE Magazine:** printed magazine that is mailed to AvMed Commercial Members and includes articles on benefits, services, programs as well as health and wellness topics. EMBRACE is published two times a year (link: Medicare - AvMed)
- **EMBRACE Digital Issue:** is sent electronically to AvMed Commercial Members and includes articles on benefits, services, programs as

well as health and wellness topics. EMBRACE Digital Issue is sent four times per year

- **ASPIRE Magazine:** printed magazine that is mailed to AvMed Medicare Members and includes articles on benefits, services, programs, as well as health and wellness topics. ASPIRE is published three times a year (link: Medicare - AvMed).
- **ASPIRE Digital Issue;** sent electronically to AvMed Medicare Members and includes articles and includes articles on benefits, services, programs, as well as health and wellness topics. ASPIRE Digital Issue is sent four times per year.
- **Network Newsbrief Magazine:** printed magazine that is mailed to AvMed Providers and includes articles on health education information, Member benefits, services and programs. This magazine is published three times a year. (ink: Provider - AvMed)
- **Network NewsWire Digital Isssue:** sent electronically three times per year to AvMed Providers. Includes articles on health education information, Member benefits, services and programs.

RESIGNATION AS A PCP

If you are unable to establish and maintain a good Physician-patient relationship with any Member or Member's family, you may terminate the relationship with no less than 30 days' written notice to the Member. Please mail or fax a copy of the letter to the Provider Service Center at:

AvMed
Provider Service Center
P.O. Box 569004
Miami, FL 33256-9004
Fax: 305-671-6149 or 1-877-231-7695

MEMBERS' RIGHTS AND 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, evaluationand/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 aclear explanation of how to obtain services and applicable charges.
- Access quality care, receive preventive health services and know the identity and professional status ofindividuals providing services to them.
- The right to be treated with respect and recognition of your dignity and your right to privacy.
- To 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 emergencycoverage, including how to obtain out-of-area coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To 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 themselves with this Physician. **
- Become knowledgeable about your health plan coverage including covered benefits, limitations and exclusions, 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

* A portion of the cost of a non-participating consultant will be the responsibility of the Member.This benefit includes consultation only and does not guarantee continued care with consulting Provider.

CHAPTER 2 CONTENTS
CLAIMS

Filing claims in the manner outlined in the following chapter will be of benefit when billing AvMed. Following these simple guidelines will expedite your accounts receivable turnover rate and decrease errors in claim payments. For your reference, we have also attached the Explanation Codes (EXCODE) that may appear on your Explanation of Payment Report, defining the status of a claim.

REIMBURSEMENTS – Electronic Claims Submission

AvMed receives claims electronically from the following clearinghouses: Availity, Caparo, eHDL, Change Healthcare, OptumInsight and RelayHealth.

Real-time eligibility is available through Availity, OptumInsight, RelayHealth and can also be obtained on AvMed's website. Following is how the claims submission process works:

- Contract with a particular clearinghouse
- The clearinghouse sends your claim electronically to AvMed
- The clearinghouse reformats the claim and sends it to us as an electronic file, which goes directly to our claims payable computer system
- The file is evaluated for "structural compliance standards"
- Electronic acknowledgments are sent to the clearinghouse and posted on the AvMed website within 24 hours after receipt (your staff can track the progress of your claim)
- The claim goes through data edits process
- If the claim passes data edits, it will go through the claims adjudication process and be paid shortly thereafter
- You will receive notification from your clearinghouse defining the specific status of your claims

Utilizing EDI allows us to convert claims to a consistent format, improve data quality and reduce processing time. By doing so, we are taking a step toward unifying and simplifying an important part of the healthcare delivery system.

To submit your claims electronically, simply log on to **AvMed.org**.

REIMBURSEMENTS – Paper Claims Submission

Physicians should always bill their usual and customary fees. AvMed will pay the lesser of your contractual agreement or the Medicare allowance for Medicare Members. When billing commercial Member claims, AvMed will pay at your contractual agreement rates.

When you provide specialty medical services to a Member, be sure to submit your claims on the standard CMS 1500 form.

The process is similar to accepting assignment of benefits in a traditional fee-for-service plan. The claims payment process is contingent upon AvMed's receipt of complete and legible claims information.

Submitting Claims According to Time Limitations

Claims are to be submitted in the filing time listed in your Provider contract(s).

YOUR BILLING AND REQUIRED INFORMATION

When submitting claims, it is very important to accurately provide all required information. Please follow the instructions outlined below when completing claims.

The following data must be included on every claim:

- Member name
- Member date of birth
- Member sex
- Member ID number
- Other insurance information
- Name of referring Physician
- Diagnosis codes
- Date of service
- Place of service code
- CPT or HCPCS procedure code with appropriate modifier when applicable (when billing for supplies that have no HCPCS code, include a copy of the supplier's invoice)
- Billed charges
- Number of days or units for each service line
- Submitting Provider tax ID or Social Security Number
- Provider name
- Provider billing name and address

AvMed requires that all professional claims be submitted on a CMS 1500 claim form found in this chapter.

- Claims submitted without the required information will be denied
- Claims submitted for services other than those authorized (if required) will be denied
- Handwritten claims are no longer accepted
- Claims coding should be in compliance with ICD-10 guidelines, as required by Medicare

Timely Filing Requirements

You have 180 days from the date of service to submit your claims for processing. All claims outside of 180 days will be denied. Please forward all claims to:

AvMed
P.O. Box 569000
Miami, FL 33256-9000

You should receive payment within 45 days of submitting a claim.

Note: If you have not received payment within 45 days of submission, please call the Call Center to get an update on the status of the claim.

Balance Billing

AvMed's Contracted Providers are not permitted to balance bill our Members. Providers who continually balance bill Members will be issued a written warning by AvMed. Violation, under State Statute 641.315 (2 and 3) may result in termination of the Provider's contract. Per Section 170, Chapter 4 of the Medicare Managed Care Manual, participating providers are precluded from balance billing Medicare Advantage members.

Adjustments

What are adjustments? Adjustments are claims that have been paid or denied and require reconsideration. You have 150 days from the original date of processing to submit your request for an adjustment. Please include an explanation of the type of adjustment needed.

Claim Status

Any claim that has not been reported on an Explanation of Payment (see sample found in this chapter) within 45 days of submission can be checked for claim status. Please do not submit a request for claim status within 45 days of sending the original claim. Claim status requests should be made by submitting a Request Claim Status form (see sample found in this chapter) by fax or mail to the address/fax number below. You may also status claims via AvMed's website at **AvMed.org.**

AvMed
P.O. Box 569004
Miami, FL 33256-9004
Fax: 1-800-452-3847

Claims Review

A claims review is considered any paid or denied claim that the Provider is questioning or correcting.

Claims Appeal

A claims appeal is any claim that is correctly paid or denied, according to contract, that involves extenuating circumstances for which the Provider is requesting an exception.

AvMed Providers have 150 days from the date of the initial Explanation of Payment to Request for Claim Review/Appeal of a paid or denied claim. A copy of your claim(s), along with a completed Request for Claim Review/Appeal form (MP-2105; sample found in this chapter) should be submitted either by fax or mail. See address for submitting adjustment requests in this chapter.

A formal letter of appeal must be submitted in writing, describing the problem in detail, giving the reasons why the Provider is appealing and giving the solution the Provider is seeking. Any supporting documentation the Provider has, such as medical records, should be sent with the letter of appeal. Requests for reconsideration of denied appeals must also be submitted in writing to the Claims Service Center Appeals Unit and must be accompanied by new evidence that would justify reconsideration. The Claims Service Center Appeals Unit will review the request and advise the Provider of its resolution in the form of either a payment on your claim, or a letter describing the reason(s) AvMed upheld the original determination.

Omitted Charges

Resubmit a copy of the original claim, identify the charges overlooked, and attach a copy of the AvMed Explanation of Payment.

Corrected Claims

Providers can submit corrected claims for claims that have been paid and they are correcting CPT code, units, etc. Attach a copy of the AvMed Explanation of Payment Report with the original claim form information highlighted. Resubmit a copy of the original claim, with the corrections, and indicate, "corrected claim."

Incorrectly Paid Contracted Rate
Resubmit a copy of the original claim, describe the payment problem and attach a copy of the AvMed Explanation of Payment Report. Whenever possible, attach any pertinent rate schedules indicating the correct contracted rate, or a copy of the updated Medicare fee schedule for the billed procedure codes.

Non-Reimbursement Due to Lack of Information
Please resubmit a copy of the original claim with a copy of the AvMed Explanation of Payment or denial letter and include a statement outlining the request for the reconsideration. Attaching any additional information to substantiate the charge, such as an additional diagnosis, operative report or charge notes, helps expedite claim processing.

Non-Reimbursement Due to Ineligibility
Resubmit a copy of the original claim and a copy of the AvMed Explanation of Payment with additional eligibility information.

Payment Made Under Incorrect Provider ID or Incorrect Patient ID
Resubmit a copy of the AvMed Explanation of Payment Report and include the correct ID information.

Please mail all adjustment and appeal requests to:
AvMed
P.O. Box 569004
Miami, FL 33256-9004

You may also call the Provider Service Center to check reviews and appeals at **1-800-452-8633**.

Refunds
A refund to AvMed is necessary when a claim is processed incorrectly and results in an overpayment. An overpayment usually occurs when another primary insurance, workers' compensation or third-party liability is discovered. The following are reasons for submitting a refund:

Incorrect or Duplicate Payments
Attach a copy of each Explanation of Payment highlighting the incorrect or duplicate payments. Provide a written explanation indicating the reason for the refund (e.g., overpayment, other coverage, duplicate or other circumstances). Please include your check for the amount of the overpayment.

Incorrect Coordination of Benefits
If AvMed has paid as the primary carrier in error, attach a copy of the other carrier's Explanation of Payment, along with a copy of the AvMed Explanation of Payment. Please include your check for the original payment amount.

Third-Party Liability Recovery
Attach a copy of the other carrier's payment or Explanation of Payment, along with a copy of the AvMed Explanation of Payment. Please include your check for the overpaid amount.

Please mail refund checks, with the above documentation to:

AvMed
P.O. Box 569000
Miami, FL 33256-9000

Encounter Reporting

Primary Care Physicians are required to complete and forward to AvMed on a weekly basis an Encounter Form or individual CMS standard claim form for each Member they have seen. Gathering this information is necessary to meet the requirements of the Agency for Health Care Administration (AHCA).

It is essential that the following information be reported on the Encounter Form for each primary care encounter:

- Member name
- Member identification number
- ICD-10 diagnosis code
- Date of service
- CPT procedure code

COORDINATION OF BENEFITS AND SUBROGATION

Occasionally, AvMed Members will have more than one type of healthcare coverage. This additional coverage may stem from a spouse's health insurance, workers' compensation, motor vehicle insurance, Medicare, Medicaid or Veteran's Administration benefits. Whenever duplicate or multiple coverage exists, AvMed will coordinate benefits with the other plan(s) to assure that only 100 percent of the allowable charges are paid by all of the group health insurance and medical plans combined. If other carriers are noted, the Primary Care Physician should call AvMed's Provider Service Center at **1-800-452-8633** to report other insurance information to determine which insurance carrier is primary. Coordination of Benefits (COB) is required before submitting claims for Members who are covered by two or more health insurance plans.

AvMed may have subrogation rights in cases where a third party, usually not an insurance carrier, may be responsible for paying for a Member's medical care. Please report possible subrogation matters to our COB representative. We will work to recover expenses.

Please use the enclosed MP-1488 form, found in this chapter, and submit a copy with your claim. You may create your own form for submission if you prefer. Please make sure that the Member signs the form.

SAMPLE COORDINATION OF BENEFITS FORM

Please fax completed form to AvMed Claims Department: FAX: 1-305-671-6121

Dear Member:
Your **AvMed** contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. In order to expedite your claim(s) process, please complete the following information:

NOTE: If the reason for your medical care was not due to an accident related injury, do not complete Section I of the questionnaire. You should complete Section I and III only when applicable.

Patient Member ID Number _____
Patient Name _____
Provider Name _____
Date of Service _____

SECTION I
Is the reason for your visit to your doctor due to an injury caused by an accident?
Yes _____ No _____
If so, please indicate:
Auto _____ Home _____ School _____ Other _____
Date of Accident _____ How and where accident happened:

Was a third party responsible for the injury? Yes ____ No ____
If so, provide the following:
Name of individual or company: _____
Name and address of attorney representing third party insurance company or party responsible:

SECTION II
Full name of your spouse: _____
Spouse's Birth date: _____ Social Security Number: _____

Spouse's Employer: _____

Employer's Address: _____
_____ Telephone Number: _____
Is your spouse covered by any other Health Insurance Company: _____Yes _____No
If **YES**, give name, address and telephone number of Health Insurance Company:

_____ Telephone Number: _____
Policy Number: _____ Effective Date: _____
Type of Coverage: _____ Family _____Couple _____ Single

Do you have Medicare coverage?
Part A ____ Effective Date _____ Part B ____ Effective Date _____

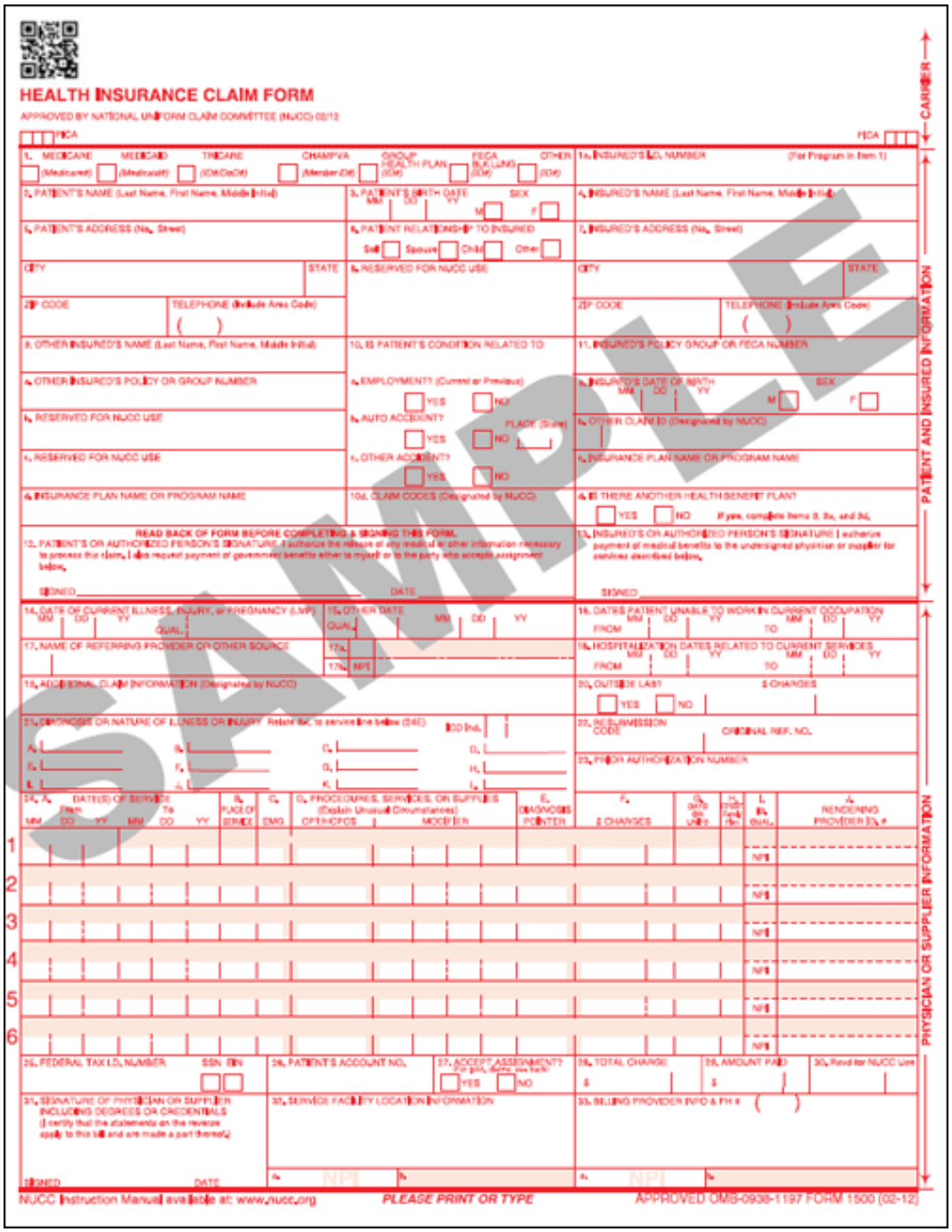
SECTION III (Information to be filled out only if auto accident)

Were you in your own or someone else's vehicle? _____
Name of your insurance company: _____
Amount of PIP coverage: _____ Amount of Deductible: _____
If represented by an attorney, please provide the following: Attorney name, address and telephone #:

Subscriber/Member Signature_____ Date _____

MP-1488 revised 5/17/06

SAMPLE CMS 1500 HEALTH INSURANCE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI
2									NPI
3									NPI
4									NPI
5									NPI
6									NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

AvMed Embrace better health.®

REQUEST FOR CLAIM STATUS

INSTRUCTIONS FOR COMPLETING FORM

- Submit legible copies of CMS 1500 or UB92 form to process your request accordingly, or
- Please enter the claims information on this form.

Please Print

FROM: CONTACT PERSON _____ PHONE _____ FAX _____

PROVIDER NAME _____ Tax ID _____ PROVIDER NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Date of Request: _____

Fax Your Request To:
(800) 452-5182

OR

Mail To:
P O Box 569004
Miami, FL 33256-9004

				For AvMed Use Only		
Member ID #	Member Name	DOS	Amount Billed	Paid Amount or Denial Code Description	Check Number	Check Date

Comments:

REMINDER: Your contract allows a specified time period to request a review. This date is calculated from the date of the original notice of payment or denial on the explanation of payment report. Late claim reviews or appeals cannot be considered.

Claims Service Rep: _____

TO REORDER ADDITIONAL FORMS CALL THE PROVIDER SERVICE CENTER AT 1-800-452-8633.

MP-2106 (10/07)

SAMPLE MEDICAL PRIOR AUTHORIZATION REQUEST FORM

Clinical Coordination Department

Medical Prior Authorization Request Form

Fax: 1-800-552-8633 **Phone: 1-800-452-8633**

All fields are REQUIRED. An incomplete request form will delay the authorization process

☐ **Standard Request**
☐ **Standard Request/Quick Response**; Process quickly due to date of Service/scheduling constraints
Pre-Scheduled date of Service_____ **Auth Date needed by**_____

Definition of Expedited/Urgent; **Waiting for a decision under Standard timeframe**:

- Could place the enrollee's life, health, safety (of member or others) or ability to regain maximum function in serious jeopardy.
- In the opinion on the practitioner, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

☐ **Expedited Request** **Physician Signature**_____

Member Information			
Last Name:	**First Name:**		
ID # A	Date of Birth	Gender F ☐	M ☐
Requesting Provider Information (Primary Care or Specialist)			
Name	Provider # or Tax ID	NPI	
Telephone/Ext	Fax	Contact Person	
Service Provider or Facility (e.g., Hospital, Surgery Center, DME provider etc.) **For Non-Par providers, please include: Name, Address, Tax ID, NPI, Phone /Fax Numbers & Contact Person.**			
Name	Provider # or Tax ID	NPI	
Telephone/Ext	Fax	Contact Person	
Requested Service - ***Please Include supporting chart notes, Diagnostic tests & Lab Values when appropriate.***			
☐ **Pre-auth** for In Patient Admission	☐ Chemotherapy	☐ Specialty Lab	☐ Transplant
☐ Out Patient Surgery	☐ Pain Management	☐ Predetermination	☐ Out of Network
☐ Wound Care	☐ Administration of Medication	☐ Durable Medical Equipment	☐ Other
☐ Clinical Trial ☐Commercial ☐ Medicare **No Auth. required for CMS approved clinical trials –Medicare only.**			
Diagnosis: ICD Code and Description			
Code	Code	Code	
Description	Description	Description	
Procedure: CPT Code/HCPCS and Description			
Code	Description		
Code	Description		
Code	Description		
Provide additional information or changes to be made to an existing authorization below:			

AN AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS
January 2024

SAMPLE REQUEST FOR REVIEW/APPEAL FORM

AvMed Embrace better health®

Request for Claim Review/Appeal

INSTRUCTIONS FOR COMPLETING FORM:

1. Use only one form per review type/per member. You may attach more than one claim per review type
2. Check the most appropriate box below for type of review requested
3. Submit legible copies of CMS 1500 or UB 04 form to process your request accordingly

* If you have a claim issue involving 25 claims or more, please contact your Claims Resp. so we may expedite corrections.

Fax Request to: (800) 452-3847 Or mail to: AvMed Health Plans, PO Box 569004, Miami, FL 33256

Member & Claim Information:

Member ID: _____ Date of Service: _____
Last Name: _____
First Name: _____ Claim Number: _____

Provider Information:

Provider Number: _____
Provider Name: _____ Tax Identification (EIN): _____

Indicate the Reason for Review/Appeal:

☐ **Corrected Claim:** ☐ Units, ☐ Service Code (CPT/HCPCS/Rev), ☐ Member ID, ☐ Other: Please Explain Below

☐ **Claim Paid Incorrectly:** ☐ Units, ☐ To Wrong Provider/Address, ☐ Not in accordance with contract

☐ **Coding Guidelines:** (CPT Bundling/Unbundling): Please include explanation/justification for additional reimbursement

☐ **Timely Filing:** Please include explanation for the untimely filing along with supporting documentation (i.e. EOB from another carrier). Please note that the EOB must show proof of a timely submission to previous carrier for consideration.

☐ **Invoice/Itemized Bill as per AvMed Health Plans request**
Note: The Invoice/PO must reflect the patient/member for which the services correspond.

☐ **Overpayment Disagreement:** Attach a letter detailing the contested portion of your payment and provide the specific reason for contesting. Reference Number: **SF**_____
Please include the reference number for the original AvMed Health Plans refund request letter in your correspondence.

☐ **Denial Review:** ☐ **AE** or **GE** – No Authorization, ☐ **ED** – Medical Necessity Not Established, ☐ **EH** – Late Notification
☐ **DN**– Missing Report or Notes, ☐ **VZ** – Pending Review of Medical Records

- If the claim was denied for "No Authorization" but you believe an applicable authorization existed, please verify the authorization before submitting the review (via the provider web portal or calling 800-452-8633). All authorizations include services authorized, date range and facility where services were authorized. A mismatch in the authorization will result in an administrative denial.
- All Requests for reconsideration must include all applicable office notes/medical records/requesting provider's ordering summary and an explanation indicating the reason an authorization was not obtained prior to the services rendered.

☐ **Other Reason/Explanation**: _____
_____
_____

NOTE: Your contract allows for a specific time period to request a review or appeal. This date is calculated from the date of the original notice of payment or denial on the explanation of payment report. Late claim reviews or appeals cannot be considered.

TO REORDER ADDITIONAL FORMS CALL THE PROVIDER SERVICE CENTER AT 800-452-8633

CHAPTER 3 CONTENTS
AUTHORIZATION AND CLINICAL INFORMATION

CLINICAL COORDINATION POLICIES AND PROCEDURES

Overview

AvMed's authorization process has been designed to achieve and sustain high-quality, coordinated, efficient and cost-effective care for AvMed Members. This process also allows AvMed to identify and enroll Members in preplanned discharge planning and specialized programs, such as Disease and Care Management. These initiatives can be best accomplished by coordinating the clinical expertise of AvMed Physicians with the clinical and cost management expertise of the AvMed Medical Directors and Clinical Coordination Team. The Clinical Coordination Team strives to cultivate a partnership with your office by providing a commitment to enhanced collaboration, effective communication and first-class customer service. When a request is submitted for authorization, your office can expect the Clinical Coordination Team to provide consistent application of internal procedures/guidelines, nationally recognized criteria and administration of benefit limitations.

Simply stated, AvMed's Clinical Coordination Team can provide valuable input and assistance with the following:

- Maximizing Member benefits
- Benefit coordination
- Medical appropriateness of a requested service
- Appropriateness of timing
- Alternative setting consideration for delivery of care

Renewed emphasis has been placed on utilization patterns/trends, Provider/employer group activity and location of care delivered. AvMed routinely monitors and challenges the authorization process and reserves the right to modify authorization requirements when significant deviations are identified.

Providers can expect timely, clear and concise communication outlining future revisions or modifications to the authorization process.

AvMed's Medical Department uses nationally recognized guidelines and resources, such as Milliman®, to guide clinical determinations. A panel of board-certified physicians is utilized, ranging from cardiologists to obstetricians, to review atypical requests. Certain Utilization Review/Care Management functions are delegated to integrated delivery systems, independent practice associations or other Provider groups. Delegated Providers utilize criteria based on reasonable medical evidence that has been determined to be consistent with AvMed's standards and guidelines.

AvMed's Medical Directors are authorized to deny service(s) based on medical appropriateness. The Clinical Coordination Team is empowered to deny services based on contractual limitation. All adverse determinations trigger a denial letter that contains detailed rationale for the denial such as any unmet criteria, standards/guidelines or contractual language. The letter also informs the Member and the Provider of the appeal process. Copies of the criteria, standards/guidelines or contractual language used in making the decision are available upon request and at no cost to the Member or Provider.

AvMed proudly offers a vast array of products, such as Classic, Open Access, POS Open Access, Choice and Medicare. While major authorization requirements are consistent throughout our product offerings, there are some variations. Although multiple product lines may seem complicated, your office can expect the Clinical Coordination Team to address questions you may have related to specific product authorization requirements. You may also log onto to **AvMed.org** for a comprehensive explanation of our product suite.

CASE TURNAROUND (TIMELINESS) STANDARDS

Providers should submit authorization requests in accordance with *CMS/NCQA guidelines to allow for the Health Plan to make determination within the standard turnaround time, unless the member urgently needs care based on the below definition of an expedited/urgent request.
*CMS – Centers for Medicaid and Medicare Services (AvMed offers only the Medicare product)
*NCQA – National Committee for Quality Assurance
Authorization requests are processed for the member as expeditiously as the member's health condition requires.
Non-Urgent/ Standard pre-service request – request is made in advance of the patient obtaining medical care or services. Decision and notification will be made no later than 15 calendar days after receipt of request for commercial plans and 14 calendar days for the Medicare plans.
Urgent/Expedited pre-service request – medical care provided for illness or injuries which require prompt attention based on the definition of urgent /expedited. An expedited request is if the Member's life, health, or ability to regain maximum function could be seriously harmed by waiting for the non-urgent/standard time-period. The decision and notification will be made no later than 72 hours after receipt of the request.
Urgent Concurrent - An on-going course of treatment. The decision and notification will be made no later than 24 hours after receipt of the request.
Post Service – Any request for approval of care or treatment that has already been received by the patient. The Decision and notification will be made no later than 30 calendar days of receipt of the request for commercial plans and 14 calendar days for Medicare Plans
In rare circumstances, service(s) may be provided prior to receipt of an authorization. AvMed offers a maximum of five calendar days to secure a retrospective authorization and extends to 14 calendar days when ongoing treatment/continuity of care can be established. In addition to the standard information necessary to process a request, retrospective authorization(s) should include the actual date of service. Please refer to AvMed's web site for Providers for a complete list of services requiring prior authorization, including codes.

SERVICES REQUIRING AUTHORIZATION

Medical Procedures

- Benefits are determined by the Member's plan.
- This document applies to all AvMed Members and benefit products/line of business.
- Items listed may have limited or no coverage.
- An authorization is not a guarantee of payment.
- Payment is subject to member eligibility, benefit, and provider contract on the date of service.
- Providers both in and out of network are responsible for verifying eligibility and obtaining authorization for non-emergent services provided to AvMed Members when a prior authorization is needed.
- Members must be eligible on the date of service and the service must be a covered benefit.
- Authorizations processed by AvMed must be requested electronically on the AvMed Authorization and Referral Tool (AART) application via the Provider Portal, or on an Authorization Request form and submitted via fax.
- Services listed below require an authorization from AvMed or a contracted Vendor, (exceptions may apply)

Providers should submit authorization requests in accordance with *CMS/NCQA guidelines to allow for the Health Plan to make determination within the standard turnaround time, unless the Member urgently needs care based on the below definition of an expedited/urgent request.

*CMS – Centers for Medicaid and Medicare Services (AvMed offers only the Medicare product)
*NCQA – National Committee for Quality Assurance

Authorization requests are processed promptly, based on the urgency dictated by the member's health condition.

Non-Urgent/Standard pre-service request – A request submitted before a patient receives medical care or services. The decision and notification will be completed within fifteen (15) calendar days for commercial plans and fourteen (14) calendar days for Medicare plans.

Urgent/Expedited pre-service request – Urgent medical care provided for illnesses or injuries that require prompt attention. An expedited request is necessary when waiting for the non-urgent or standard time could seriously harm the member's life, health, or ability to regain maximum function. The decision and notification for urgent care will be made no later than 72 hours after receiving the request.

Urgent Concurrent - An on-going course of treatment. The decision and notification will be made ***no later than 24 hours*** after receipt of the request.

Post-Service – Decisions for care or treatment that the patient has already received will be made within thirty (30) calendar days for commercial plans and fourteen (14) calendar days for Medicare Plans.

How to Submit Authorization Requests

Behavioral Health

- **Behavioral Health and Substance Abuse Services** are authorized by **Optum Behavioral Health** effective January 1, 2021. Authorization may be requested by phone via AvMed's Behavioral Health Service Center powered by Optum at the numbers listed below.
    - AvMed Medicare Advantage: 866.284.6989
    - AvMed Commercial: 866.293.2689
    - You can also visit:
        - http://www.AvMed.org/BehavioralHealth-Members
        - http://www.AvMed.org/BehavioralHealth-Medicare
    - AvMed PCP Provider Communication form https://www.AvMed.org/media/qlupczjr/pcp-behavioral-health-coordination-form.pdf

Cardiology for Medicare Plan

- **Cardiology (non-complex diagnostic & surgical)** for Medicare Plan Members – please contact New Century Health at **1-888-999-7713** or https://my.newcenturyhealth.com
- **Cardiology for Commercial Plans**
    - **See how to submit authorizations for All other prior authorizations.**

Chemotherapy

- **Chemotherapy Services (Outpatient) and Specialty Medications**
    - For **Medicare Advantage Plans** Chemotherapy and Hematology treatment requests along with supportive medications requested by all specialties will require review or an authorization by **NewCentury Health.**
        - Log into the New Century Health Provider web portal: https://my.newcenturyhealth.com
        - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
            - Medical Oncology – Option 1

- **Chemotherapy Services (Outpatient)**
  - Authorizations for AvMed Members with coverage through either Fully Insured or Self-Insured CommercialProducts will continue to be managed by AvMed.
  - For all other chemotherapy requests, complete a Medical Prior authorization request form and fax to
  - **1-800-552-8633**
    https://www.AvMed.org/prescriptions/#4ecf8f31-0125-4dac-b425-d769e933d4c8
- **Chemotherapy Services (Inpatient) and Specialty Medications**
  - **For all Members contact AvMed for Inpatient authorization requests.**

- **Chemotherapy Services Specialty Medications**
  - For all **Commercial and Self-Insured plans**, please contact NovoLogix via the web-based online pre authorization tool for providers. A list of all Medications (office and O/P facilities) reviewed by this vendor is available on the website.
  - For specialty drugs Log into Novologix via the AvMed Provider Portal at www.AvMed.org
    - To visit the Prescriptions page on the AvMed website www.AvMed.org/prescriptions/
    - Prior authorization requirements for specialty drugs
    - www.AvMed.org/prescriptions/#4ecf8f31-0125-4dac-b425-d769e933d4c8

Dermatology

- **Dermatology Services** for Medicare Plan Members are authorized by **(DNS) Dermatology Network Solutions**. You may contact **DNS** by phone at **305-667-8787** or by Fax at **(305) 402-2269**.
  - A referral is not required for in-network Dermatologists.

Dermatology cont.

- **Dermatology services** for all other benefit plans are managed by AvMed.
  - A referral is not required for in-network Dermatologists.
  - An auth may be required for certain surgical dermatology procedures.

Home Health and DME Services

- **Home Health and** certain **DME** items require prior authorization. Authorizations are processed by the following delegates based on what county the member lives in. See below for list of Medical Equipment and Prosthetics/Orthotics reviewed by AvMed.
  - **Integrated Home Care Services (IHCS)** for all counties except those listed below.
    - Call 844.215.4264 or FAX to 844.215.4265.
    - For Ostomy, Urology and Wound Care supplies [**new orders only**]
  - **BayCare Home Care**: Hillsborough, Hernando, Pasco, Polk, and Pinellas counties.
    - 800.940.5151
- **Advanced Care Solutions** for Ostomy, Urology and Wound Care supplies
  - Phone: 800.748.1977, Fax: 877.748.1985 [**Previously serviced Members only; refer new orders to Integrated Home Care**]

Ophthalmology: HN1 Providers and non HN1 Providers have different authorizations requirements.

- Ophtalmology codes https://www.avmed.org/media/ldvlikqo/avmed_emi_ophthalmology-cpt-code-list-_7_01_2022.pdf

- **Health Network One HN1 Ophthalmology services for the Medicare Advantage Members are part of the Eye Management Inc. (EMI) network.**
  - **To initiate an authorization request,**
    - **Health Network One (HN1) EMI Provider obtains authorization or a control number** to perform surgery for an AvMed Medicare Member through HN1.
    - Visit Health Network One website: www.myemifl.com
    - Call: 1.800.329.1152 option one (1).
    - Fax: 305.868.7640 or 800.922.4132
  - **AvMed in network facility authorization requirements**: None

Ophthalmology: Non-HN1 Providers for Medicare Advantage and Commercial Members.

- **Submit authorization requests through AvMed using one of the methods below:**
  - **Preferred:** Submit a referral or an authorization request via our new AvMed Authorization and Referral Tool **(AART).**
  - Complete a Medical Prior authorization request form and fax to **1-800-552-8633.**
    - Medical Prior Auth Request Form https://www.AvMed.org/media/mvcdgdnv/physicians-prior-authorization_-outpatient_in-patient-request_form.pdf
    - AvMed No Authorization Required List of Procedure Codes https://www.AvMed.org/media/2acp1hkl/no-authorization-required-list-of-procedure-codes-08_23_2022.pdf

  - **The following non-HN1 Providers will continue to require an authorization** for both procedure and facility **through AvMed for Medicare Advantage Members**.
    - All **non**-Health Network One EMI Providers.
    - University of Miami/Bascom Palmer doctors and facilities.
    - All out of network doctors and facilities.
    - All out of area and emergency related services.
    - **All Provider and facility claims** will continue to be processed by AvMed Claims Department.
    - **Refer to the No Auth list for codes that will continue to not require an auth.**

      - AvMed No Authorization Required List of Procedure Codes https://www.AvMed.org/media/2acp1hkl/no-authorization-required-list-of-procedure-codes-08_23_2022.pdf

Podiatry:

- For All Members contact PNS (Podiatry Network Services) 844.222.3939
- Surgical procedures may require prior authorization.
  - AvMed No Authorization Required List of Procedure Codes https://www.AvMed.org/media/2acp1hkl/no-authorization-required-list-of-procedure-codes-08_23_2022.pdf

Radiation Therapy

- **Medicare Radiation Oncology** is managed by **(NCH) New Century Health for the following plans:**
  - Medicare Advantage,
  - Fully Insured Commercial Products (incl. Exchange),
  - Sentara Health Plans
    - The requesting physician must complete an authorization request using one of the following methods:
      - Log into the New Century Health Povider web Portal: www.my.newcenturyhealth.com
      - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
        - Radiation Oncology – Option 2

- **Commercial Radiation Oncology** authorizations for AvMed Members with coverage through Miami-Dade County Jackson Health System, or City of Sunrise will continue to be managed by AvMed.
  - To submit a Radiation Therapy request to AvMed, complete a Medical Prior authorization request form and fax to **1-800-552-8633.**
    - Medical Prior Auth Request Form Below: https://www.AvMed.org/media/mvcdgdnv/physicians-prior-authorization_-outpatient_in-patient-request_form.pdf

Radiology authorizations for all AvMed Members are overseen by eviCore for In-office and Outpatient setting.

- **Diagnostic Testing List of codes below** https://www.AvMed.org/media/e1ybittu/evicore-radiology-codes-for-authorization-effective-jan-1-2022-01-20-22.pdf
- **Complex Radiology Services & Nuclear Medicine:** CAT Scan, MRI, PET Scan, CT Angiography
- **Nuclear and Cardiac Imaging**
  - Visit the website at http://www.evicore.com/,
  - Call **800-792-8790**
  - Fax **800-540-2406**
  - Access guidelines https://www.evicore.com/provider/clinical-guidelines

Referrals: For a list of Specialties requiring a referral below

- https://www.AvMed.org/media/amvgxw3j/21-15518-aart-referral-list.pdf

Visit our website Provider Education for AvMed Authorization and Referral Tool (AART) at:

- https://www.AvMed.org/web/provider/provider-education/referral-programs/
- **Referral requirements by Plan type:**
  - **Medicare Advantage Plans:** Choice, Circle, Premium Saver
  - **Individual and Family:** Engage and Entrust (HMO)
  - **Small Group:** Focus (HMO)

ALL OTHER PRIOR AUTHORIZATIONS AND VENDORS

Preferred: Submit a referral or an authorization request via our new AvMed Authorization and Referral Tool **(AART).**

- To access AART, please log in to the **Provider Portal**
  - Visit https://www.AvMed.org/news/new-service-portals/ and review the following resources:
    - Quick reference guide
    - Video tutorial
    - List of specialties requiring a referral

- Providers may also submit authorization requests via fax to **AvMed** prior authorization department at 1-800-552-8633. The prior authorization request form may be found on the forms tab on the AvMed website.
- https://www.AvMed.org/media/mvcdgdnv/physicians-prior-authorization_-outpatient_in-patient-request_form.pdf

- **AvMed Coverage Guidelines:** https://www.AvMed.org/web/provider/provider-education/protocols/
- **Hospital/Skill Nursing Facilities: Hospital Discharge Planning Resource:** https://www.AvMed.org/media/dqkpstad/inpatient-discharge-planning-resource-10_06_23.pdf
- All procedures outlined on this list require prior authorization.
  - All Inpatient admissions and Observation stay for surgical and non-surgical stays require authorization notification.
  - Hospital Use only - Emergent Urgent Direct Admissions: https://www.AvMed.org/media/gtomsuwh/service-plus-emergent-urgent-direct-admissions-authorization-request-form.pdf
    - Emergency room visits without an overnight stay will not require authorization.
  - Maternity and Newborn confinements require authorization.
  - Inpatient SNF (Skilled Nursing), LTAC (Long Term Acute Care) and Acute Rehabilitation facilities require prior authorization.
  - **Behavioral Health/Substance Abuse Services** for both inpatient and outpatient hospital services (including Partial Hospitalization and Intensive Outpatient Programs) require authorization by Optum. See above for contact information.

Investigational/Experimental Items and Non-Covered Services

- **Any item or service potentially considered investigational or experimental** must be authorized in advance and may not be covered per Members' plan.
- **Examples of Services** that may not be covered include but not limited to:
  - Magnetoencephalography (MEG),
  - Thermal Capsulorrhaphy,
  - Chronic Intermittent Intravenous Insulin Therapy (**CIIT**),
  - Platelet Rich Plasma & Fibrin Matrix (**PRP**),
  - Percutaneous Tibial Nerve stimulation (**PTNS**),
  - MLS Laser Therapy for Treatment of Pain,
  - Ligament Augmentation and Reconstruction **LARS.**
  - Acoustic Rhinometry
  - Cosmetic Services– surgical and non-surgical
  - Custodial Care

Laboratory Services

- All Specialty Labs
- Genetic Testing: does not include standard Down Syndrome and Cystic Fibrosis Screening when performed by capacitated /contracted laboratory listed below.

- Quest Diagnostics All Florida Counties except as listed below 866-697-8378,
- Visit the Quest Lab Portal at **https://myquest.questdiagnostics.com/web/home**
- Consolidated Laboratory Services for Clay, Duval, Nassau, and St Johns Counties
    - Contact 904-308-5600

Medical Equipment and Prosthetics/Orthotics (see above for DME items processed by delegate) includes but not limited to:

- Bone growth stimulators
- Dynasplint
- Home PT/INR Monitor
- External Defibrillator (The Vest)
- External prosthetic devices (excludes post-cancer breast prostheses)
- Implanted devices including cochlear device and /or implantation.
- Insulin Pumps, Continuous Glucose Monitors, and supplies.
- Lower limb prosthetics
- Myoelectric prostheses
- Negative Pressure Wound Therapy (Wound Vacuum Device)
- Neurostimulators trial or implantation
- Implanted Pain Pumps,
- Prefabricated Orthotics (please call to verify Member's coverage and authorization requirements)
- Snore Guards (Oral appliances)

Out of Network Services

- **Authorization is mandatory for all Out of Network (OON) services**, except for emergency care, for Commercial, Medicare, and Individual plan Members.
- Second Medical Opinions by an out of network, non-contracted Provider
- Select out-patient services for Members with POS (point of service) and Choice (out of network) benefits may not require prior authorization.
    - **Please verify coverage at www.AvMed.org** or contact the Provider Service Center at 800.452.8633 prior to rendering service.

Outpatient Rehabilitative Services (Speech, Occupational, Physical and Habilitative Therapy)

- **Authorization is not necessary when the Provider is in network.**
- **Habilitative Therapy** encompasses physical, occupational and speech therapies offered in an outpatient or home care setting and is a covered benefit when provided to help a person keep, learn, or improve skills and functioning necessary for daily living.

- **Optum** oversees Autism Services (see **Page 2** for contact information)

- **The coverage for the following Physical Therapy modalities is currently unavailable due to their investigational status,** but this list is not exhaustive:
  - Interactive Metronome Program
  - Augmented Soft Tissue Mobilization
  - Kinesio Taping/Taping
  - MEDEK Therapy
  - Hands-Free Ultrasound and Low-Frequency Sound (Infrasound)
  - Hivamat Therapy (Deep Oscillation Therapy)

- **Rehabilitative physical, occupational and speech therapies** provided in an outpatient environment or home care setting are covered to improve or restore physical functioning following disease, injury or loss of a body part does not require prior authorization **when performed at non-hospital affiliated facilities or offices**. Refer to Member's plan for benefit limits.
  - See **Page 3** for Home Health Rehab needs.

- **Rehabilitative therapy (outpatient)**
  - **Health Network One (HN1) oversees** speech, occupational and physical/lymphedema therapy benefits for **Medicare Advantage** Plan Members.
  - For Outpatient free standing therapy centers visit **HN1** website https://www.ataflorida.com
  - Provider contact #: 1-888-550-8800 option one.
  - Provider Fax: 855-410-0121

Pain Management (PM)

- For in-network outpatient services, such as those provided by ambulatory surgery centers or hospitals, an authorization is necessary for pain management services, this includes surgical pain management procedures.
- Pain Management services provided by an in-network (PM) Specialist in an office setting does not require prior authorization.
- **Acupuncture**
  - Covered for **Medicare Members with diagnosis of chronic low back pain only.**
    - Verify Member benefits for coverage requirements and limitations.
    - Acupuncture provided by an in-network Acupuncturist (**Medicare only**) will not require prior authorization
  - Covered for **select ASO (Self-Funded) plans with (POS) out of network benefits**. Refer to Member's specific plan for coverage and benefit limitations.
    - For ASO plans with this benefit, prior authorization is not necessary. However, the benefit is exclusively accessible from an out-of-network Provider for ASO plan Members with POS benefit.

Reconstructive Procedures performed to restore function or correct deformities after trauma or a medical condition such as cancer requires prior authorization. **Cosmetic surgeries are not a covered benefit.** Examples below are not a complete list.

- Abdominoplasty/Panniculectomy (excision of excessive skin due to weight loss)
- Blepharoplasty/Canthoplasty
- Mammoplasty
- Breast Reduction Reconstruction
- Rhinoplasty
- Panniculectomy
- Penile implant
- Surgery for Varicose veins
- Earlobe repair/Keloids/Scar revision

Select Items and Services

- **Ambulance Services:** Including air, land, and water for Emergency and Non-Emergency
- **Cardiac Rehabilitation:** Verify Member benefits and coverage for authorization requirements.
- **Chiropractic:** Contact Chiro Alliance - HMO Members: 877-434-8258, POS and HSAQ Members: 888-693-3296
- **Dermatology** See No auth required list for codes that do not require prior auth. https://www.AvMed.org/media/2acp1hkl/no-authorization-required-list-of-procedure-codes-08_23_2022.pdf
- **Diabetic Supplies –** Insulin pumps, Continuous Glucose Monitors
- **Dialysis and related services**
- **Drug Infusion Therapy** – Verify auth requirements as the requirements may be plan specific.
- **Gender Reassignment Procedures and Surgery**
- **Hyperbaric Oxygen treatments – may have limited treatments.**
- **Hospice**
- **Infertility Diagnostic Testing:** Hysteroscopy, Hysterosalpingogram, Sono-hysterogram, Laparoscopy
- **Lymphedema Therapy**
- **Neuropsychology Testing:** For all out of network Providers
- **Neurostimulators:** Includes Trial and Implantation
- **Ophthalmology:** See **page three (3)** for details.
    - **See Ophthalmology Code List** https://www.AvMed.org/media/ldvlikqo/avmed_emi_ophthalmology-cpt-code-list-_7_01_2022.pdf
- **Orthotic Devices:** Coverage for Orthotic Devices or Orthotic Appliances may be limited to custom-made leg, arm, backand neck braces when related to a surgical procedure or when used to avoid surgery and when necessary to conduct normal activities of daily living.
    - **Verify individual plan benefits and authorization requirements.**
- **Podiatry**: Contact PNS (Podiatry Network Services) 844-222-3939
- **Prosthetic Devices** are specifically designed to restore bodily function or replace a physical portion of the body. The coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses, and cochlear implants.
- **Radiation Oncology** contact **NCH** www.*my.newcenturyhealth.com*
    - Medicare Advantage, Fully Insured Commercial Products (incl. Exchange) and Sentara Health Plans.
    - Log into the NCH provider web Portal: www.*my.newcenturyhealth.com*
    - Call 1-888-999-7713 (Monday–Saturday, 8 a.m. to 8 p.m. ET)
        - For Radiation Oncology – **select Option 2**
- **Radiation oncology:** AvMed reviews and makes decisions regarding radiation oncology authorizations for Members with Miami-Dade County, Jackson Health System and City of Sunrise benefit plans.

Supplies

- When medically necessary, ostomy, urostomy and wound care supplies are covered.
    - The provision of ostomy and urostomy supplies is subject to applicable copayments and coinsurance. Items which are not medical supplies, or that could be used by the Member or a family member for purposes other than ostomy care are not covered.
    - Wound care supplies are included in an approved treatment plan if either of the following criteria is met:
        - treatment of a wound resulting from a surgical procedure; or treatment of a wound necessitating debridement.
        - See **page two (2)** for Home Health Care providers.

Surgical Procedures in a Hospital or Ambulatory Surgery Center

- All surgical procedures performed in the hospital or ambulatory surgery center setting require prior authorization EXCEPT those listed on the No Auth Required List.

  AvMed No Authorization Required List of Procedure Codes
  https://www.AvMed.org/media/2acp1hkl/no-authorization-required-list-of-procedure-codes-08_23_2022.pdf

Transplants

- Comprehensive services are offered for pre-transplant evaluations, organ transplants and post-transplant care. These services cover a wide range of major organs including Kidney, Liver, Heart, Lung, Pancreas, Small Bowel and Bone Marrow. Additionally, stem cell transfer is available after high dose chemotherapy.
    - For Case Management Programs:

        - Medicare
        - https://www.AvMed.org/medicare/programs-tools/manage-conditions/
        - Individuals and Families
          https://www.AvMed.org/individuals-families/programs-tools/manage-conditions/

Wound Care

- Hospital Inpatient and Outpatient setting requires prior authorization.
- Wound care procedures rendered by an in-network Provider in an office setting do not require prior authorization.
- Wound Vacuums/Negative Therapy Wound Management Systems requires prior authorization.
- HBO (**Hyperbaric Oxygen Therapy**) requires prior authorization and is subject to benefit limitations.

Other resources:

- **New Member Transition of Service:** Designed To assist newly enrolled Members in transitioning their medical services and prescription needs from their previous health plan to AvMed.
    - New Member Transition of Service form
      https://www.AvMed.org/media/nnkakvqn/final-tos-form-rev-11-02-21.pdf

- **Continuation of Care for existing Members**: Use this form when a treating Provider becomes out of network but needs to complete treatment already started for an existing Member.

  Continuity of Care Authorization Form
  https://www.AvMed.org/media/00wbv1ma/for-current-members_continuation-of-care_08_31_22.pdf

- **Claims**
  - Submit New Claims: P.O. Box 569000 Miami, FL 33256
  - Claims Correspondence, Reviews, and Appeals: P.O. Box 569004 Miami, FL 33256
    - Fax: 1-800-452-3847

** **Services not included on the precertification list are subject to the coverage terms of the Member's plan.**

SERVICES RENDERED BY A NON-PARTICIPATING PROVIDER

AvMed covers emergency care rendered by non-participating Providers.[2] With an authorization, coverage and reimbursement are applicable for medical or facility services when prescribed care cannot be provided in the health plan's Provider Network.

With an authorization, a Member may seek a second opinion from any participating or non-participating physician located within the health plan's service area. If a non-participating physician is selected, the Member may have a financial obligation for 40 percent of the physician charge.

Members with Choice and POS benefits may receive care/services from a non-participating provider; however, some services may require prior authorization. Benefits and authorization requirements may be verified by visiting **AvMed.org** or by calling Provider Service Center at **1-800-452-8633**

MEDICARE PHYSICIAN-TO-PHYSICIAN REFERRAL

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. With the launch of our Physician-to-Physician referral program, PCPs must now provide referrals for AvMed Medicare Members to access most specialty care services. PCPs can access the referral system to create and verify referrals, and specialists can access it to verify referrals. A referral does not require AvMed's approval. It has been established to promote better communication and coordination between treating Physicians.

The most current detailed list of services needing referral and exceptions to the guidelines can be found on AvMed's Provider Portal.

Diabetic Teaching

Diabetes self-management and training includes educational requirements related to self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and self-management skills.

Diabetic teaching does not require authorization in any setting; however, the benefit is limited to a one-hour initial individual training/assessment (G0108) and nine hours of group training (G0109).

Upon completion of the initial 10-hour training, two hours of annual follow-up training are covered.

Prior Authorization System

Effective 2/1/2017, AvMed's implemented the online Prior Authorization (PA) system **NovoLogix** to manage prior authorization requests for impacted medications administered in your office, participating facility, or in the home by a healthcare practitioner. The PA system link is available on AvMed's website at **AvMed.org**.

Some of the benefits of AvMed's NovoLogix web-based PA system are:

- A single, web-based site to enter all healthcare practitioner administered medication Prior Authorizations for both Commercial and Medicare Members
- Ability to directly answer PA criteria questions specific to each type of medication
- Ability to receive automatic PA decisions for a significant number of medications
- Real-time tracking of authorization status for PAs requiring manual review by AvMed

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Important to note is that requests for self-administered medication authorizations will continue to use the Medication Exception Request forms on AvMed's website.

Authorization Confirmation

AvMed transmits updated reports of approved/denied authorizations to providers via fax nightly. Please leave your fax machine in the "ON" position to receive nightly confirmations. You may also contact AvMed's automated Confirmation Line for authorization status at **1-800-816-5465** or check status on our website at **AvMed.org** using your Provider number and Tax ID or username and password.

All authorization numbers issued are subject to Member eligibility at the time of service.

AVMED'S CLINICAL COORDINATION QUESTIONS AND ANSWERS FOR PHYSICIANS THIS IS FOR A SELECT GROUP OF MEDICARE AND QHP PRODUCTS

Q. How do I refer a Member to a specialist for consultations?

A. A professional referral from the PCP to the specialist is required for a majority of AvMed's product offerings.[5] AvMed maintains the expectation that the PCP continue to play an same integral role with our Members by coordinating their medical care with specialists and other healthcare Providers.

Q. Do I need to give the Member anything to take to the specialist?

A. No. The only requirement related to specialist visits is a Physician-to-Physician communication, unless the specialist requires a script from the referring Physician.

Q. Can we obtain retroactive preauthorizations?

A. Yes. AvMed offers a maximum of five calendar days to secure a retroactive authorization and extends to 14 calendar days when ongoing treatment/continuity of care can be established.

Q. What about preauthorization for Point of Service (POS) Members?

A. POS Members utilizing AvMed's Network are subject to the same requirements as AvMed HMO Members. AvMed POS Members utilizing non-participating Providers can self-refer but are subject to deductibles and coinsurances. For specific benefits on a POS Member, please contact the Member Engagement Department at **1-800-882-8633**, 24 hours a day, 7 days a week, or visit our website at **AvMed.org** using your Provider number.

Q. Can lab work still be performed in our office?
A. Yes. If the patient is being treated for a chief complaint or sick diagnosis.

[5] This is excluding Members covered by the Open Access, Choice Product or when executing a POS rider (if applicable). Plans that referral is required

Discharge Planning
1-800-432-6676, option 1, ext. 40408. After hours, weekends and holidays.

OTHER MEDICAL DEPARTMENTS

Utilization Review

AvMed administers statewide Utilization Review supported by unrestricted statewide licensed Medical Directors and clinical staff including UM Managers (RNs), Inpatient Case Managers (RNs) and Discharge Planners (LPNs) as well as nonclinical Discharge Coordinators and support staff.

The Utilization Review Department is responsible for the daily operations of Utilization Management. Concurrent reviews are conducted both on-site and telephonically. Physicians may contact AvMed or a specific Medical Director to discuss any UM denial decision.

Discharge Planning

Discharge planning is conducted statewide. Licensed Discharge Planners (LPNs), Discharge Coordinators (nonclinical) and Utilization Management Coordinators work together to facilitate Members' access to benefits for discharge arrangements. Discharge Planning is available during normal business hours, after hours, on weekends and holidays at **1-800-432-6676**, **option 1, ext. 40408**.

Clinical Pharmacy Management

The Clinical Pharmacy Management Department administers the Prescription Drug Plan statewide. Pharmacists supervise clinical decision making. Nonclinical staff, under the supervision of the Director of Clinical Pharmacy, provides technical support.

Currently, the Pharmacy Department includes: Director of Clinical Pharmacy Management, Clinical Pharmacist, Pharmacy Manager of Operations and Pharmacy Benefit Consultants.

If you or your staff have any questions on dispensing limits and coverage guidelines, the "Coverage and Dispensing Limits Guide" is available online at **AvMed.org**.

To submit pharmacy authorization 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 **AvMed.org**. Click on **Providers**, **Tools**, and **Forms**. Then, select the appropriate MER form (Commercial or Medicare).

AvMed's Member Engagement Department

AvMed Member Engagement's main telephone number is **1-800-882-8633**, 8 am-8 pm, 7 days a week (TTY 711). Member Engagement hours may vary slightly by department. For exact hours, please call the number listed on the Member's AvMed ID card.

AvMed's Nurse On Call

AvMed's Nurse On Call program is a Member-centric, high-touch call center designed to assist Members with health related questions and advice and direct them to medical resources. Our Nurse On Call line is staffed by licensed, registered nurses and is available 24/7/365, via a toll-free number, to provide immediate symptom assessment, health information and self-care education.

Nurses use nationally recognized clinical algorithms to assess symptoms and consistently identify the appropriate care and recommendation to callers. In addition, Nurse On Call RNs follow-up with call-backs within 24 hours to Members who have been referred to the ER or Urgent Care to ensure that Members received the appropriate care and provide additional support if needed.

Along with the direct access to an RN, Nurse On Call provides Members access to an Audio Health Library where they can choose from over 1,000 articles offering a concise overview of selected health-related topics.

The service can be used in a number of ways. For example, questions could be: Does an injury require simple first aid and follow-up with the PCP, or is a trip to the emergency room in order? New symptoms are present, but it's after Physician's office hours; what should I do? These are questions that can be answered through AvMed's Nurse On Call. Members can speak with a registered nurse 24 hours a day, 7 days a week by dialing the toll-free number, **1-888-866-5432**.

Clinical Coordination Department

Medical Prior Authorization Request Form

Fax: 1-800-552-8633 **Phone: 1-800-452-8633**

All fields are REQUIRED. An incomplete request form will delay the authorization process

☐ **Standard Request**
☐ **Standard Request/Quick Response**; Process quickly due to date of Service/scheduling constraints
Pre-Scheduled date of Service_____ Auth Date needed by_____

Definition of Expedited/Urgent; **Waiting for a decision under Standard timeframe**:

- Could place the enrollee's life, health, safety (of member or others) or ability to regain maximum function in serious jeopardy.
- In the opinion on the practitioner, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

☐ **Expedited Request** **Physician Signature_____**

Member Information			
Last Name:		**First Name:**	
ID # A	Date of Birth	Gender F ☐	M ☐
Requesting Provider Information (Primary Care or Specialist)			
Name	Provider # or Tax ID	NPI	
Telephone/Ext	Fax	Contact Person	
Service Provider or Facility (e.g., Hospital, Surgery Center, DME provider etc.) **For Non-Par providers, please include: Name, Address, Tax ID, NPI, Phone /Fax Numbers & Contact Person.**			
Name	Provider # or Tax ID	NPI	
Telephone/Ext	Fax	Contact Person	
Requested Service - ***Please Include supporting chart notes, Diagnostic tests & Lab Values when appropriate.***			
☐ **Pre-auth** for In Patient Admission	☐ Chemotherapy	☐ Specialty Lab	☐ Transplant
☐ Out Patient Surgery	☐ Pain Management	☐ Predetermination	☐ Out of Network
☐ Wound Care	☐ Administration of Medication	☐ Durable Medical Equipment	☐ Other
☐ Clinical Trial ☐Commercial ☐ Medicare **No Auth. required for CMS approved clinical trials –Medicare only.**			
Diagnosis: ICD Code and Description			
Code	Code	Code	
Description	Description	Description	
Procedure: CPT Code/HCPCS and Description			
Code	Description		
Code	Description		
Code	Description		
Provide additional information or changes to be made to an existing authorization below:			

AN AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS
January 2024

CHAPTER 4 CONTENTS
CLINICAL PHARMACY MANAGEMENT

RETAIL PHARMACY SERVICES

Due to the dynamic and frequently changing nature of formularies, in order to keep you updated on the most current information, AvMed maintains the list of covered drugs on the AvMed website at **AvMed.org/prescriptions**.

The AvMed Formularies list medication by therapeutic category. Since Members have different contractual benefits and copay and/or coinsurance requirements vary by contract for each tier level, actual copay and/or coinsurance amounts are not listed on the formulary. You can obtain cost information by logging onto the AvMed Provider Portal website. Once logged in, you can enter the Member's ID number to obtain copayment and coinsurance requirements specific to that Member. If you do not have Internet access, AvMed's Provider Service Center is available to assist.

Most prescriptions will process without prior authorization. However some drugs do require prior authorization. For a list of drugs that require a prior authorization, please see the AvMed Formularies that are located on our website at **AvMed.org**. If the medication you are prescribing requires a prior authorization, please fax your request to **305-671-0200**.

COMMERCIAL FORMULARY

Introduction

The AvMed Commercial Formulary was developed to serve as a guide for prescribers, pharmacists, healthcare professionals and Members in the selection of cost-effective medication therapy. AvMed recognizes that medication therapy is an integral part of effective health management. Due to the vast availability of medication options, a reasonable program for medication selection and use is warranted.

The Commercial Formulary reflects the expert opinion and effort of AvMed's Pharmacy and Therapeutics (P&T) Committee, which is comprised of practicing prescribers and pharmacists representing different specialties. The P&T Committee continually reviews new and existing medications to ensure that the formulary remains responsive to the needs of our Members and healthcare professionals. The criteria used by the P&T Committee to evaluate medication selection for the formulary includes, but is not limited to, medication safety profile, medication efficacy and effectiveness data, comparison of similar prescription or over-the-counter (OTC) medications with equivalent indications, and/or use while minimizing potential duplications and assessment of equitable cost of medication.

Definitions

Brand Additional Charge – The additional charge that must be paid if a Member or prescriber chooses a brand medication when a generic equivalent is available. The charge is the difference between the cost of the brand medication and the generic medication. This charge must be paid in addition to the applicable non-preferred brand copay. The brand penalty is part of the Member's copayment and is not eligible to be waived.

Brand Medication – A prescription medication that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a brand medication by AvMed. AvMed delegates determination of generic/brand status to our Pharmacy Benefits Manager.

Generic Medication – A prescription medication that is comparable to the referenced brand listed medication in dosage form, strength, route of administration, quality and performance characteristics and intended use or is identified as a generic medication by AvMed's Pharmacy Benefits Manager. FDA-approved generic products are just as effective and safe as the brand-name products. Generic medications contain identical active ingredients, have the same indication for use, meet the same manufacturing standards, and are identical in strength and dosage form as brand-name medications.

Maintenance Medication – A medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

Participating Pharmacy – A pharmacy (retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide prescription drugs to AvMed Members and has been designated by AvMed as a participating pharmacy.

Preferred Medication List (Formulary) – The listing of preferred medications as determined by AvMed's Pharmacy and Therapeutics (P&T) Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multitiered list establishes different levels of copay for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's P&T Committee.

Prescription Medication – A medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

Prior Authorization – The process of obtaining approval for certain prescription drugs (prior to dispensing), according to AvMed's guidelines. The ordering prescriber must obtain approval from AvMed. The list of prescription drugs requiring prior authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring prior authorization is available on AvMed's website. To initiate a prior authorization, please visit our website at **AvMed.org** to obtain a Medication Exception Request (MER) form. Completed MER Forms must be faxed to AvMed at **305-671-0200**.

Progressive Medication Program (Step Therapy) – Medications included in this program require trial of a first-line medication in order for a second-line medication to be covered under your patients pharmacy benefit. Coverage for a third-line medication requires trial of one or more first-line AND second-line medications. If for medical reasons, your patient cannot use the first-line medication, and require a second-line or third-line medication, you may request a prior authorization to have this medication covered. Certain medications may be grandfathered for Members who are controlled on a second-line or third-line medication.

Self-Administered Injectable Medication – A medication that has been approved by the FDA for self-injection and is administered by subcutaneous injection. Prior authorization is required for all self-administered injectable medications, except insulin.

Quantity Limit – Medications included in this program allow a maximum quantity per prescription and/or time period for one copay or coinsurance. Quantity limits are developed based upon FDA-approved medication labeling and nationally recognized therapeutic clinical guidelines. If your prescription exceeds the quantity limit, a prior authorization will be required.

BENEFIT COVERAGE AND LIMITATIONS

The Medication Formulary is for reference purposes only and does not guarantee nor define benefit coverage and limitations. Many Members have specific benefit exclusions, which are not reflected in the AvMed Formularies. You may contact AvMed's Provider Service Center or log into AvMed's website to obtain member specific benefit information. Please note that the formulary process is dynamic and generally changes throughout the year. These changes typically occur due to, but not limited to, the following reasons: approval of new medications, availability of new approved generics, changes in clinical data and medication safety concerns. AvMed is not held responsible for payment

in the event that either a medication was omitted/included in error or that a medication was placed at an incorrect tier on this formulary. The following topics may or may not be applicable to individual Members depending on Member-specific benefit parameters.

Coverage

Medication coverage includes medications that require a prescription, are filled by an AvMed Network pharmacy, and are prescribed by Providers in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.

Generally, retail prescription medication coverage provides up to a 30-day supply of a medication for a 30-day copay. Prescriptions may be refilled via retail or mail order after 75 percent of the previous fill has been used and are subject to a maximum of 13 refills per year. In most cases, Members can obtain a 90-day supply of medications from the retail pharmacy for the applicable copay per 30-day supply. However, prior authorization may be required for certain covered medications.

Mail-order prescription medication coverage includes up to a 90-day supply of a medication for the listed copay per the Member's specific prescription benefits. If the amount of medication is less than a 90-day supply, such as a 75-day supply, Members are still charged the listed mail-order copay per their prescription benefits.

Self-administered injectable medication coverage extends to many injectable medications approved by the FDA. These medications must be ordered by a prescriber and dispensed by a retail or specialty pharmacy. The copay levels for self-administered injectable medications apply regardless of Provider. This means that Members are responsible for the appropriate copay whether the self-administered injectable medication is provided by the pharmacy, or during home health visits. Self-administered injectable medications are limited to a 30-day supply.

Quantity limits are set in accordance with FDA-approved prescribing limitations; general practice guidelines supported by medical specialty organizations; and/or evidence-based, statistically valid, clinical studies. This means that a medication-specific quantity limit may apply for medications that have an increased potential for overutilization or an increased potential for a Member to experience an adverse event at higher doses.

Tier Description

Each copay tier is assigned an established copayment, which is the amount paid by the member when a prescription is filled. Member Benefit documents specify copayments, coinsurance and/or deductibles (in some cases Brand Penalty) applicable to each tier. Regardless of Tier assignment, you decide which medication is most appropriate for your patients. However, AvMed encourages the use of generic medications when available and appropriate.

Commercial 4-Tier Formulary

- **Tier 1 - (Generics)** - These are preferred generic medications and are in the low to mid-range for out-of-pocket expense. You should always consider Tier 1 medications if you and your doctor decide they are appropriate to treat your condition.

- **Tier 2 - (Preferred Brands)** - These are preferred brand- or high cost generic medications and are in the mid to higher range for out-of-pocket expense. Sometimes there are alternatives available in Tier 1 that may be appropriate to treat your condition. If you are currently taking a Tier 2 medication, ask your doctor whether there are lower copayment alternatives that may be right for your treatment.
- **Tier 3 - (Non-Preferred Brands)** - These are non-preferred brand- or non-preferred generic medications and are in the higher range for out-of-pocket expense. Sometimes there are alternatives available in Tier 1 or Tier 2 that may be appropriate to treat your condition. If you are currently taking a Tier 3 medication, ask your doctor whether there are lower copayment alternatives that may be right for your treatment.
- **Tier 4 - (Specialty Medications)** - These are brand- or generic-name specialty medications or high cost medications and are typically the highest out-of-pocket expense. Distribution of specialty medications is limited to our specialty pharmacy.

Commercial 5-Tier Formulary

- **Tier 1 - (Preferred Generics)** - These are preferred generic medications and are in the low range for out-of-pocket expense. You should always consider Tier 1 medications if you and your doctor decide they are appropriate to treat your condition.
- **Tier 2 - (Non-Preferred Generics)** - These are non-preferred generic medications- or higher cost generic medications and are in the low to mid-range for out-of-pocket expense. Sometimes there are alternatives available in Tier 1 that may be appropriate to treat your condition. If you are currently taking a Tier 2 medication, ask your doctor whether there are lower copayment alternatives that may be right for your treatment.
- **Tier 3 - (Preferred Brands)** - These are preferred brand medications and are in the mid to higher range for out-of-pocket expense. Sometimes there are alternatives available in Tier 1 or Tier 2 that may be appropriate to treat your condition. If you are currently taking a Tier 3 medication, ask your doctor whether there are lower copayment alternatives that may be right for your treatment.
- **Tier 4 - (Non-Preferred Brands)** - These are non-preferred brand medications and are typically the higher range for out-of-pocket expense.
- **Tier 5 - (Specialty Medications)** - These are brand- or generic-name specialty medications or high cost medications and are typically the highest out-of-pocket expense. Distribution of specialty medications is limited to our specialty pharmacy.

Common Medication Exclusions

Due to benefit design parameters, there could be certain medication classes that are excluded from pharmacy benefit coverage. Prior authorization is generally not available for medications that are specifically excluded by benefit design. Commonly excluded products may include, but are not limited to:

- Over-the-counter, or OTC, medications or their equivalents unless otherwise specified in the Medication Formulary listing.
- Experimental medication products, or any medication product used in an experimental manner.
- Foreign medications or medications not approved by the FDA.
- Diaphragms and other contraceptive devices.
- Fertility drugs.
- Medications or devices for the diagnosis or treatment of sexual dysfunction.
- Dental-specific medications for dental purposes, including fluoride medications.
- Prescription and nonprescription vitamins and minerals, except prenatal vitamins.
- Nutritional supplements.
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications.
- Prescription and nonprescription appetite suppressants and products for the purpose of weight loss.
- Pharmaceuticals that would be covered under the medical benefit. These may include, but are not limited to, immunizations; allergy

serums; medical supplies, including therapeutic devices, dressings, appliances and support garments; medications administered by the attending Physician to treat an acute phase of an illness; and chemotherapy for cancer patients. Such benefits are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to copay or coinsurance and prior authorization requirements, as outlined in the Schedule of Benefits.

Mandated Generic Substitution

AvMed advocates the use of cost-effective generic medications where FDA-labeled brand equivalent medications are available. A generic medication is approved by the FDA once the manufacturer has proven that it has the same active ingredient(s) as the brand-name medication. Generally, generic medications cost less than brand-name medications. If a Member or prescriber requests a brand-name product in lieu of an approved generic, the Member, based upon his or her coverage, will typically be required to pay the non-preferred brand copay plus the brand additional charge.

Exception Requests

AvMed's Formularies are extensive and should meet the needs of most Members. However, we do recognize there are times when it is appropriate to review a request for a non-formulary medication for medical necessity.

All requests for consideration of a non-formulary medication must be submitted through the prior authorization process by completing and submitting a Medication Exception Request (MER) form. Please indicate on the MER form that you are requesting review of a non-formulary medication. If the medication you are prescribing requires a prior authorization, please fax your request to **305-671-0200**.

Requests for a non-formulary medication require documentation from the Member's medical records and/or in the Member's prescription claims history verifying **ALL** of the following criteria:

1. Statement of medical necessity

AND

2. Specific details of contraindications to all other formulary alternatives

OR

3. Therapeutic failure of adequate trials of one to three months for any and ALL other formulary alternatives

If the Member meets all of the above criteria, the request can be approved for up to one (1) year within the established quantity limit for each drug. Tier placement would depend on if the medication is a generic, brand, or specialty medication. You will be notified via fax of the approval determination.

IN-OFFICE AND OUTPATIENT FACILITY MEDICATION ADMINISTRATION

Certain medications administered in-office or at an outpatient facility require prior authorization. The coverage criteria for these medications are available on AvMed's website at **AvMed.org**. They are easily accessed by following these simple steps after logging into the AvMed Provider Portal. From the home page:

1. Select **Preferred Medication Lists** (left side of the screen under Quick Links).

2. Under Medication PA Criteria, select **Office, Outpatient Facility**, Home Health

Approval for these medications must be obtained through NovoLogix (AvMed's online prior Authorization system). Providers must log into AvMed's website in order to request the prior authorizations (PA). In most cases, a PA request can be instantly approved as long as required criteria is entered correctly into the system. A list of in-office and out-patient administered medications that require a PA can be found on AvMed's website.

Medications to be administered in-office should be supplied from your office stock and may be purchased from a manufacturer or distributor of your choice. Submit your claim to AvMed for both the medication and the administration.

Physicians participating in AvMed's Drug Replacement programs are required to order the medications from AvMed's specialty pharmacy Provider. Please refer to the Specialty Pharmacy section for additional information about these programs.

SPECIALTY PHARMACY

AvMed contracts with Proprium for specialty pharmaceutical services. These services are generally defined as those that service patients of chronic conditions with high-cost injectable and infusion therapies or biologic medications. The major conditions these medications treat include, but are not limited to, cancer, HIV/AIDS, hepatitis C, multiple sclerosis, Crohn's disease and rheumatoid arthritis. Payment of these services can come from either the medical OR pharmacy benefit.

MEDICARE FORMULARY

Beneficiaries enrolled in AvMed's Medicare product have a medication benefit included with their medical coverage. The benefit is annual, with a 6-tier copayment/coinsurance structure and an out-of-pocket maximum (TrOOP) requirement.

A unique formulary is used for Part D products. This formulary is based on guidelines established by CMS and is focused on providing benefits for those medications most frequently utilized and most medically appropriate for the over age 65 population. The Part D formulary is also developed and reviewed on an ongoing basis by the AvMed Pharmacy and Therapeutics (P&T) Committee.

The appearance of this formulary is slightly different from AvMed's commercial formulary in order to meet the guidelines and standards set by CMS.

AvMed's Part D formulary includes some Utilization Management tools including preauthorization, step therapy and quantity limits for select medications.

Certain medications within classifications of medications are not covered. Excluded medications include:

- Nonprescription medications
- Medications for the treatment of anorexia, weight loss or weight gain
- Medications used to promote fertility
- Medications used for cosmetic purposes or hair growth
- Medications used for the symptomatic relief of coughs and colds
- Prescription vitamins and mineral products

- Outpatient medications for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

The Part D formulary has 6 tiers:

1. Preferred Generics
2. Generics
3. Preferred Brands
4. Non-preferred Drugs
5. Specialty
6. Condition-Specific Generic Medications

FORMULARY CHANGES

Generally, if a Member is taking a drug on the formulary that was covered at the beginning of the year, AvMed will not discontinue or reduce coverage of the drugs during the benefit year except when a new, less-expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from the formulary, will not affect Members who are currently taking the drugs. It will remain available at the same cost sharing for those Members taking it for the remainder of the coverage year.

If AvMed removes drugs from the formulary, or adds prior authorization, quantity limits and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier, AvMed is required to notify affected Members of the change at least 60 days before the change becomes effective or at the time the Member requests a refill, at which time the Member will receive a 60-day supply of the drug. If the FDA deems a drug on the formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to Members who take the drug. This notice is provided to affected Members through the monthly Explanation of Benefits (EOB) letter, also sometimes referred to as the TrOOP letter and/or a member-specific letter.

EXCEPTIONS TO THE MEDICARE FORMULARY

If a Member new to the AvMed Medicare plan is taking a drug that is not on AvMed's formulary, the Member is instructed to contact AvMed's Member Engagement Department to confirm that the drug is not covered. If the drug is not covered, Members have two options:

1. Request a list of similar drugs that are covered from AvMed's Member Engagement Department. Members are then advised to show the list to the prescribing Physician and request a similar drug that is covered.
2. Request that an exception be made to cover the drug.

There are several types of exceptions that AvMed Medicare Members may request:

- Members can request us to cover a drug even if it is not on our formulary (as described above).
- Members may ask us to waive coverage restrictions or limits on drugs, for example, for certain drugs with limits on the amount of the drug that we will cover. If a Member's drug has a quantity limit, Members may ask us to waive the limit and cover more.
- Members may also request that we provide a higher level of coverage for a drug. If a drug is contained in our Non-Preferred Brand Name tier, Members may ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Name tier instead.

This would lower the amount the Member pays for the drug. Please note, if AvMed grants a request to cover a drug that is not on our formulary, the Member may not ask us to provide a higher level of coverage for the drug.

AvMed's criteria regarding coverage determinations for exceptions can be found on the website at **AvMed.org**.

Members may request an exception by contacting AvMed's Member Engagement Department or logging into AvMed's website. When requesting a formulary, tiering or utilization restriction exception, Members are advised to include a statement from the Physician supporting the request.

Generally, AvMed must make a decision within 72 hours of getting the statement from the prescribing Physician. Members can ask for an expedited exception if the prescribing Physician believes that a Member's health could be seriously harmed by waiting up to 72 hours for a decision.

TRANSITION

New or continuing Members in our plan may be taking drugs that are not on our formulary. Or they may be taking a drug that is on our formulary but their ability to get it is limited. For example, a Member may need a prior authorization from us before filling a prescription. We advise Members to talk to the Physician to decide whether a switch to an appropriate drug that we cover or a request for a formulary exception is more appropriate. During the time it takes to determine the right course of action for the Member, we may cover the drug in certain cases during the first 90 days the Member is enrolled.
In these situations, AvMed will cover a temporary 30-day supply filled at a Network pharmacy. After the first 30-day supply, we will not pay for drugs, even if the Member has been with the plan less than 90 days.

Details on the transition policy can be found on AvMed's website at **AvMed.org**.

COMMERCIAL MEDICATION EXCEPTION REQUEST FORM

AvMed

PHARMACY/MEDICAL DRUG NECESSITY REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

This form is intended for use when a medication being requested is:
Non-Formulary and/or a specific preauthorization form is not available.

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

PREVIOUS THERAPIES FAILED: Complete information below to ensure authorization will **NOT** be delayed.

Medication Name	Dose	Length of Trial
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

MEDICARE MEDICATION EXCEPTION REQUEST FORM

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
Express Scripts
Attn: Medicare Reviews
PO Box 66587
St Louis, MO 63166-6587

Fax Number:
1-877-328-9660

You may also ask us for a coverage determination by phone at 1-800-935-6103 (TTY: 1-800-716-3231) 24 hours a day, 7 days a week (including holidays), or through our website at https://www.express-scripts.com/pa

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

CHAPTER 5 CONTENTS
MEMBER BENEFITS

This section describes which prescriptions will always be covered and excluded regardless of a Member's coverage. In addition, the various types of eye care benefits are reviewed.

The AvMed Members you treat may have different types of coverage. This means that their copayment, deductible and/or coinsurance for office visits, prescriptions and eye care benefits may vary.

UNDERSTANDING MEMBERS' BENEFITS

AvMed offers many benefit plans and riders. Most plans have varying copayments, deductibles and/or coinsurance, limitations and exclusions. For eligibility and copayment information on a particular Member, please call AvMed's Verification Unit at **1-800-452-8633 (option 1)**, or visit our website at **AvMed.org**.

Please be aware that the copayments associated with various services may differ from plan to plan. Use the Member's ID card to identify the applicable plan.

Expect Members to ask benefit questions. If you are not able to answer their questions, refer all commercial Members to the Member Engagement Department. This telephone number can be found on the Member's ID card.

NEW COMMERCIAL PRODUCTS

AvMed is pleased to introduce a variety of new products. These products have been designed to meet the needs of employers and their employees while maintaining our standards for quality care and patient safety.

While most of AvMed's current membership is not affected by these changes, you should begin to see new Members with these products and benefit designs soon. A description of each of the products and benefit designs as well as sample ID cards for each of the products follows. Please share this information with your office staff. If you have any questions regarding our new products, please feel free to contact AvMed's Verification Unit at **1-800-452-8633**.

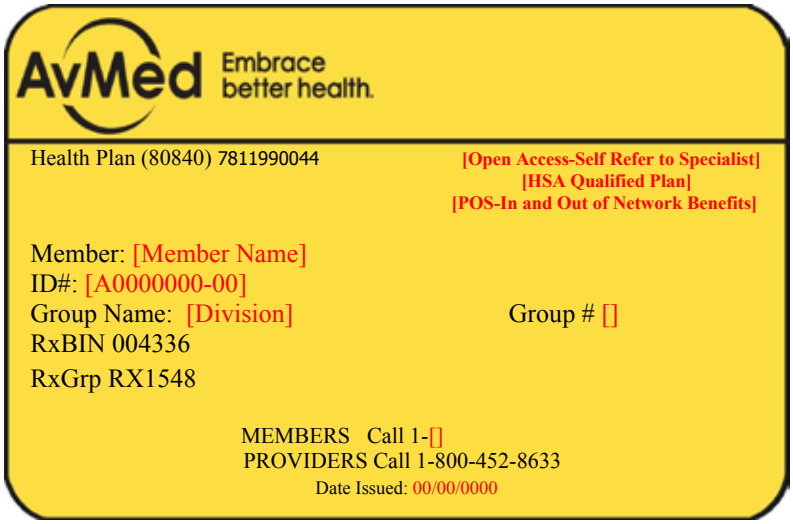
Nonemergency hospital admissions still have a preadmission authorization. AvMed Providers are responsible for making sure that the Member has the appropriate authorization, if required.

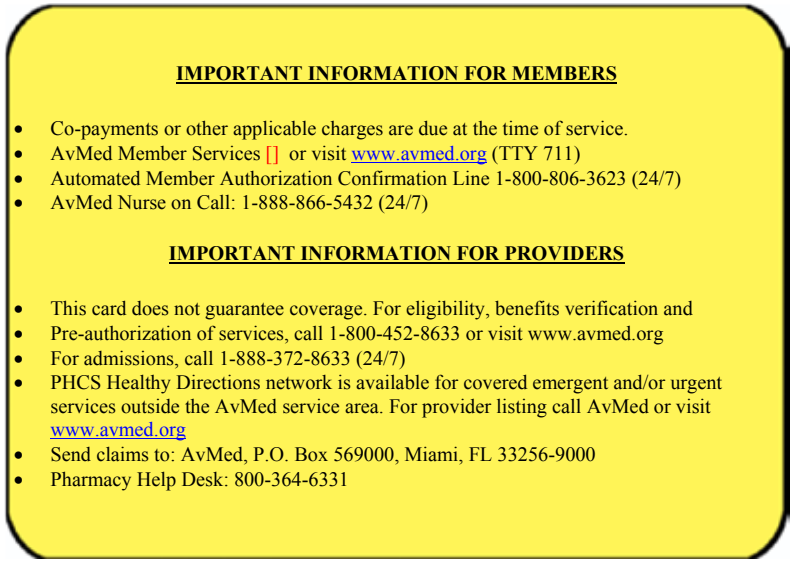
AVMED MEDICARE CHOICE HMO

A Medicare Advantage HMO plan that uses a full Network of AvMed-participating PCPs, specialists, hospitals and other Providers located in Miami-Dade and Broward counties. A Member can use any Provider who is part of the AvMed Medicare Choice HMO Network.

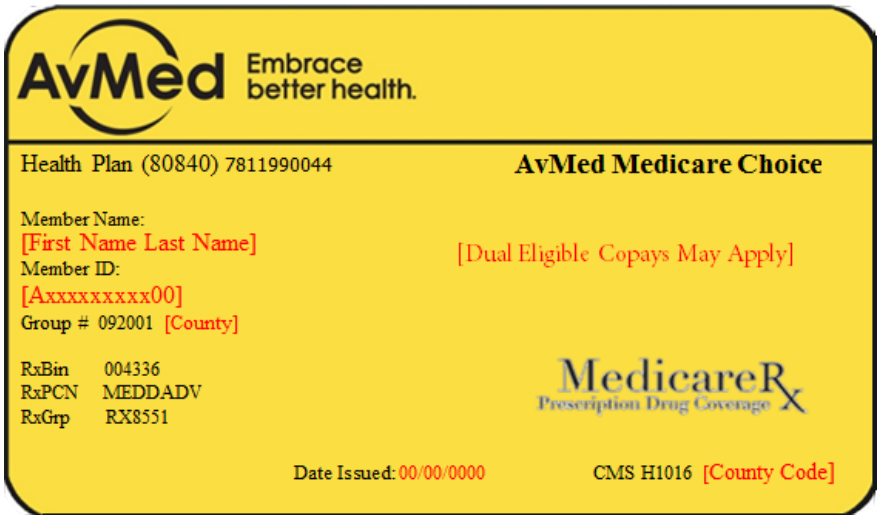
To verify Member eligibility and copayment information for a particular Member, please call the Link Line at **1-800-816-LINK**, or check our website at **AvMed.org**.

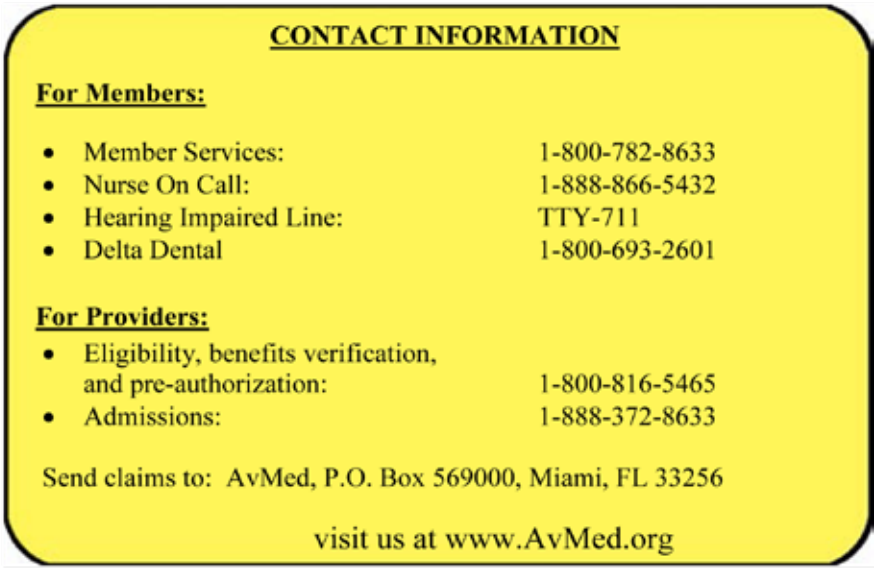
STANDARD COMMERCIAL CARDS





STANDARD MEDICARE CARDS





EYE CARE BENEFITS – EYE EXAMS AND LENSES

All Members are covered for medically necessary eye exams. Medicare Members are covered for special vision care benefits. Please note that vision care is not covered by the POS benefit. In addition, all Members are entitled to a discount on lenses purchased through a participating vision care Provider.

Routine eye exams are covered without authorization for commercial Members less than 18 years of age and for all Medicare Members. Routine eye exams are not covered for most commercial Members 18 to 64 years of age. (Providers can call **1-800-452-8633** to verify vision benefits.) However, our participating vision care Providers do offer a discount to all AvMed Members. The Member Engagement Department can answer questions regarding specific contract provisions.

ELIGIBILITY LISTS

HMO Members

On the first day of each month, Primary Care Physicians should retrieve an "eligibility list" for all Members whose plan requires them to select a PCP. Log on to **AvMed.org** and select **Patients/ Eligibility/ My Panel** to access a list that includes:

- Member name
- Identification number
- Effective date with plan
- Date of birth

The PCP should see only Members that appear on the eligibility list. If a Member requests an appointment and is not on the eligibility list, the Member should call the Member Engagement Department to verify eligibility and PCP assignment. Eligibility information is also available on AvMed's website at **AvMed.org.**

Capitation List (If Applicable)

Capitation lists are mailed at the end of each month for services rendered that month to AvMed Providers with a capitated arrangement.

Non-Payment for Non-Members

AvMed will not be liable for payment of services provided to patients that do not appear on the eligibility list, unless verification has been received from the Member Engagement Department.

MEMBER TRANSFER BETWEEN PCPs

To change PCPs, Members may call the Member Engagement Department to request a change of PCP. The Member must notify and receive approval from AvMed prior to changing PCPs. The Member's change of PCP will become effective on the same day the Member receives approval of the change from Member Engagement. Afterward, the Member may schedule an appointment with a new PCP, and the change will be made effective the date of the appointment.

The Member must personally request this change unless the following occurs:

- Members may be transferred by AvMed to another PCP when the current PCP is terminating from the health plan. It is AvMed's obligation to notify the Member, in writing, of any changes.

- Members may also be transferred if the PCP cannot establish a good Physician-patient relationship, due to the Member's:
  a. Unwillingness to follow the prescribed treatment plan
  b. Excessive lateness or missing more than three consecutive appointments
  c. Physically or verbally abusive behavior toward the Physician, staff or other patients

Provider Request to Terminate a Member From Panel

As the PCP, you have the right, after reasonable efforts to establish and maintain satisfactory Physician-patient or hospital-patient relationship with any Member, to terminate the relationship, giving not less than 30 days' written notice to the Member. Please provide a copy of written notice to AvMed Member Engagement. You can fax a copy notice to the Physician Service Center at **305-671-4936**.

Until the PCP transfer is complete, you must continue to provide services for urgent and emergency care. The Member transfer to another PCP should be completed within 30 days.

MEDICARE MEMBER SERVICE APPEALS

The Centers for Medicare & Medicaid Services (CMS) require that all Medicare Members and Providers be fully informed of appeal procedures. AvMed is required to monitor these procedures.

An appeal (request for consideration) is any expression of dissatisfaction involving an initial determination regarding the denial of a service. CMS requires that written notification be sent to the subscriber following such an event. See the following example:

A Medicare Member visits your office requesting an authorization for a procedure. The PCP feels the care can be more appropriately managed through his or her service. This is considered the **initial determination**.

Following are the steps that should be taken:

- Explain to the Member the reason for denial of request
- Inform Member of his or her right to appeal this decision to AvMed through the Member Engagement Department or through CMS directly
- Follow up with a letter to the Member advising of the right to appeal and the procedure for accomplishing this effort

To assist you in this process, we have attached mportant information about appeal rights that AvMed sends to Medicare Members when a **denial of a service** has occurred through our Pre-Authorization Call Center. Also attached is a sample letter for Notice of Discharge & Medicare Appeal Rights. This sample may be used as a guide in developing your written notification to the Member.

NOTICE OF DISCHARGE AND MEDICARE APPEAL RIGHTS

AvMed
P.O. Box 569004
Miami, FL 33256-9887
352-372-8400
1-800-346-0231

Notice of Discharge & Medicare Appeal Rights

Enrollee's Name: **<<Member Name>>**
Health Insurance Claim (HIC) Number: **<< ID Number>>**
Admission Date: **<<Admit Date>>**
Attending Physician: **<<Doctor>>**
Hospital: **<<Facility>>**

Date of Notice**:<<Today's Date>>**

Discharge Date: **<<D/C Date>>**
Health Plan: AvMed

YOUR IMMEDIATE ATTENTION IS REQUIRED TODAY

Your doctor has reviewed your medical condition and has determined that you can be discharged from the Hospital because (check one):

_____ You no longer require inpatient hospital care.
_____ You can safely get any medical care you need in another setting.
_____ Other _____

This also means that, if you stay in the hospital, it is likely that your hospital charges for **<<date of noon of following day>>** and thereafter will not be covered by your Health Plan.

If you agree with your doctor's discharge decision, you can either read further to learn more about your appeal rights, or you can skip to the end of this notice and sign to show that you have received this notice.

However, if you disagree with your doctor's discharge decision, Medicare gives you the right to appeal. In that case, please continue reading to learn how to appeal a discharge decision, what happens when you appeal, and how much money you may owe.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON, REQUEST AN IMMEDIATE REVIEW

HOW DO YOU GET AN IMMEDIATE REVIEW?

1. KEPRO is the name of the Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients. **You, or your authorized representative, attorney or court-appointed guardian**, must contact the QIO by telephone or in writing at: KEPRO, 5201 West Kennedy Boulevard, Suite 900, Tampa, Florida 33609-1822; phone: **1-800-844-0795** or **1-813-354-9111**; fax: **1-813-354-0737**. If you file a written request, please write, **"I want an immediate review."**
2. Your request must be made **no later than noon of the first working day** after you receive this notice. "Working day" is defined as the days Monday-Friday.
3. The QIO will make a decision within one full working day after it receives your request, your medical records and any other information it needs to make a decision.
4. While you remain in the hospital, your health plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the QIO notifies you of its official Medicare coverage decision.

What if the QIO agrees with your Physician's discharge decision?

If the QIO agrees, you will be responsible for paying the cost of your hospital stay, beginning at noon of the calendar day following the day the QIO notifies you of its Medicare coverage decision.

What if the QIO disagrees with your Physician's discharge decision?

You will not be responsible for paying the cost of your additional hospital days, except for certain convenience services or items (e.g., television, telephone, etc.) not covered by your health plan.

What if you do not request an immediate review?

1. If you **remain** in the hospital and **do not** request an immediate review by the QIO, **you** may be financially responsible for the cost of many of the services you receive beginning [specify date of first noncovered day, which is the date of noon of the first day following receipt of the notice].
2. If you **leave** before [specify date of first noncovered date, which is the date of noon of the first day following receipt of the notice], you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your health plan.

WHAT IF YOU MISS THE DEADLINE TO FILE FOR AN IMMEDIATE REVIEW?

1. If you are late or miss the noon deadline to file for an immediate review by your QIO, you may still request an expedited (fast) appeal from your health plan. A "fast" appeal means your health plan will have to review your request within 72 hours. However, you will not have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your hospital stay beginning [specify date of first noncovered day, which is the date of noon of the first day following receipt of the notice].

HOW DO YOU REQUEST A FAST APPEAL?

You may call or fax your request to the health plan:

AvMed
P.O. Box 569004
Miami, FL 33256-9887
Phone: 1-800-882-8633
Fax: **305-671-4736**

Monday through Friday 8 am-8 pm, Saturday, 9 am-1 pm (TTY 711). Member Service hours may vary slightly by department. For exact hours, please call the number on the back of the Member's AvMed ID card.

- If you filed a request for immediate QIO review, but were late in filing the request, the QIO will forward your request to your health plan as a request for a fast appeal.
- If you are filing a written request, please write, "I want a fast appeal."
- If you or any Physician asks your health plan to give you a fast appeal, your health plan must process your appeal within 72 hours of your request.
- Your health plan may take up to 14 extra calendar days to make a decision if you request an extension, or if your health plan can justify how the extra days will benefit you. For example, you should request an extension if you believe that you or your health plan needs more time to gather additional medical information. Keep in mind that you may end up paying for this extended hospital stay.

PHARMACY BENEFITS/DRUG FORMULARY

Commercial Members

Most Members have a prescription rider for prescription medication coverage, which varies in terms of covered medications, copayments and quarterly maximum benefit dollar amounts. All prescriptions must be filled at a participating pharmacy. In addition to the contracted independently owned pharmacies, AvMed has a pharmacy Network that includes CVS, Winn-Dixie, Walgreens, Publix and Target.

We encourage the use of cost-effective prescribing habits. Use AvMed's continually updated PML for the most current information available. If a Physician or Member requests a brand-name medication when a generic equivalent is available, most Members will have to pay the cost difference between the brand and generic products plus their applicable copayment. This is determined by the Member's prescription benefit.

With a copayment, a Member may receive a partial amount of medication to treat an acute indication, or up to a 30-day supply, whichever is less. Some Members have a prescription medication mail-order benefit and may receive up to a 90-day supply of a maintenance medication for an equivalent of three months copayment.

Members with prescription drug benefits will use one of two preferred drug lists:

Open Formulary With a Three-Tier Preferred Drug List

The Three-Tier Preferred Drug List establishes three levels of copayment for medications within managed therapeutic classes. Therapeutic classes not managed in the three-tier schedule are considered open. Levels of copayment are, in general, applied as follows:

Three-Tier Managed Therapeutic Classes

Tier 1 - Preferred generic medications
Tier 2 - Preferred brand medications
Tier 3 - Non-preferred brand and generic medications

Open Therapeutic Classes

Generic medications
Brand medications

As new medications become available in the market, they will be excluded from coverage in all therapeutic classes until a sufficient amount of information has been collected for review. AvMed's Pharmacy and Therapeutics (P&T) Committee reviews medications in managed therapeutic classes and compares them to medications with similar actions for relative efficacy, relative safety and relative cost. The final decision may be that the medication will remain excluded from coverage. P&T Committee decisions are published on AvMed's website and distributed quarterly. Current preferred listing information can always be found at our website, **AvMed.org**.

Covered medications with available generic equivalents are listed in bold type and will cost Members least.

CHAPTER 6 CONTENTS
PHONE / ADDRESS / FAX

AvMed is here to help if you have questions or need assistance. For your convenience, this section lists AvMed phone numbers, addresses and fax numbers by plan office location and department, as well as a quick reference for important resources on our website.

IMPORTANT RESOURCES

AvMed.org

For general questions and to request supplies:

- **Provider Service Center**
  P.O. Box 569004
  Miami, FL 33256-9004
  Phone: **1-800-452-8633**,
  Fax: **305-671-6149** or **1-877-231-7695**
  Providers@AvMed.org

To obtain authorizations:

- **Prior Authorizations Call Center – (CCD)**
  Phone: (AvMed Link) **1-800-816-5465**
  Fax: **1-800-552-8633**

For authorizations that originate in the ER, or direct admits from the Physician's office:

- **Service Plus**

Phone: **1-888-372-8633** (Monday–Friday 8 am-5:30 pm)
Fax: **1-800-339-3554** (24 hours a day, 7 days a week)

Authorization request forms are available online:
AvMed.org under **Providers**

To confirm authorizations and verify Member eligibility:

- **Provider Service Center**
  Phone: **1-800-452-8633,** authorizations may also be verified online at **AvMed.org** under **Providers**

To submit claims:

- **Claims (Statewide)**
  P.O. Box 569000
  Miami, FL 33256-9000

For claims status and request reviews/appeals:

- **Claims Review/Appeals**
  Phone: **1-800-452-8633,**

Claims status online at our website, under "Providers."

For questions regarding Member benefits:

- **Member Engagement** Phone: **1-800-882-8633**
  Fax: **305-671-4736**
  State of Florida: **1-888-762-8633**
  Small Group, Commercial: **1-800-376-6651**
  IU65: **1-800-477-8768** (Monday-Friday, 8 am-6 pm only)
  MDC: **1-800-682-8633**
  JHS: **1-800-682-8633**
  Medicare: **1-844-439-5378**

Ophthalmology:

For questions regarding benefits, eligibility and authorization:

- **AvMed Provider Services**
  Phone: **1-800-452-8633,**

Optometry:

For general questions (statewide):

- **iCare Health Solutions**
  Phone: **1-855-373-7627** or **786-441-8466**
  Website: **MyiCareHealth.com**

For eye care authorizations:

- **iCare**
  Phone: **1-855-373-7627**

For urgent requests, please call **1-800-816-5465**. A list of the surgical ophthalmology codes that require an authorization is available upon request.

For questions regarding benefits, eligibility, authorization and medical claims for commercial products:

- **Provider Service Center**
  Phone: **1-800-452-8633**

For questions regarding Medicare routine vision eligibility, benefits and authorizations:

- **iCare Health Solutions**
  Phone: **1-855-373-7627** or **786-441-8466**
  Website: **MyiCareHealth.com**

Mental Health/Behavioral Health:
For statewide assistance:

- **Optum**
  1-877-614-0484

For Disease Management:

- **Healthy Living Program**
  1-855-81-AVMED (28633), available 6 days a week.
  Nurses available 24 hours a day, 7 days a week.

To refer suspect issues, anonymously if preferred:

- **Audit Services and Investigation Unit**
  Phone: **1-877-286-3889**

Verify Member eligibility/benefits on our website, under **Providers**

WEBSITE QUICK REFERENCE GUIDE

AvMed.org

Requirements

You will need a username and password to access **AvMed.org**.

Welcome Page

To login:

- Click on **Providers**
- Insert AvMed Provider ID (AvMed six-digit Provider number) or group login
- Insert password
- Click on **Log In** button

Provider Portal

Choose from the following menu options:

- Patients
- Claims
- Authorization
- Tools
- My Profile
- Recent important communications that have been mailed or faxed to Providers can be found here.
- You can provide an e-mail address for communications.

Claim Inquiries

Search by:

- Appeals
- Clear Claim Connection
- Cost Share Calculator
- EDI (electronic claims submission)
- Inquiries
- Online entry
- Reports

For detailed claim information, click on the **Inquiries Claim Number** and insert claim number.

Online Claims Entry – This allows you to submit HCFA claims directly to AvMed via our website.

Clear Claim Connection – You can view how AvMed's code-auditing software evaluates code combinations during the adjudication of a claim by entering certain claim data elements.

To run a claim through Clear Claim Connection, follow these steps:

1. Click one of the gender buttons
2. Enter the Member's date of birth
3. Enter the procedure codes and modifier (optional)
4. Enter the date of service
5. Enter the place of service
6. Diagnosis
7. Click **Review Claim Audit Results**

The results will be shown with a recommended value of **Allow**, **Disallow** or **Review**. A Clinical Edit Clarification will be provided for claims with a recommendation value of **Disallow** or **Review**. To view a Clinical Edit Clarification, double-click on the procedure line, and then click **Review Clinical Edit Clarification**.

Cost Share Calculator – This allows you to calculate an estimate of the patient's responsibility at the time of service for AvMed Members with a deductible and/or coinsurance benefit plan (approximately 6 percent of AvMed's current membership). Please note that this tool supplies an estimate of the final cost for which the Member is responsible. The actual value will not be determined until the claim is adjudicated.

For an estimate of the Member's responsibility with the Cost Share Calculator, follow these steps:

1. Specify your county, the fee schedule your contract stipulates, and the reimbursement percentage, then click **Next**
2. Fee schedule (Medicare fee schedule/AvMed fee schedule)
3. Reimbursement percentage
4. Member number
5. Deductible remaining
6. Applicable coinsurance
7. Type of service (Global, Technical)
8. Next

Patient Eligibility

- Eligibility
- Member ID, name
- Insert Member ID number and search
- Click on Member ID

For detailed Member information (including benefits), click on the highlighted Member ID number.

Provider References

- Find a Doctor
- Find a pharmacy
- Urgent care centers
- Medication lists

- Forms
- Provider Reference Guide
- Guidelines and Standards

Referral Entry

To verify/create a referral for a Medicare Member:
Log in, select **Quick Medicare Referral**, read disclaimer to access third party site (Change Healthcare), and select **I agree**.

To obtain authorizations, or status of an authorization request:

- Enter Member ID number, referred to Provider number, diagnosis code, CPT code
- Click the **Request Authorization** button on Referral Entry screen
- Authorization number with details will be displayed; this information can be printed

Note: At this time, referral entry is limited to services currently authorized automatically via AvMed Link.

P2P Medicare Referral Tool

To verify or create a referral for a Medicare Member:

- Log in and select **Quick Medicare Referral**
- Read disclaimer to access third-party site (Change Healthcare) and select **I agree**

Inquiry

Search by:

- Inpatient census
- Inpatient admission
- Inpatient by tax ID number
- Referred from
- Referred to
- Request by tax ID number

For detailed authorization information, click on the highlighted authorization number. Authorization information can be printed.

In addition, from the AvMed home page via Quick Links, the following can be accessed:

- Find a Physician
- Find a pharmacy
- Find vision Providers
- Urgent care centers
- Products and services
- Medication lists
- Generic forms

Additional Website Resources

- Emergency-preparedness resources
- ePay enrollment forms
- Important communications
- Online Provider Directory
- EDI
- Provider reference guide
- Provider news and publications
- Guidelines and standards
- Quick claim status
- Quick eligibility verification
- My profile
- Fraud Waste and Abuse/ Compliance Traing

If you do not have a username and password, please contact the Provider Service Center at **1-800-452-8633**.

CHAPTER 7 CONTENTS
CREDENTIALIZING

AvMed conducts a thorough credentialing process prior to accepting Physicians into its Network. This section outlines the types of credentialing we utilize and the information we require. This section highlights AvMed's credentialing process and some of the information we require.

INTRODUCTION

An important component of AvMed's Quality Improvement Process is the Credentialing Program. The Credentialing Program is designed to ensure that participating practitioners possess the practice experience, licenses, certifications, privileges, professional liability coverage, education and other professional qualifications to provide a level of quality care consistent with professionally recognized standards.

The Credentialing Committee is composed of a multidisciplinary representation of Participating Community Physicians and is chaired by the Miami Regional Medical Director. The committee meets monthly to review the applications and credentials of each practitioner and makes recommendations for all participants in the AvMed Provider Network, both upon credentialing and re-credentialing.

The Provider will be notified of the Credentialing Committee's decision within 30 days following the committee meeting. Physicians also have the right, upon request, to be informed of the status of their application.

All practitioners have the right to review information submitted in support of their credentialing applications. This information is limited to data that is not peer-review protected and can be obtained by the practitioner from the same primary sources utilized by AvMed.

All practitioners have the right to correct erroneous information submitted to AvMed by another party. In the event that any information obtained during the credentialing process varies substantially from the information provided to AvMed by the practitioner, the practitioner will be notified in writing and asked to submit written clarification. All information obtained in the credentialing process is maintained in a confidential manner.

The practitioner will have fifteen (15) days to advise the Credentialing Department of the error in data submitted by another party. Upon receipt, the practitioner will be sent an acknowledgement letter.

The practitioner will be given thirty (30) days to correct the information with the appropriate agency(ies) and advise the Credentialing Manager

Once notified by the practitioner that the data has been corrected by the appropriate agency(ies), the Credentialing Manager will re-verify the data with the reporting agency(ies).

In the event that the practitioner was denied credentialing/recredentialing based on erroneous information, the practitioner will be afforded the right to submit corrected information for reconsideration by the Credentialing Committee no later than thirty (30) calendar days after the receipt of the denial notice.

There is no appeal mechanism available to a practitioner who is denied initial credentialing into AvMed's Provider Network.

In the event that a practitioner is denied re-credentialing, the practitioner will be given the right to a hearing in compliance with NCQA standards and in accordance with the Health Care Quality Improvement Act.

When selecting Providers, AvMed does not discriminate against sex, race, religion, creed, color, age and/or national origin.

CREDENTIALING

The credentialing process is initiated when an AvMed credentialing application and appropriate documentation is submitted to the Credentialing Department for review. AvMed conducts primary source verification of the below documents.

- Current state license to practice
- Copy of current DEA certificate, if applicable
- Copy of current malpractice liability insurance coverage, or statement of compliance to the state medical malpractice financial responsibility law, as set forth in Florida Statutes Section 458.320

These malpractice limits are preferred but not mandatory:

- $100,000/$300,000: Allied Health and Chiropractors
- $250,000/$750,000: PCPs, Dermatologists and Podiatrists
- $250,000/$750,000: Specialists
- Board certification (if applicable)
- Completion of medical school, internship, residency and/or fellowship
- Copy of W-9
- Copy of curriculum vitae (CV), which reflects, at a minimum, all professional services and all educational activities within the past five years
- Clinical privileges at the hospital designated as the primary admitting facility
- Professional liability claims history
- Investigations or any adverse actions against medical license
- Medicare and Medicaid sanctions
- Physical/mental impairment, or other practice limitations

RE-CREDENTIALING

All participating practitioners are re-credentialed at a maximum of every three years. The re-credentialing process is organized to update and re-verify practitioner credentials, and to assess clinical performance based on information gathered through Quality Improvement activities such as:

- Quality reviews
- Member complaints

If AvMed is unable to re-credential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or sabbatical, but the contract between the organization and the practioner remains in place, AvMed may re-credential the practitioner within 60 days of his or her return.

CHAPTER 8 CONTENTS
QUALITY ACTIVITY

AvMed's Quality Improvement Program is designed to help promote and maintain high-quality medical services for AvMed Members. This section offers an overview of AvMed's Quality Improvement Program and discusses quality standards we require of our Physicians.

QUALITY IMPROVEMENT PROGRAM

The policies, procedures and activities of AvMed's Quality Improvement (QI) Department, committees and related functions are integrated into a single QI Program. AvMed's Board of Directors oversees the QI Program to ensure that the performance of QI functions are timely, consistent and effective.

The QI Committee structure is composed of AvMed's Board of Directors, AvMed's Corporate Quality Improvement Committee (CQIC), chaired by the Physician Quality Executive (PQE); Practitioner Quality Improvement Committee (PQIC), chaired by the Quality Improvement Medical Director; and various committees including, but not limited to, a Credentialing Committee, Member Satisfaction Improvement Committee, Pharmacy and Therapeutics Committee and a Medical Technology Assessment Committee.

Corporate Quality Improvement Committee (CQIC)

AvMed's CQIC oversees the implementation of the QI Program statewide. The CQIC reviews QI activities and makes recommendations to provide consistency and effective management of the QI Program. Peer-review activities of credentialing and re-credentialing functions are delegated to the Credentialing Committee. All recommendations from the CQIC are presented for approval and implementation.

The Corporate Quality Improvement Committee is composed of:

- Physician Quality Executive, Chairperson
- AvMed's Executive(s) appointed by the President/Chief Operating Officer
- Member Engagement Executive appointed by the President/Chief Operating Officer
- Director of Quality, Accreditation and Wellness
- Medical Directors (two) appointed by the President/Chief Operating Officer
- Physicians (two to three) from the Network/Community
- Quality Medical Director
- Network Executive appointed by the President/Chief Operating Officer

The Corporate Quality Improvement Committee is staffed by the following:

- Manager of Quality and Accreditation
- Manager of Quality Performance
- Director of UM
- Director of Risk Management
- Director of Clinical Pharmacy Management
- Director, Disease Management, Case Management, Care Transitions

The functions of the Corporate Quality Improvement Committee are as follows:

- Oversee the implementation of AvMed's QI Program with reports generated by the Practitioner QI Committee. Structured supervision promotes the consistent implementation of QI activities and monitors the effective, appropriate corrective actions for identified problems. The Corporate Quality Improvement Committee also recommends practice guidelines and QI policies to the Board of Directors for approval.
- Make recommendations to address statewide issues requiring changes in policy and benefit design that are identified through QI processes.
- Integrate QI issues from AvMed's service areas to ensure consistency of the QI Program procedures and sharing of information.

- Review the Quality Improvement Annual Evaluation and recommend for approval; assess the overall effectiveness of the QI Program and submit to the President/Chief Executive Officer for Board of Directors' approval.
- Monitor the implementation and effectiveness of corrective action(s) taken across all service areas.
- Review all quality monitors and indicators in order to promote quality care, service and safety to AvMed Members.
- Monitor the integration, coordination and supervision of the Risk Management Program activities through its formal reporting.
- Annually review the QI Program and recommend changes to the Board of Directors for approval.
- Assess and confirm that quality of care and service is delivered to AvMed membership.

Practitioner Quality Improvement Committee (PQIC)

AvMed's Practitioner Quality Improvement Committee (PQIC) monitors specific areas of the program. The Quality Medical Director or Physician Designee has the responsibility for the Practitioner Quality Improvement Committee and serves as Chairperson. All recommendations from the PQIC are presented to the CQIC for approval and implementation.

Practitioner Quality Improvement Committee membership is composed of:

- Quality Medical Director or Physician designee as Chairperson
- Four (4) or more practitioners to include representation from Primary Care and Specialty Physicians from the community
- Medical Director appointed by the President & COO

The Practitioner Quality Improvement Committee is staffed by:

- Director of Quality, Accreditation and Wellness
- Manager of Quality and Accreditation
- Quality Performance Manager
- Medical Director
- Network Designee
- Marketing/Sales Representative (quarterly as needed)
- Corporate Risk Manager (as needed)
- Quality Improvement Project Leads (as needed)
- Clinical Pharmacy Management Designee
- Delegated Behavioral Health Designee (as needed)

The functions of the Practitioner Quality Improvement Committee are to:

- Oversee the implementation of specified areas of the QI Program
- Provide appropriate monitoring of quality care, quality of service and safety for AvMed Members
- Act as a peer-review committee to review the potential quality of care, quality of service and safety issues through focused activities, clinical studies, and performance of Providers and practitioners against established criteria
- Assist in the evaluation of the efficiency and effectiveness of the Quality Improvement Work Plan and the achievement and maintenance of desired outcomes
- Assist in the evaluation of procedures, standards of care, peer-review indicators, and explicit criteria used in the performance of QI activities, and make recommendations for changes to the Director of Quality and Accreditation

- Identify potential problems or issues through analysis of both patterns of practice and outcomes that affect the quality of healthcare
- Propose appropriate corrective actions to resolve quality issues and/or to improve the quality of care and service delivered to Members
- Monitor the implementation and effectiveness of corrective action plans
- Provide feedback to AvMed Providers and practitioners regarding the findings of focused reviews and practice performance reviews
- Assist in the evaluation of quality indicators and activities and recommend corrective action plans for potential or identified quality of care or service problems
- Provide input regarding practitioner performances
- Review the Utilization Management Program and criteria associated with Utilization Management activities

Corporate Health Promotion and Wellness Program – WELLfluent™ Living

AvMed is committed to providing quality preventive health and wellness services to our Members. Our programs include:

- Disease Management programs: Asthma, Cardiac, Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Congestive Heart Failure
- Employer health fairs
- Weight Watchers™
- Smoking cessation
- Choosehealthy™: Discounted rates for fitness center membership, nutritional counseling, relaxation techniques, tai chi, yoga, acupuncture, massage therapy and biofeedback

YOUR ROLE IN QUALITY

1. Every practicing Physician is a participant in the Quality Improvement Program. You may be asked to serve on a Quality Improvement Committee (QIC) or contribute to the development of clinical guidelines, audits, Member education programs, etc.
2. You can help us identify any problems that may impact Member care or safety by reporting them to the Provider Service Center.
3. If a QIC reviews a case that relates to your Member, you may be asked to speak to the committee personally or to provide more information inclusive of copies of the medical records.
4. As per your contract, an Annual Medical Record Review and Appointment Availability Survey may be performed in your office. You will be required to have a specified sample of medical records available for review. Advance notice will be given to assist your staff in obtaining the required medical records prior to a reviewer's arrival. Your cooperation with this process is greatly appreciated.
5. There are other occasions where AvMed may need to review medical records in your office(s) or have copies made of the medical records for inclusion in HEDIS® (Healthcare Effectiveness Data and Information Set), clinical studies or miscellaneous projects. Advance notice will always be given to assist your staff in obtaining the requested medical records prior to the reviewer's arrival. Your participation is required and greatly appreciated.
6. Care Opportunity Reports are now available on the Provider portal. We ask that PCP offices review their Member's gaps prior to a Member's scheduled visit to ensure that during the visit the PCP documents the relevant quality related care that the Member has received and/or provides referral for any necessary care the Member has yet to receive.

REGULATORY AGENCIES

There are multiple agencies that have standards in place with which AvMed must comply.

Agency for Health Care Administration (AHCA)

The Bureau of Managed Care AHCA is a federation of 50 state health organizations. It represents the long-term care community to the nation at large. AHCA is committed to developing necessary and reasonable public policies that balance economic and regulatory principles to support quality care and quality of life, and is dedicated to professionalism and ethical behavior among all who provide long-term care.

Centers for Medicare and Medicaid Services (CMS)

With the passage of the 1997 Balanced Budget Amendment, many substantive changes were dictated for the regulations governing the operations of the federal Medicare program. CMS has initiated a new set of standards for managed care organizations who have a Medicare Advantage contract. All of the required actions for the Medicare Advantage organizations are outlined in Title 42 of the Code of Federal Regulations (CFR), Part 422. These standards affect all aspects of care and service rendered to the Member by a practitioner, facility or plan. Within these standards, Quality Improvement System for Managed Care (QISMC) was initiated.

CMS also contracts with Florida Medical Quality Assurance, Inc. (FMQAI) to ensure that the highest level of quality care is available to given recipients. The Quality Improvement Organization (QIO) is responsible for carrying out the initiative as outlined in the Scope of Work (SOW).

CMS has identified the following requirements of the QIO:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of care
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary, and provided in the most economical setting
- Protect beneficiaries by expeditiously addressing individual cases, such as beneficiary complaints, hospital-issued notices of non-coverage (HINNs), dumping and advance beneficiary notices (ABNs) issued by physicians, and other statutory responsibilities
- The QIO will assist managed care organizations with the National Quality Improvement Projects (NQIP) as mandated.

National Committee for Quality Assurance (NCQA)

NCQA works with the managed care industry to develop standards that measure the quality of care and service provided by the managed healthcare organization. The standards provide a basis for objectively determining whether a managed care organization is founded on principles of quality and is continuously improving the clinical care and services it provides. NCQA reviewers use standards to evaluate managed care organizations in the following areas:

- Quality Management and Improvement (includes medical records)
- Utilization Management
- Credentialing
- Members' Rights and Responsibilities
- Member Engagement
- Network Management
- Population Health Management

Accreditation from NCQA includes an on-site evaluation review based on the standards categories (listed above) and HEDIS®. The goal of

combining both of these evaluation programs for accreditation is:

1. To evaluate health plans based on HEDIS® results.
2. Provide purchasers and consumers with better information.
3. Focus attention on areas of public concern.

PHYSICIAN ASSESSMENT AUDITS

Medical Record Audits

All PCPs and Specialists may receive a medical record review audit. The number of medical records reviewed is based upon the number of AvMed PCPs in the office; the number of AvMed Members seen at the office; and whether or not Member panels are shared. If an on-site review is conducted, results are tallied and scored at the time of review. A corrective action plan will be requested when your score is below AvMed's minimum compliance level.

With the increasing utilization of the electronic medical record (EMR), special attention should be given to the documentation of consultations in the medical record, as well as the initialing of the laboratory/imaging reports by the PCP to indicate that they have been reviewed. Documentation that the Member has/has not executed advance directives also need to be addressed.

Release of Members' Medical Records

As outlined in the Physician's Agreement, the medical records of Members shall be made available, at no charge, to any Provider treating the Member, and shall also be available for Quality Improvement and Utilization Review activities endorsed by AvMed, including state and federal regulatory agencies.

Accessibility and Availability

PCPs may be assessed annually to ensure their compliance with making appointments for Members within the recommended AvMed guidelines. Scores are presented to the PCPs at the time of review. A corrective action plan will be requested when your score is below AvMed's minimum compliance level. (The guidelines are attached in this chapter.)

Member's Satisfaction With PCP

AvMed conducts surveys to determine Member satisfaction with his or her PCP. These surveys are conducted and the results are tabulated for AvMed by an NCQA-certified market research firm. Participants (Members) are chosen randomly from a PCP's Member panel and asked a series of questions regarding their entire experience of care with their PCP. 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.

After-Hours Accessibility

PCPs are assessed annually for Members' ability to reach their PCP after-hours. According to the PCP contract, you or a designee must be available to Members 24 hours a day.

QUALITY IMPROVEMENT STANDARDS/TOOLS

Medical Record Review Standards (Commercial and Medicare Product Lines)

Audit Elements		Acceptance Criteria	
Medical Record Structural Integrity			
1	All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier.	MET: Not MET: N/A	All entries in the Member's MR contain the author's identification Evidence exists that not all entries in the medical record contain the author's identification as prescribed by the standard No exceptions
2	Each page in the record contains the patients name or ID number.	MET: Not MET: N/A	Each page of the medical record contains the information as prescribed by the standard Evidence exists in the medical record that pages within the patient's medical record do not contain the information as prescribed by the standard No exceptions
3	Personal biographical data include the Member name, Member identification number, DOB, gender, address, employer, home and work telephone numbers and marital status. ***Note:*** Pediatric Members are not required to have employer, work telephone number or marital status. For pediatric Members the name of the parent or legal guardian must be present.	MET: Not MET: N/A	Member medical record contains the information as prescribed by the standard. Evidence exists that the Member's medical record does not contain the minimum personal and biographical data as prescribed by the standard. No exceptions.
4	All entries are dated.	MET: Not MET: N/A	All entries in the Member's medical record are dated Evidence exists that entries in the Member's medical record that are not dated as prescribed by the standard. No exceptions
5	Advance directives; ≥ to 18 years of age.	MET: Not MET: N/A	Documentation of advance directives are displayed in a prominent part of the Member's record that he/she has/has not executed an advanced directive. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive in accordance with section 765.110, F.S. NO documentations exists in Member's record documenting if he/she has executed an advanced directive (written instructions for living will or power of attorney). Less than 18 years of age.

QUALITY IMPROVEMENT STANDARDS/TOOLS (CONT.)

Medical Record Review Standards (Commercial and Medicare Product Lines)

Audit Elements		Acceptance Criteria	
Medical Management			
6	Past medical history (for patients seen three or more times) is appropriate to age, and is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.	MET: Not MET: N/A	For patients seen three or more times the medical record contains information as prescribed by the standard Evidence exists that patients seen three or more times do not have information in the medical record as prescribed by the standard Patient not seen by PCP at least three times
7	The reason for the visit/chief medical complaint is documented on each visit.	MET: Not MET: N/A:	Evidence exists in the medical record that the reason of the visit/ chief complaint is documented on each visit. No evidence exists in the medical record that the reason of the visit/chief complaint is documented on each visit. No exceptions
8	A summary of Significant surgical procedures, past and current diagnoses illnesses and medical conditionsare indicated on the problem list (EMR) or in the office notes. This includes any chronic or acute co-morbidity that have occurred in the Member's medical history.	MET: Not MET: N/A	Evidence of a completed problem list is found in the medical record or, Health Maintenance Flow for Members without problems or, Flow Chart indicating a problem is found on the medical record No evidence of a completed problem list is found in the medical record or, No flow Chart indicating a problem is found on the medical record No exceptions
9	All Medications prescribed are indicated on the Medication/Problem list (EMR) or in the office notes.	MET: Not MET: N/A	Evidence of a completed medication prescribed in found in the medical record. No evidence medications are documented when prescribed. No exceptions
10	The evaluation of the patient includes a pertinent history and physical exam.	MET: Not MET: N/A	Documentation exists of subjective assessment, (e.g., of how or when symptoms or injury first occurred, the severity, etc. and,the patient is being seen for a routine history and physical exam. Documentation exists of a objective assessment, (e.g., physical assessment (exam) relevant to the complaint) No evidence exists of how or when symptoms or the injury occurred, and/or, The physical exam is not relevant to the complaint No exceptions

QUALITY IMPROVEMENT STANDARDS/TOOLS (CONT.)

Medical Record Review Standards (Commercial and Medicare Product Lines)

Audit Elements		Acceptance Criteria	
Medical Management			
11	Continuity of care is evidenced if consultation is requested and there is a note from the consultant in the record (includes but is not limited to: Pharmacy Utilization, Home Health, Specialty Physicians, Hospital Discharges, Physical Therapy, Preventive Services/ Risk Assessment).	MET: Not MET: N/A	Documentation of either communication or consultation exists in the medical record that as prescribed by the standard within 90 days of the date of referral. Evidence exists that neither documentation of communication or consultation exists in the medical record that as prescribed by the standard within 90 days of the date of referral. No specialists were used in patient's care or, The review is within 90 days of referral or, There is a written attempt by the PCP to obtain the information.
12	Consultations, Lab/ Imaging, EKG, therapies administered and prescribed,and other reports Reflect PCP's Initials To Signify Review ***Note:*** Review and signature by professionals other than the PCP, such as the nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of Physician review.	MET: Not MET: N/A	Consultation, lab and imaging reports filed in the chart are initialed as prescribed by the standard, and consultation, abnormal lab, and imaging study results have an explicit notation in the record as prescribed in the standard. Evidence exists that consultation, lab and imaging reports filed in the chart are not initialed as prescribed by the standard nor consultation, abnormal lab, and imaging study results have an explicit notation in the record as prescribed in the standard. No consultations or test were ordered.
13	Encounter forms or notes have a notation, when indicated, regarding recommendations, patient instructions, evidenced follow-up care, calls or visits. The specific time of return is noted in days, weeks, months or as needed.	MET: Not MET: N/A	Notations referencing follow-up care, calls or visits are documented as prescribed by the standard Evidence exists in the medical record that notations referencing follow-up care, calls or visits are not documented as prescribed by the standard No exceptions
14	Allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	MET: Not MET: N/A:	Medical record contains information as prescribed by the standard Evidence exists that the medical record does not contain the information as prescribed by the standard No exceptions

QUALITY IMPROVEMENT STANDARDS/TOOLS (CONT.)

Medical Record Review Standards (Commercial and Medicare Product Lines)

Audit Elements		Acceptance Criteria	
Medical Management			
15	Diagnoses or medical impressions are consistent with objective findings.	MET: Not MET: N/A	Diagnosis would be deemed within the standard of care for the findings documented in the medical record. No evidence exists to support the primary diagnosis. Visit is a well visit
16	Appropriate treatment consistent with diagnoses.	MET: Not MET: N/A	The treatment prescribed for the diagnosis is the most effective treatment for documented diagnosis Care does not fall within the standard of care for documented diagnosis No treatment available for diagnosis
17	Plans for further treatment.	MET: Not MET: N/A	If necessary, plans for further treatment are clearly documented in the record. It is not documented in the record that ailment has been healed and there is no evidence of further treatment plans. Evidence that ailment has been healed and there is no need for further treatment

PRIMARY CARE PRACTITIONER & SPECIALIST PHYSICIAN APPOINTMENT AND AFTER-HOURS ACCESSIBILITY STANDARDS

Initial Appointment

Type of Appointment	Criteria	Appointment Examples
Regular and Routine Care / Physical Exam	• Within 1 month (30 calendar days)	• Yearly well female physical exam • Recheck for cholesterol • Stable diabetic follow-up
Behavioral Health	• Within 10 business days • Urgent Care within 48 hours • Care for non-life threatening emergency within 6 hours	• Psychiatric Evaluation • Initial Diagnostic Evaluation • Priority / Urgent outpatient appointments received via CM Referral
Urgent	• Within 48 hours • Office to office interaction or Physician services intervention may be required	• 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	• Within 2-3 days	• Intractable pain • Progressive weakness
Behavioral Health	• Within 10 business days	• Medication Management follow-up • Therapy visit • Psychiatric Testing

Wait Time In Office

Waiting Time: 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.

ADVANCE DIRECTIVES

1. An advance directive is a written instruction, such as a Living Will or Durable Power of Attorney for Health Care, recognized under state law and relating to the provision of such care when the individual is incapacitated.
2. AvMed is required by Florida Law to have written policies and procedures that delineate the healthcare facility's position with respect to state law relative to advance directives.
3. AvMed's medical record review includes documentation that advance directives were discussed with the Member. If the Member has an advance directive, a copy or documentation that one exists should be included in the medical record.
4. Please contact your Network contracting representative for copies of the advance directives brochure presented by AvMed.

ADVANCE DIRECTIVE STATEMENT – FLORIDA LIVING WILL

Florida lawmakers have expressed concern about the number of people in this state who lack the capacity to make decisions about their healthcare. These people may not have a family member or a guardian who can make decisions for them.

The Florida Designation of Health Care Surrogate lets you name someone to make decisions about your medical care – including decisions about life support – if you can no longer speak for yourself. The Designation of Health Care Surrogate is especially useful because it appoints someone to speak for you anytime you are unable to make your own medical decisions, not only at the end of life.

The Florida Living Will lets you state your wishes about medical care in the event that you become persistently vegetative or develop a terminal condition and can no longer make your own medical decisions. The Living Will becomes effective if your death would occur without the use of life-sustaining medical care. (A second physician must agree with your attending physician's opinion of your medical condition.)

The law requires that you sign your Living Will in the presence of two adult witnesses, who must also sign the document. If you are physically unable to sign, you may instruct one of the witnesses to sign the document for you in your presence. At least one of your witnesses must not be your spouse or blood relative.

The next two documents will best ensure that your patients receive the medical care they want when they can no longer speak for themselves.

FLORIDA DESIGNATION OF HEATH CARE SURROGATE SAMPLE FORM

Name: _____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for healthcare decisions:

Name: _____

Address: _____

City: _____ ZIP Code: _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____

Address: _____

City: _____ ZIP Code: _____

Phone: _____

I fully understand that this designation will permit my designee to make healthcare decisions and to provide, withhold or withdraw consent on my behalf to apply for public benefits to defray the cost of healthcare; and to authorize my admission to or transfer from a healthcare facility.

Additional instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: _____

Address: _____

City: _____ ZIP Code: _____

Phone: _____

Name: _____

Address: _____

City: _____ ZIP Code: _____

Phone: _____

Signed: _____ Date: _____

Witness 1 Signed: _____

Address: _____

Witness 2 Signed: _____

Address: _____

FLORIDA LIVING WILL SAMPLE FORM

Declaration made this ____ day of, _____. I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth, and I do hereby declare:

If at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration.

Name: _____

Address: _____

_____ ZIP Code: _____ Phone: _____

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf:

Name: _____

Address: _____

_____ ZIP Code: _____ Phone: _____

Additional instructions (optional):

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration:

Signed: _____

Witness 1 Signed: _____

Address: _____

Witness 2 Signed: _____

Address: _____

ADVANCE DIRECTIVE STATEMENT – FLORIDA LIVING WILL (CONT.)

Therefore, a new law has been enacted which requires hospitals to ask the following questions:

1. Do you have a Living Will?

   Yes No Please attach copy. Copy attached? Yes No

2. Do you have a Durable Power of Attorney?

   Yes No Please attach copy. Copy attached? Yes No

3. Have you completed a legal document designating anyone (other than your family or guardian) to make healthcare decisions for you in the event you were incapacitated and could not make them yourself?

   Yes No If Yes, who?

   Name: _____

   Phone: _____

4. Is this person aware of your choice?

   Yes No

5. Advance directive information given to patient?

   Yes No

This information was given by: _____

This information was obtained by: _____

Date: _____

Member Name: _____

DISROBING/GOWNING GUIDELINES

AvMed is committed to providing quality preventive healthcare and wellness services to our Members. These guidelines are recommended to amplify and reinforce our Members' confidence that they are unquestionably receiving quality medical services and care, and to help protect Providers and their staff against claims and litigation.

Recommended Disrobing/Gowning Procedure

- In the event that gowning is necessary, the clinical staff person who checks in the patient should ask if they want to request a professional staff member to accompany the Provider during the exam. If the patient says "no," the staff member will document (and initial) "pt declines chaperone" on the patient's medical record of the encounter. The Provider should also ask the patient if he or she wishes to have a chaperone or professional staff member present and will also document and sign this information in the medical record. However, if the staff person or Provider believes that a chaperone would be appropriate, then one should attend the exam anyway.
- If the patient requests a chaperone, a professional staff member will be present during the medical examination, and throughout the entire time the patient is in a gown. Staff will document "pt requests chaperone" on the medical record, and document specifically which professional staff member served as a chaperone. The Provider will verify the information and initial.
- A professional staff member, preferably a female, should always attend exams with Providers when breast, pelvic, rectal or femoral pulse exams are conducted on female patients. No choice to refuse the chaperone should be offered to the patient in these cases.
- Providers should always consider providing the patient an explanation of the exam as the exam proceeds, especially with pelvic, breast, rectal, femoral pulse, lung and cardiac exams. An initial explanation should be made before touching the patient. Anytime a patient requests that a particular exam, or portion of an exam, not be performed, that request should be honored and so documented.
- All Providers and staff members are encouraged to wear name tags clearly visible on their upper chest area, which should include their full name and job title. New employees should be issued temporary name tags. Nothing should be attached or affixed to the name tags that covers or obstructs any part of the identifying information.
- Upon entering an occupied exam room, the physicians are encouraged to introduce themselves as Dr. _____ or Physician Assistant _____.
- Any and all complaints received from a Member should be promptly reported to the office manager or designated administrative staff person. All statements should be explored to determine if the Member is verbalizing dissatisfaction with services received.

Proper clinical protocol and good communication are essential to providing the high-caliber medical care that our Members expect and deserve. Your assistance in achieving and maintaining these standards will help to ensure a positive experience for our Members and continued growth of our relationship with your practice.

RISK MANAGEMENT OFFICE SAFETY GUIDELINES

AvMed Members have a right to expect a safe environment where they are receiving healthcare.

AvMed Provider offices and clinics are considered to be places of public accommodation.

A Provider office safety plan provides for reasonable and necessary accommodations to ensure a safe environment for AvMed Members using or visiting the facility.

Federal, state and local laws and ordinances usually require businesses to have a written plan, which includes, but is not limited to, fire reporting and evacuation routes, hurricane evacuation policies, handling and disposal of biohazard and hazardous material, handicap access, and 911 emergencies.

The Provider's site must plan for any event where practitioners are unable to provide care at their place of business due to a fire, hurricane, tornado or other disaster. Therefore, a written contingency plan to shift services to another location or Provider is recommended.

Site Survey Confirmation:
The Credentialing staff will ensure site visits are conducted for practitioners' offices when required, and that these offices meet AvMed's acceptable performance standards for quality, safety and accessibility of offices where care is delivered. Site visits will be conducted as warranted upon receipt of Member complaints.

The following are some criteria that are reviewed:

- Fire alarms and extinguishers are installed
- Building evacuation routes are conspicuously posted and easy to understand
- Exits are clearly marked with no obstruction for egress
- The site is handicap-accessible, and the staff is trained to assist handicapped Members
- There is a policy/procedure for the handling and disposal of hazardous waste and biohazards, and the staff is trained regarding them
- Medications and drugs are properly secured, controlled and documented
- The office/clinic has a written disaster-preparedness plan to provide continuing care in the event of loss of facilities due to accident, fire or other catastrophic disaster
- Hallways and examination rooms are free from obstruction and allow for easy access and freedom of movement

RISK MANAGEMENT INCIDENT REPORTING GUIDELINES

Chapter 641.55 F.S. (d) requires the development and implementation of an incident reporting system based upon the affirmative duty of all Providers and all Agents and Employees of AvMed to report injuries and adverse incidents to AvMed's Risk Manager.

AvMed contracts with Providers who are independent practitioners. Incidents occurring in any independent facility, such as a Physician's office, ambulatory care center, skilled nursing facility or hospital, that contracts with AvMed are to be reported to Risk Management. These incidents include:

- An unexpected or unexplained death of a Member (patient)
- Severe brain or spinal damage to a Member during the care process (patient)
- A surgical procedure being performed on the wrong Member (patient)
- A surgical procedure unrelated to the Member's (patient) diagnosis
- Wrong surgical procedure performed
- Surgical procedures to remove foreign objects remaining from a surgical procedure
- Surgical repairs of injuries from a planned surgical procedure

Timely reporting is required:
It is requested that reports be forwarded to the AvMed Corporate Director of Risk Management within 24 hours of the occurrence by using the attached incident report form and following the instructions on the top of the fax cover sheet.

If you have any questions regarding these guidelines, please call the AvMed Corporate Risk Management Office at **1-800-346-0231**, extension 40635.

AVMED RISK MANAGEMENT INCIDENT REPORT CONFIDENTIAL FAX COVER SHEET

AvMed Risk Management
Incident Report

Cover Sheet

- Complete your identification in the "From" section.
- Transmit both pages of the completed Risk Management Incident Report within 24 hours of the occurrence by either fax or email.
- For assistance call the AvMed Corporate Director of Risk Management at 1-800-346-0231.

Confidentiality: This transmission is a privileged communication and is protected by Florida law

Date: _____

To: AvMed Corporate Director, Risk Management
Fax: 1-352-337-8551 or
Email: daniel.tandy@avmed.org

Phone: 1-800-346-0231

From: _____ (Provider)

1-352-337-8551 _____ (Fax, Phone)

_____ (Address)

_____ (City, State, Zip)

Number of Pages, Including Cover Sheet: _____

Confidentiality Note:
The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity name above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone and return the original message to us at the address above by United States Postal Service.
Thank you.

Updated: 01/2016

AVMED RISK MANAGEMENT MEMBER INCIDENT REPORT SAMPLE

AvMED
Risk Management Member Incident Report

Email to daniel.tandy@avmed.org or Fax to Dan Tandy @ 352-337-8551

INCIDENT REPORT FORM INSTRUCTIONS

This form needs to have all information provided. This form has been created in a way to help you complete the form. As such, there are drop-down boxes in certain fields, including "unknown". It is important that "unknown" be entered in these fields if specific information for that field cannot be determined.

PRIVILEGED AND CONFIDENTIAL **NOT A PART OF THE MEMBER FILE**

I. MEMBER IDENTIFICATION INFORMATION:

NAME (LAST, FIRST, M.I.) _____ DATE OF BIRTH _____ MEMBER NUMBER _____

ADDRESS _____ ☐ MALE ☐ FEMALE

CITY, STATE, ZIP _____ ☐ COMMERCIAL ☐ MEDICARE

II. TIME, DATE & LOCATION OF INCIDENT/INJURY

FACILITY OR PROVIDER OFFICE _____ LOCATION:

ADDRESS _____ ☐ PROVIDER'S OFFICE ☐ OUTPATIENT CLINIC
☐ EMERGENCY ROOM ☐ SKILLED NURSING FACILITY
☐ INPATIENT SURGERY ☐ OUTPATIENT SURGERY
☐ HOSPITAL I/P UNIT ☐ HOME CARE
☐ 23 HOUR OBS UNIT ☐ OTHER: _____

CITY, STATE, ZIP _____ TIME: _____

DATE: _____

IF HOSPITALIZED:

ADMISSION DATE: _____ TIME: _____

NAME OF ADMITTING PHYSICIAN (PROVIDER) _____ DIAGNOSIS(ES) _____

III. NATURE/CAUSE OF INJURY: Incident reports are medical errors that ARE under the practitioner's control. For serious errors, such as unexpected deaths and severe surgical mishaps, please use the Code 15 Form.

ICD-9-CM INJURY CODE: _____

IV. PRE-INCIDENT CONDITION:

☐ ALERT ☐ DISORIENTED ☐ UNCONSCIOUS
☐ SEDATED ☐ CONFUSED ☐ AGITATED
☐ UNKNOWN

RM Incident Report (Rev. 01/2016)

AVMED RISK MANAGEMENT MEMBER INCIDENT REPORT SAMPLE (CONT.)

PRIVILEDGED AND CONFIDENTIAL **NOT A PART OF THE MEMBER FILE**

V. WITNESSES

NAME & TITLE	CONTACT INFORMATION & PHONE NUMBER

VI. ANAYSIS (APPARENT CAUSE) OF THIS INCIDENT:

VII. PHYSICIAN COMMENTS INCLUDING RECOMMENDED TREATMENT:

VIII. DESCRIBE CORRECTIVE OR PROACTIVE ACTION(S) TAKEN:

IX. PERSON MAKING REPORT

NAME: **TITLE:**

PHONE #: **EMAIL:**

PLAN LOCATION: Ft. Lauderdale

* *

FOR USE BY RISK MANAGEMENT ONLY

DATE RECEIVED: **TIME:** **RECEIVED BY:** DANIEL C. TANDY, DIR., RISK MANAGEMENT

INJURY ASSESSMENT: A = GRAVE ☐ B = MAJOR ☐ C = MINOR ☐ D = NO ADVERSE EFFECT ☐ U = CANNOT DETERMINE ☐

INCIDENT TYPE	DEGREE OF INJURY	STATUS
☐ S = SURGICAL	☐ N = NONE	☐ ALERT QI
☐ D = DIAGNOSTIC	☐ T = TEMPORARY	☐ FOLLOW UP WITH CREDENTIALING
☐ A = ANESTHESIA	☐ P = PERMANENT	☐ FOLLOW UP WITH CONTRACTING
☐ E = EMERGENCY CARE	☐ D = DEATH	☐ ALERT SUBROGATION
☐ M = MEDICATION	☐ U = UNKNOWN	☐ TRACK & TREND
☐ O = OTHER		

X. RISK MANAGER'S ANALYSIS:

RM Incident Report (Rev. 01/2016)

CHAPTER 9 CONTENTS
PRACTICE GUIDELINES AND STANDARDS

AvMed is actively involved in the adoption and dissemination of standards, guidelines and related documents relevant to Members for the provision of preventive, acute or chronic medical services and behavioral healthcare services. for use by AvMed's Network Practitioners and AvMed's Members. These documents contain current information related to clinical practice and help practitioners and Members to make decisions about appropriate healthcare for specific clinical circumstances and behavioral healthcare services. It is a convenient and important resource for all healthcare professionals who care for AvMed Members.

If your office needs a hard copy of any of these documents, please call the Provider Service Center at **1-800-452-8633**. You may also email your request to: **Providers@AvMed.org**.

AvMed Clinical Guidelines and Standards
Pediatric and Adult Preventive Care Recommendations and Immunizations
AvMed Medical Technology/Coverage Guidelines
Pharmacy Coverage Guidelines
Preventive Services

CHAPTER 10 CONTENTS
HEDIS / MEDICARE / STARS / HOS / CAHPS

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)/MEDICARE STARS

HEDIS is a nationally recognized Quality Improvement initiative designed by the National Committee for Quality Assurance (NCQA), which examines medical record samples to measure quality on an annual basis. The program is meant to monitor the performance of managed care organizations and is not a physician review.

CMS developed the Medicare Star Ratings in order to help consumers compare health plans and Providers based on quality and performance. The Medicare Star Ratings helps Medicare beneficiaries compare Medicare Advantage (MA) plans, helps educate consumers on quality, and makes quality data more transparent and comparable between plans. Up to 44 unique quality measures are included in the Medicare Part C and D Star Ratings, including success in providing preventive services, managing chronic illness, access to care, HEDIS measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS©) survey, and responsiveness.

HEDIS measures are used to gauge the quality of care health plan Members are receiving. The **HEDIS Measures Provider Matrix** and **Pediactric and Adolescent Provider Matrix** through the Provider portal, provide measure-specific information for needed services and directions on how to close gaps in care for your Members.

Utilizing proper coding practices is the best way to close Member gaps in your Care Opportunity Report, and it reduces the need for medical record reviews. Your Care Opportunity Report can be found by logging into the **Provider Portal**. Care Opportunity report are also available upon request. To request your most up-to-date report, please send an email to CareOpportunities@avmed.org with your name and AvMed Provider ID.

However, if a medical record review is necessary, here are some tips for a smooth HEDIS review:

- Grant remote EMR access, if possible, for the AvMed team to pull the necessary records
- Be flexible when scheduling appointments with the reviewers in your office
- Clarify date/time of appointments, name of reviewer and health plan represented
- Identify patients and pull their medical record charts prior to the reviewer's arrival
- If you have multiple office locations, arrange to have all medical charts available at one location
- Designate an area where the reviewer can sit and work, and provide an electrical outlet so the reviewer can plug in his or her own 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 deadlines

During the annual HEDIS hybrid season (February through May), AvMed partners with a medical record reviewer organization to act on behalf of AvMed to collect and review charts from physician offices. Every effort is made to minimize disruption in patient care activities; HIPAA regulations section 164.506 indicates the routine form you obtain is sufficient for disclosures to carry out healthcare operations. Section 164.506 defines healthcare operations to include quality assessment and improvement activities; such as HEDIS. Therefore, for the purposes of HEDIS review, no specific authorization is required from your patient prior to releasing a copy of the medical record. Under HIPAA regulations, the form you obtain from your patient permitting you to bill AvMed is satisfactory.

In addition, participating Provider and Network agreements, as well as the Member's application for coverage with AvMed, provide a release

of medical record information to AvMed or its designee for Quality Improvement efforts at no charge. Your assistance in the data collection process for HEDIS/Medicare Stars is extremely important to its success.

Click on the **HEDIS Report Card** to review the annual results.

All are made available on the AvMed website at **AvMed.org**.

Medicare Health Outcomes Survey (HOS)

The HOS measure was developed to assess the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its Members over time. It is a longitudinal survey administered each spring to a random sample of Members from eligible organizations. The same group of Members is resurveyed after two years. HOS results can be used to monitor, assess and promote Quality Improvement.

Members are asked to evaluate their most recent experience with their Provider. They are asked if their provider has spoken to them about their physical activity, evaluated their risk of falling, and spoken to them about bladder control issues and how to improve control. Four HOS measures (two functional health measures and two HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Improving Bladder Control

The HOS survey can be found on the CMS website or by clicking on one of the links below:

HOSOnline.org/EN/Survey-Instrument

HOSOnline.org/GlobalAssets/HOS-Online/Survey-Instruments/

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. To be accredited by the National Committee for Quality Assurance, health plans must submit the results of a modified version of the commercial questionnaire. Experiences with Primary Care and Specialist Physicians have significant influence on the survey composite results listed below.

- Getting needed care
- Getting appointments and care quickly
- How well doctors communicate
- Care coordination
- Rating of healthcare quality

Notes

AvMed:
PROVIDER SERVICE CENTER

P.O. Box 569004
Miami, FL 33256-9004
Phone: **1-800-452-8633**,
Fax: **305-671-6149** or **1-877-231-7695**
Providers@AvMed.org

AvMed.org

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