



PHYSICIAN AND FACILITY REFERENCE GUIDE





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CHAPTER 1 CONTENTS

PHYSICIAN RESPONSIBILITIES

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

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PHYSICIAN RESPONSIBILITIES

WHAT WE ASK OF YOU

As a primary care Physician (PCP), you are the Member's personal Physician and first contact point within his or her healthcare delivery system. As such, there are a number of responsibilities you should assume.

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.

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 Employees and management to assist them in their obligation to comply with laws and regulations. These standards are neither exclusive nor complete.

1. AvMed is diligent in its efforts to provide frequent and comprehensive updates to its Employees addressing recent legislative or regulatory changes that may impact the operations of the company. Employees 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 that characterize the service differently than that actually rendered, or claims that do not otherwise comply with applicable program or contractual requirements.
 - 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. AvMed will vigorously enforce compliance and will 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 discussing, agreeing or exchanging information regarding any competitively sensitive information with an Employee of any competitor. Such information includes, but may not be limited to:

1. Prices or premiums charged for managed care or insurance products
2. Any increase, decrease or discount in prices or premiums
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, class or group of Providers
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.

PHYSICIAN RESPONSIBILITIES

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. To ensure that Employees fully understand the importance of upholding this particular standard of conduct, they are required to sign a Statement of Confidentiality at the time of hire and on an annual basis thereafter.

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 contributions to candidates or campaigns should only be made 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.

PHYSICIAN RESPONSIBILITIES

Equal Employment Opportunities/Sexual Harassment

At AvMed, we value diversity in our workforce. We are committed to the principles and practice of equal opportunity and affirmative action. We are committed to continuing to develop and maintain a highly qualified, culturally diverse workforce that is able to meet the cultural and linguistic needs of our Members, Clients and Customers. Furthermore, it is the policy of AvMed to operate under sound and legal employment practices. The objective is to be fair and equitable in the treatment of all Employees and in all situations. This includes at least the following:

1. Selection and placement of any Employee is based on that Employee's qualifications, without regard to race, religion, national origin, gender, age, disability or veteran status.
2. Compensation is in accordance with the Employee's contribution to AvMed, and compensation decisions will be made entirely independent of the considerations listed above.
3. AvMed will provide a safe and healthy work environment for all Employees. AvMed will not tolerate any type of harassment – including sexual harassment – in the workplace and will take appropriate disciplinary action should any instance of harassment be discovered.

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 749

Gainesville, FL 32627-0749

PHYSICIAN RESPONSIBILITIES

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:

- 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** (option 1 for the Link Line or IVR)
- 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 can call AvMed Link, the Member Engagement Department or 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**.

PHYSICIAN RESPONSIBILITIES

MEMBER ENGAGEMENT ONLINE - TEMPORARY CARD REQUEST

AvMed is providing this image as a temporary membership ID card only. This document should be destroyed once you receive your permanent membership card. The card displayed below may not be an exact replica of the membership ID card you will receive in the mail.



Visit us at **AvMed.org**

Classic (Copay Only)

Benefits Information

	Name	ID	Effective Since	Termination
Member				
Group				

Copayments, Coinsurance and Deductibles

Rx	\$ / \$ / \$ C
Rx Deductible	\$
PCP/Spec	\$ / \$
Hospital	\$ / A
ER	\$ / \$
Urgent Care	\$ / \$

Additional Information

NOTICE TO MEMBER:

- Present this card each time health services are sought.
- Copayment (or other applicable charges) are due at the time of service.
- AvMed Member Engagement: 1-800-882-8633 8 am-8 pm, 7 days a week (TTY 711).
- Automated Member Authorization Confirmation Line: 1-800-806-3623.
- AvMed Nurse On Call: 1-888-866-5432 (24 hours a day/7 days a week).

NOTICE TO PROVIDERS:

- This card does not guarantee coverage. For eligibility, benefits verification and preauthorization of services, call 1-800-452-8633.
- For emergent/urgent admissions, call 1-888-372-8633.
- PHCS network is available for emergent/urgent care while outside the AvMed service area. For Provider listing, call AvMed Member Engagement or go to **AvMed.org**.
- Send live claims to:

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

Benefits, eligibility, claims and authorizations can be confirmed by visiting our website at **AvMed.org**
Commercial Rx Bin: 004336 Rx Grp: RX1548
Medicare Rx Bin: 004336, RX PCN: MEDDADV, Rx Grp: RX8551



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

PHYSICIAN RESPONSIBILITIES

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
 - Hours
 - Physicians in your group
 - Phone number
 - Covering Physicians
 - Services you provide
 - Fax number
 - Hospital privileges
 - 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
 - Tax ID number
 - Credentials
 - Board certification
 - Professional liability insurance
 - 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

P.O. Box 569004

Miami, FL 33256-9004

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 a Physician Service Liaison. 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 Physician Service Liaison, 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(11), 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	TISUE 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
83014	HELICOBACTER PYLORI; DRUG ADMINISTRATION
83051	HEMOGLOBIN; PLASMA
83861	MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRATED COLLECTION AND ANALYSIS
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 SEMIQUANTITATIVE, 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
87804	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL
87880	INFECTIOUS AGENT DETECTION BY IMMUNOASAY WITH DIRECT OPTICAL

PHYSICIAN RESPONSIBILITIES

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 AvMed Link at **1-800-816-5465** for preauthorization. Please call the Provider Service Center at **1-800-452-8633** for more information.

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.

MAILINGS YOU WILL RECEIVE

- **Capitation Payment:** The primary care capitation payment, along with a capitation remittance advice report, itemizes the gross monthly capitation payable for each Member on your monthly eligibility list.
- **Quality Activity Reports:** Various Quality Activity and Utilization Review reports mailed to you periodically. These reports include care opportunity, office record reviews, patient satisfaction surveys, pharmacy reports and facility site reviews.
- **AvMed Magazine:** Our quarterly magazine for AvMed Members includes articles on AvMed policies and procedures, as well as health education information.
- **Executive Report:** Our report on healthcare issues and AvMed's performance ratings.
- **Network Newsbrief:** Our quarterly newsletter to AvMed's Participating Physicians on AvMed policies and procedures, as well as health education information.
- **Network News Bulletin:** Monthly update containing relevant Provider information.

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 on not 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, evaluation and/or referral for specialty care.
- Receive information about AvMed, our products and services, our contracted practitioners and Providers, and Members' rights and responsibilities.
- Be informed of the health services covered and available to them or excluded from coverage, including a clear explanation of how to obtain services and applicable charges.
- Access quality care, receive preventive health services, and know the identity and professional status of individuals providing services to them.
- The confidentiality of information about their medical health condition being maintained by the plan and the right to approve or refuse the release of Member-specific information, including medical records, by AvMed, except when the release is required by law.
- Participate in decisions involving their healthcare and to give informed consent for any procedure after receiving information about risk, length of inactivity and choices of alternative treatment plans available regardless of cost of benefit coverage.
- To refuse medical treatment, including treatment considered experimental, and to be informed of the medical consequences of this decision.
- Have available and reasonable access to service during regular hours and to after-hours and emergency coverage, including how to obtain out-of-area coverage.
- A second opinion from another Participating Physician or non-participating consultant in the AvMed service area. *
- Know about any transfer to another hospital, including information about why the transfer is necessary and any alternatives available.
- Be fully informed of the complaint and grievance processes and use them without fear of interruption of health services.
- To make recommendations regarding the plan's Members' rights and responsibilities policies.
- Written notice of any termination or change in benefits, services or the Member's Providers.

* 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.

Members have the responsibility to:

- Choose an AvMed-participating PCP and establish themselves with this Physician. **
- Become knowledgeable about their health plan coverage, including covered benefits, limitations and exclusions, procedures regarding use of participating Providers and referrals.
- Take part in improving their health by maximizing healthy habits.
- Provide accurate and complete information about their health.
- Ask any questions and seek any clarification necessary to adequately understand their illness and/or treatment. Follow the recommended and mutually agreed-upon treatment plan.
- Keep appointments reliably, and promptly notify the Provider when unable to do so.

PHYSICIAN RESPONSIBILITIES

- Fulfill financial obligations for receiving care, as required by their health plan agreement, in a timely manner.
- Show consideration and respect to Providers and Provider staff.

*** Certain AvMed plans do not require that you choose a PCP. However, AvMed encourages all Members to establish a relationship with a PCP, to help coordinate care.*



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.

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REIMBURSEMENTS – Electronic Claims Submission

AvMed receives claims electronically from the following clearinghouses: Availity, Capario, 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 resubmit an original claim form to your respective claims address. Be sure to indicate "second submission" on the claim form.

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

Claims can be corrected if they have been denied, either for invalid information, missing information or both. Do not send corrected claims until you have received either your payment, or a denial of your original claim. 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 Claims Service Department to check reviews and appeals at **1-800-452-8633**, or fax **1-800-452-3847**.

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

ICA FCA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> FECA (LUMP SUM) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S ID NUMBER (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/YY) SEX (M/F)					
4. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		5. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 8. OTHER INSURED'S POLICY OR GROUP NUMBER 9. RESERVED FOR NUCC USE 10. RESERVED FOR NUCC USE 11. RESERVED FOR NUCC USE 12. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: 11. EMPLOYMENT? (Current or Previous) 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 13. OTHER CLAIM ID (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) If yes, complete items 3, 5a, and 5b.					
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 (MM/DD/YY) QUAL: _____		15. OTHER DATE (MM/DD/YY) QUAL: _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. OUTSIDE LAB? (Yes/No) \$ CHARGES		20. PERMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24)) (ICD-9-CM)		22. PHYSICIAN AUTHORIZATION NUMBER		23. REFERRING PROVIDER INFO & PH #			
24. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (EMG) C. PROCEDURE, SERVICE, OR SUPPLIES (Establish Unusual Circumstances) (CPT/HCPCS) D. MODIFIER E. DIAGNOSIS (ICD-9-CM) F. \$ CHARGES G. \$ COINSURANCE H. \$ DEDUCTIBLE I. \$ CO-PAY J. \$ OUT-OF-POCKET K. \$ TOTAL L. \$ PAID M. \$ REMAINING PROVIDER INFO #		25. FEDERAL TAX ID NUMBER SSN (99) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For 99, 9929, 99299, not task) (Yes/No) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Paid for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this claim and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #			
SIGNED: _____ DATE: _____		SIGNED: _____ DATE: _____		SIGNED: _____ DATE: _____			

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



SAMPLE MEDICAL PRIOR AUTHORIZATION REQUEST FORM

Clinical Coordination Department



Medical Prior Authorization Request Form

Phone: 1-800-816-5465

Fax: 1-800-552-8633

Standard: Submit requests 10-15 days prior to the anticipated date of service

Expedited: Call when MD orders care to be performed within 72 hours.

Post Service: Submit via Fax within 5 days of service date

- **All fields are REQUIRED.** An incomplete request form will delay the authorization process.
- **Most authorization requests are considered standard unless care is medically necessary in 72 hours or less.**
- **Definition of STAT/Expedited/Urgent requests:** must be supported by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected in any of the following:
 - Serious jeopardy to the health of the patient, including pregnant women or her fetus.
 - Serious impairment to bodily functions; serious dysfunction to any organ or body part.

Member Information			
Last Name	First Name	ID # A	
Date of Birth	Gender F <input type="checkbox"/> M <input type="checkbox"/>	Date of Service	
Requesting Provider Information (Primary Care or Specialist)			
Name	Provider #	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 #	Tax ID	
		NPI	
Telephone/Ext	Fax	Contact Person	
Requested Service - Please Include supporting chart notes, Diagnostic tests & Lab Values when appropriate.			
<input type="checkbox"/> In Patient Admission	<input type="checkbox"/> Out Patient Surgery	<input type="checkbox"/> Specialty Lab	<input type="checkbox"/> Non Par Provider
<input type="checkbox"/> Observation	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Predetermination	<input type="checkbox"/> Non Par Facility
<input type="checkbox"/> Wound Care (Facility)	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Other
<input type="checkbox"/> Wound Care (WTN)	<input type="checkbox"/> Admin. of Medication	<input type="checkbox"/> Transplant	
<input type="checkbox"/> Clinical Trial	<input type="checkbox"/> Medicare	<input type="checkbox"/> Commercial	No Auth. required for CMS approved clinical trials –Medicare only.
Diagnosis: ICD Code and Description			
Code	Code	Code	
Description	Description	Description	
Procedure: CPT Code and Description			
Code	Description		
Code	Description		
Code	Description		
Provide additional information or changes to be made to an existing authorization below			

Medical Prior Auth Request Form January_2016

SAMPLE REQUEST FOR REVIEW / APPEAL FORM



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

PAYMENT AND DENIAL CODE EXPLANATIONS

EXCODE	DESCRIPTION
EX01	DENY-PR-COVERED BY PREPAYMENT - NO ADDITIONAL REIMBURSEMENT DUE
EX02	DENY-PR-RESUBMIT TO PARITY HEALTHCARE
EX12	BN-PENDING TO EVALUATE IF DUE TO INJURY / NATURAL SOUND TEETH
EX21	DENY-AU-MEDICAL NECESSITY FOR ROOM & BOARD NOT ESTABLISHED
EX23	DENY-PR-OFFICE VISIT CODES NOT PAYABLE FOR EMERGENCY ROOM VISITS
EX32	DENY-AU-AN AUTHORIZATION IS NOT ON FILE FOR THIS MEMBER
EX33	DENY-PR-RESUBMIT TO PRIMARY PLUS FOR PAYMENT
EX36	PR-DENY-THIS MEMBER HAS ALREADY HAD A POSTPARTUM VISIT
EX42	PAY-PR-PAYMENT LIMITED PURSUANT TO FEDERAL REG CFR 42, SEC 422.214
EX44	DENY-PR-YOU MUST FILE A CLAIM WITH CHIRO-ALLIANCE CORP
EX45	DENY-PR-YOU MUST FILE A CLAIM WITH PMMI
EX50	DENY-AU-AN AUTHORIZATION IS NOT ON FILE FOR THIS MEMBER
EX61	DENY-AU-AN AUTHORIZATION IS NOT ON FILE FOR THIS MEMBER
EX89	BN-EXAMINER TO EVALUATE IF BILLED WITH A LEG BRACE OR PTE HAS PREV HX
EX99	PAY-CL-ALLOWABLE CHARGES *
EXA0	DENY-BN-NO COVERAGE FOR ARTIFICIAL AID OR CORRECTIVE APPLIANCE
EXA2	DENY-BN-NON-NETWORK PROVIDERS ARE NOT COVERED, PAR PROVIDERS AVAILABLE
EXA3	DENY-BN-THIS SERVICE(S) IS NOT AN EMERGENCY PER DIAGNOSIS
EXA4	DENY-SERVICE NOT PAYABLE. ELIGIBILITY VERIFICATION REQUIRED FROM MEMBER
EXA5	DENY-BN-BENEFIT TYPE EXHAUSTED FOR APPLICABLE GROUP/CALENDAR YEAR
EXA6	DENY-BN-THIS SERVICE OCCURRED AFTER THE TERMINATION OF PLAN COVERAGE
EXA7	DENY-BN-THIS SERVICE OCCURRED PRIOR TO PLAN'S EFFECTIVE DATE OF COVERAGE
EXA8	DENY-BN-THIS SERVICE(S) IS NOT COVERED UNDER YOUR BENEFIT PLAN
EXA9	DENY-BN-SUICIDE ATTEMPT IS NOT A COVERED BENEFIT UNDER YOU PLAN
EXAA	DENY-MB-THE MEMBER IS INELIGIBLE AT THE TIME OF SERVICE
EXAB	DENY-BN-A MODIFIER IS REQUIRED FOR THIS TYPE OF SERVICE
EXAC	DENY-BN-MEDICAL NECESSITY IS NEEDED FOR REPLACEMENT OF GLASSES
EXAE	DENY-AU-AN AUTHORIZATION IS NOT ON FILE FOR THIS MEMBER
EXAF	DENY-AU-THE SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
EXAG	DENY-AU-THE SUBSCRIBER IS INELIGIBLE AT THE TIME OF SERVICE
EXAH	DENY-BN-THE SERVICE IS NO LONGER A BENEFIT
EXAI	DENY-AU-CLAIM DENIED AFTER PHYSICIAN REVIEW
EXAJ	DENY-BN-THIS SERVICE EXCEEDS THE BENEFIT LIMITATION
EXAK	DENY-CL-D.O.S IS BEYOND 120 DAYS FROM DATE OF RECEIPT.DO NOT BILL MEMBER
EXAL	DENY-CL-D.O.S.IS BEYOND 180 DAYS FROM DATE OF RECEIPT.DO NOT BILL MEMBER
EXAM	DENY-CL-D.O.S.IS BEYOND 90 DAYS FROM DATE OF RECEIPT.DO NOT BILL MEMBER
EXAN	DENY-CL-AMOUNT CHARGED FOR SERVICE EQUALS ZERO
EXAO	DENY-MB-DIVISION DOES NOT HAVE A DIVISION -SPAN RECORD
EXAP	DENY-PI-GLOBAL/PACKAGE RATE MAY BE EXCEEDED
EXAQ	DENY-PR-YOU MUST FILE A CLAIM WITH PHYSICIANS CONSULTANT & MGMT. CORP.
EXAR	DENY-PR-THIS SERVICE IS NOT PAYABLE ACCORDING TO YOUR SPECIALTY
EXAS	DENY-PR-THIS SERVICE IS PAYABLE, BUT MEMBER NOT IN YOUR PANEL
EXAT	DENY-PR-NOT PAYABLE AS STAT. PAYABLE AT AVMED CONTRACTED LAB PROVIDER
EXAU	DENY-PR-LAB TEST IS PAID TO CONTRACTED PROVIDER UNLESS MARKED AS STAT

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXAV	DENY-PR-THIS SERVICE IS INCLUDED IN NEWBORN GLOBAL PAYMENT
EXAW	DENY-PR-THIS SERVICE NOT INCLUDED IN YOUR CONTRACTUAL AGREEMENT
EXAX	DENY-BN-INDIVIDUAL MAX. DOLLAR LIMIT HAS BEEN MET FOR THIS BENEFIT
EXAY	DENY-PR-THIS MEMBER HAS ALREADY HAD AN ANNUAL OBGYN VISIT
EXAZ	DENY-PR-LAB TEST IS PAID TO CONTRACTED PROVIDER, UNLESS MARKED AS STAT
EXB0	DENY-BN-90 DAY WAITING PERIOD FROM MEMBER'S EFF. DATE NEEDED FOR GLASSES
EXB1	DENY-BN-TYPE OF BENEFIT WAS NOT IN EFFECT WHEN SERVICE WAS RENDERED
EXB2	DENY-BN-YOUR BENEFIT PLAN DOES NOT COVER COSMETIC SURGERY
EXB3	DENY-CL-EXCEEDS MAXIMUM AMOUNT ALLOWED PER LIFETRACT CONTRACT
EXB4	DENY-BN-PHYSICAL EXAM FOR SCHOOL, FAA, OR EMPLOYMENT IS NOT COVERED
EXB5	DENY-BN-MATERNITY BENEFIT FOR DEPENDENT CHILDREN NOT COVERED
EXB6	DENY-BN-THIS ITEM IS EXCLUDED FROM COVERAGE UNDER PRESCRIPTION BENEFIT
EXB7	DENY-BN-NO BENEFIT COVERAGE FOR OVER-THE-COUNTER MEDICATION(S)
EXB8	DENY-BN-THIS SERVICE EXCEEDS PRE-EXISTING LIMITATION AMOUNT
EXB9	DENY-BN-AN ANNUAL GYN EXAM WAS ALREADY PAID FOR THIS CALENDAR YEAR
EXBA	DENY-BN-SEND TO DENTAL CARRIER
EXBB	DENY-BN-THIS IS A NON COVERED DRUG ITEM UNDER YOUR BENEFIT PLAN
EXBC	DENY-BN-PRESCRIPTION DOLLAR LIMIT HAS BEEN EXHAUSTED
EXBD	DENY-PI-YOU MUST FILE A CLAIM WITH SURGICAL ASSOCIATES OF SOUTH FLORIDA
EXBE	DENY-CL-THIS SERVICE IS TO BE PROCESSED UNDER MEMBER'S INDEMNITY BENEFIT
EXBF	DENY-CL- SERVICE NOT PAYABLE DUE TO ASSISTANT NOT ALLOWED FOR THIS SURG
EXBG	DENY-CL-SEVERAL ITEMS MISSING TO PROCESS THIS CLAIM FOR REIMBURSEMENT
EXBH	DENY-CL-MISCELLANEOUS CODE FOR CONVERSION PURPOSE
EXBI	DENY-CL-COLLECTION OF SPECIMEN PAYABLE ONLY WHEN USING OUTSIDE LAB
EXBK	DENY-CL- *NO PAYMENT DUE* PROCESSED ACCORDING TO AVMED GUIDELINES
EXBL	DENY-CL-NOT REIMBURSABLE UNDER CAPITATION. BILL SEPARATELY
EXBM	DENY-CL-PROCEDURE IS NOT VALID FOR EXTRACTED TEETH
EXBN	DENY-CL-SERVICE(S) BY A "PHYSICIAN ASSISTANT" IS NOT COVERED BY AVMED
EXBO	DENY-CL-NO COVERAGE FOR PERSONAL INJURY PROTECTION DEDUCTIBLE
EXBP	DENY-MB-THE CONTRACT'S UNDERWRITING STATUS IS NOT ELIGIBLE
EXBQ	DENY-CL-THIS AMOUNT EXCEEDS THE SEMI PRIVATE ROOM RATE
EXBR	DENY-CL- MISSING OR INVALID DX. (SEND INFO. AS A REVIEW)
EXBS	DENY-CL-PAYABLE THROUGH PRESCRIPTION DRUG PROGRAM. CONTACT PHARMACY
EXBT	DENY-CL-NOT A VALID VISTA REFERRAL
EXBU	DENY-CL-SERVICE(S) NOT AUTHORIZED BY VISTA
EXBV	DENY-CL-PERSONAL CONVENIENCE ITEM(S) NOT COVERED
EXBW	DENY-CL-NON- COVERED ITEM(S)
EXBX	DENY-CL-VITAMINS AND NUTRITIONAL SUPPLEMENTS ARE NOT COVERED
EXBY	DENY-PI-ONLY THE GREATEST BASIC ANESTH. VALUE IS PAID FOR MULTIPLE SURG.
EXBZ	DENY-PR-A MORE SPECIFIC PRINCIPAL DIAGNOSIS REQUIRED/SUBMIT AS A REVIEW
EXC1	DENY-PR-CLAIM WITHIN DEBARMENT PERIOD - DO NOT BILL MEMBER
EXC2	DENY-BN-MBR'S 18/ OLDER EXCLUDED FOR EYE EXAMS FOR CORRECTION OF VISION
EXC3	DENY-BN-OP MH/SA VISITS HAVE BEEN EXHAUSTED FOR CONTRACT YEAR
EXC4	DENY-BN-IP MH/SA VISITS HAVE BEEN EXHAUSTED FOR CONTRACT YEAR
EXC5	DENY-BN-THIS DENTAL SERVICE(S) IS NOT COVERED UNDER YOUR PLAN BENEFITS

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXC6	DENY-PR-NO PAYMENT DUE - PROCESSING ACCORDING TO AVMED GUIDELINES
EXC7	DENY-CL-AVMED NO LONGER ACTS AS TPA FOR GROUP
EXC8	DENY-CL-CHARGES NOT PAYABLE ACCORDING TO CONTRACT
EXC9	INFO-CL-THIS CLAIM IS PART OF A SETTLEMENT-DO NOT ADJUST
EXCA	DENY-CR-SERVICE DENIED AFTER REVIEW OF CURRENT PROCEDURE CODE GUIDELINES
EXCB	DENY-PR-PAYMENT ISSUED IN PREVIOUS SETTLEMENT
EXCC	DENY-PR--SERVICE BILLABLE ONCE PER DAY
EXCD	DENY-PR-SERVICE BILLABLE THREE TIMES PER DAY
EXCE	DENY-PR-SERVICE NOT BILLED ACCORDING TO YOUR CONTRACTUAL AGREEMENT
EXCF	DENY-PR-SERVICE BILLABLE TWO TIMES PER DAY
EXCG	DENY-AU-MANAGED DRUG REQUESTED - AVMED COVERAGE GUIDELINES NOT MET
EXCH	DENY-PI-PLEASE RESUBMIT CLAIM ELECTRONICALLY
EXCI	DENY-CL-BILL MEDICARE AVMED NOT RESPONSIBLE FOR PAYMENT OF DEFIBRILLATOR
EXCK	DENY-ANESTHESIA SERVICE BILLED INCORRECTLY FOR AN IN OFFICE PROCEDURE
EXCL	DENY-CL-CLAIM SUBMITTED BEYOND TIMELY FILING LIMIT
EXCM	DENY-CL-SERVICE CONSIDERED CONCURRENT CARE PROVIDED BY SAME SPECIALTY
EXCN	DENY-CL-CONSULT REPORT WAS NOT RECEIVED. DO NOT BILL MEMBER
EXCO	DENY-CL-DOCUMENTATION DOES NOT SUPPORT CODE BILLED. DO NOT BILL MEMBER
EXCP	DENY-CL-THIS SERVICE IS INCLUDED IN CRITICAL CARE PAYMENT
EXCQ	DENY-CL-AMT. REFLECTS MULTIPLAN'S AGREEMENT DISCOUNT. DO NOT BILL MEMBER
EXCR	DENY-CR-SERVICE DENIED DUE TO CURRENT PROCEDURE CODING GUIDELINES
EXCS	DENY-CL-CAP. EOB FROM AUTO INS. CARRIER NOT ATTACHED. DO NOT BILL MEMBER
EXCT	DENY-CL-CLAIM NOT PAYABLE BY AVMED. CONTACT SUBSCRIBER'S EMPLOYER
EXCU	DENY-CL-CLAIM NOT PAYABLE BY AVMED. BILL MEMBER
EXCV	DENY-MB-THIS SERVICE OCCURRED PRIOR TO PLAN'S EFF. DATE OF COVERAGE
EXCW	DENY-CL-CAP. NO MP-1488 FORM ATTACHED. DO NOT BILL MEMBER
EXCX	DENY-ADJ-CHARGE(S)DOES NOT EXCEED AGREEMENT WITH HOSP.FOR ADD'L PAYMENT
EXCY	DENY-CL- DENIED DUE TO PRE/POST OPERATIVE CARE INCLUDED IN SURGERY FEE
EXCZ	DENY-CL-INVALID REVENUE CODE. DO NOT BILL MEMBER
EXD0	DENY-PR-NOT A REIMBURSABLE REVENUE CODE
EXD1	DENY-PR-NOT A REIMBURSABLE SERVICE
EXD2	DENY -PR- BUNDLED-INCIDENT TO THE OTHER SERVICES
EXD3	DENY-PR-PREADMISSION TESTING INCLUDED IN PAYMENT FOR ADMISSION
EXD4	DENY-PR-MISSING OR INVALID SERVICE CODE - SEND CORRECT CODE AS A REVIEW
EXD5	DENY-PR-RESUBMIT WITH A VALID OR CORRECT CPT CODE
EXD6	DENY-CB-MANUAL-EOB FROM PRIMARY CARRIER NOT RECEIVED. AVMED NOT PRIMARY.
EXD7	DENY-PR-SERVICE COVERED UNDER CAPITATION AGREEMENT
EXD8	DENY-CB-INFORMATION REGARDING OTHER INSURANCE COVERAGE NOT RECEIVED
EXD9	DENY-CL-MAN-INFO REGARDING POSSIBLE PRE-EXISTING CONDITION NOT RECEIVED
EXDA	DENY-CANCEL-AU-NO AUTHORIZATION NEEDED FOR THIS SERVICE
EXDB	DENY-CANCEL-AU-AUTHORIZATION ALREADY EXISTS FOR THIS SERVICE
EXDC	DENY-CL-CLAIM IS A DUPLICATE OF A PENDED CLAIM AWAITING ADDTL INFO
EXDD	DENY-CL-DUPLICATE OF A PREVIOUSLY DENIED CLAIM
EXDE	DENY-CL-NO PAYABLE BENEFIT DUE TO DEPENDENT NOT COVERED UNDER THE PLAN
EXDF	DENY-CB-INFORMATION ON ACCIDENT DETAILS & SPOUSE INSURANCE NOT RECEIVED

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXDG	DENY-CB-INFORMATION REGARDING SPOUSE'S INSURANCE COVERAGE NOT RECEIVED
EXDH	DENY-CB-EOB FROM OTHER INSURANCE CARRIER NOT RECEIVED/AVMED NOT PRIMARY
EXDI	DENY-CB-EOMB FROM MEDICARE INTERMEDIARY NOT RECEIVED/AVMED NOT PRIMARY
EXDJ	DENY-CB-INFORMATION REGARDING SLIP & FALL/ACCIDENT/MVA DETAILS NOT REC'D
EXDK	DENY-CB-INFORMATION REGARDING CHILD'S NATURAL PARENT'S INS. NOT RECEIVED
EXDL	DENY-CB-INFORMATION REGARDING MOTOR VEHICLE ACCIDENT NOT RECEIVED
EXDM	DENY-CB-THIS PLAN DOES NOT COVER WORKER'S COMPENSATION RELATED SERVICE
EXDN	DENY-CL-MISSING REPORT OR NOTES TO PROCESS CLAIM, SEND INFO AS A REVIEW
EXDO	DENY-CL-INFO. REGARDING POSSIBLE PRE-EXISTING CONDITION NOT RECEIVED
EXDP	DENY-CL-THIS CLAIM WAS PREVIOUSLY PAID
EXDQ	DENY-CANCEL-AU-PROVIDER REQUEST
EXDR	DENY-CANCEL-AU-AUTH HAS BEEN SUPERSEDED/OVERRIDDEN BY ANOTHER
EXDS	DENY-CANCEL-AU-OTHER (INCLUDING NARRATIVE)
EXDT	DENY-CL-LINE DENIED DUE TO MISSING TOOTH# OR LETTER (SEND INFO AS REVIEW
EXDU	DENY-CL-ITEMIZED BILL NOT RECEIVED (SEND INFO AS A REVIEW)
EXDV	DENY-CL-NO INVOICE SUBMITTED WITH CLAIM
EXDW	DENY-CL-CLAIM DENIED DUE TO "PROOF OF PAYMENT" NOT RECEIVED
EXDX	DENY-PR-PROCEDURE CODE OR CONTRACT NOT VALID AT TIME OF SERVICE
EXDY	DENY-PR-PARTICIPATION IN DRUG REPLACEMENT PROGRAM
EXDZ	DENY-PR-PROFESSIONAL SERVICES MUST BE BILLED BY THE PHYSICIAN
EXEA	DENY-CL-INFORMATION REQUESTED NOT RECEIVED
EXEB	DENY-AU-NEED REFERRAL FROM CURRENT PCP
EXEC	DENY-AU-SERVICE IS INVESTIGATIONAL OR EXPERIMENTAL
EXED	DENY-AU-MEDICAL NECESSITY NOT ESTABLISHED
EXEE	DENY-AU-HOSPITAL CONFINEMENT WAS CEASED AS PER MEDICAL DEPARTMENT REVIEW
EXEF	DENY-CR-PROCEDURE REPLACED DUE TO CURRENT PROCEDURE CODING GUIDELINES
EXEG	DENY-AU-MEMBER TO PAY DIFFERENCE BETWEEN BRAND NAME AND GENERIC DRUGS
EXEH	DENY-AU-LATE NOTIFICATION - SERVICE PERFORMED PRIOR TO AUTHORIZATION
EXEJ	DENY-AU-REQUESTED PROVIDER NOT CONTRACTED FOR THIS PROCEDURE
EXEL	DENY-CL-NO PAYABLE BENEFIT DUE TO DEPENDENT NOT COVERED UNDER THE PLAN
EXEN	DENY-CL-EXTENSION OF BENEFITS. PLEASE SUBMIT CLAIM TO THE PRIOR CARRIER
EXER	DENY-PR-EMERGENCY ROOM FOLLOW UP VISITS INCLUDED IN INITIAL VISIT
EXEX	DENY-MB-SERVICES NOT COVERED DUE TO PRE-EXISTING CONDITION
EXF6	DENY-PR-THIS SERVICE IS INCLUSIVE OF PART A PAYMENT MADE TO HOSPITAL
EXF7	DENY-BN-NON EMERGENCY TRANSPORTATION IS COVERED ONLY WHEN AUTHORIZED
EXF9	CL-DENY NO RECORD OF IMPLANTABLE PUMP/RESERVOIR.SEND DOCUMENT AS REVIEW
EXFB	PAY-PR-CLAIM PAID ACCORDING TO MEMBER REIMBURSEMENT GUIDELINES
EXFC	PAY-CL-PAYMENT AMT PER NEGOTIATION WITH CONCENTRA PREFERRED SYSTEMS
EXFD	PAY-CL-DISCOUNT TAKEN THROUGH TRPN/MCS
EXFE	PAY-CL-DISCOUNT TAKEN THROUGH IHP
EXFF	PAY-CL-DISCOUNT TAKEN THROUGH PPONEXT
EXFG	DENY-AU-NON-FORMULARY DRUG REQUESTED - AVMED COVERAGE GUIDELINES NOT MET
EXFH	DENY-PR-FHCP
EXFI	PAY-CL-BEECH STREET ACCELERATED PAYMENT NEGOTIATED RATE APPLIED
EXFJ	PAY-CL-DISCOUNT TAKEN THROUGH TRPN

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXFK	DENY-PR-INTERPRETATION NOT BILLABLE/INAPPROPRIATE MODIFIER BILLED
EXFL	DENY-PR-INTERPRETATION CODES NOT BILLABLE WITH THIS PROCEDURE
EXFM	DENY-PR-SERVICE INCLUDED UNDER MATERNITY GLOBAL
EXFO	INFO: SPECIFIC WARN/LOSS LIMIT HAS BEEN REACHED. NOTIFY TPA SL UNIT.
EXFP	PAY-CL-DISCOUNT TAKEN THROUGH MRI
EXFQ	PAY-CL-DISCOUNT TAKEN THROUGH DEVON
EXFR	PAY-CL-DISCOUNT TAKEN THROUGH TRPN/BUCKEYE
EXFU	DENY-PR- RECHECK EMERGENCY ROOM VISITS NOT COVERED BY MEDICAID
EXFV	PAY-CL-DISCOUNT TAKEN THROUGH NPN
EXFW	PAY-CL-DISCOUNT TAKEN THROUGH AMN/HMN/RAN
EXFX	PAY-CL-DISCOUNT TAKEN THROUGH THE INITIAL GROUP
EXFY	PAY-CL-DISCOUNT TAKEN THROUGH FPN
EXFZ	DENY-BN-AUTHORIZATION FOR HIGH RISK SERVICES WAS NOT OBTAINED
EXG1	DENY-BN-BILL MEDICARE DIRECTLY/AVMED NOT RESPONSIBLE FOR HOSPICE CHARGES
EXG2	DENY-BN-SNF BENEFIT EXHAUSTED FOR THIS BENEFIT PERIOD
EXG3	DENY-BN-LIFETIME BENEFIT EXHAUSTED
EXG4	DENY-BN-BILL MEDICAID DIRECTLY/AVMED NOT RESPONSIBLE
EXG5	DENY-CL-NOT A VALID CODE FOR AVMED. C-CODES ONLY VALID FOR MEDICARE PPS
EXGB	PAY-CL-DISCOUNT TAKEN THROUGH GALAXY/MANAGED CARE INC.
EXGC	PAY-CL-DISCOUNT THROUGH CONCENTRA SUPPLEMENTAL NETWORK
EXGE	DENY-AU-AUTHORIZATION IS NOT FILE FOR THIS MEMBER. DO NOT BILL MEMBER.
EXGG	DENY-PR-SHANDS AFFILIATE CAPITATED SERVICE
EXGK	PAY-PR-\$200 INITIAL VISIT PAYMENT DEDUCTED FROM DELIVERY
EXGL	DENY-BN-BILL FOR AVMED'S ROUTINE GLASSES BENEFIT WITH CONTRACTED CODES
EXGN	DENY-PR- THIS SERVICE IS INCLUDED IN NEWBORN CARE GLOBAL PAYMENT
EXGP	DENY-PR-CHARGES INCLUDED IN GLOBAL FACILITY PAYMENT
EXGQ	DENY-BN-THIS SERVICE IS NOT COVERED UNDER YOUR MEDICARE POS BENEFITS
EXGR	PAY-PR GARNISHMENT OF WAGES
EXGS	XX-DENY-OTHER (INCLUDING NARRATIVE)
EXGV	DENY-BN-MAXIMUM ALLOWABLE AMOUNT PER VISIT EXCEEDED
EXGW	DENY-BN-MEDICARE POS MAXIMUM BENEFIT AMOUNT HAS BEEN MET
EXGY	DENY-BN-PREVENTIVE MEDICINE DOLLAR LIMIT EXHAUSTED
EXGZ	DENY-BN-SEND TO INDEMNITY PLAN INSURANCE CARRIER
EXH0	INFO-ADJ-BASED ON CLAIM REVIEW- NO ADJUSTMENT TO PAYMENT NECESSARY
EXH1	INFO-BN-SERVICE APPLIED TO MEMBER'S ALLERGY SKIN TESTING COPAYMENT
EXH2	INFO-BN-SERVICE APPLIED TO MEMBER'S DEDUCTIBLE
EXH3	INFO-BN-THIS PAYABLE PRESCRIPTION WAS APPLIED TO ANNUAL RX DEDUCTIBLE
EXH4	INFO-BN-INDIVIDUAL LIFETIME MAX DOLLAR AMT HAS BEEN MET FOR THIS BENEFIT
EXH5	INFO-BN-FAMILY LIFETIME MAXIMUM DOLLAR AMT HAS BEEN MET FOR THIS BENEFIT
EXH6	INFO-BN-INDIVIDUAL MAXIMUM DOLLAR AMOUNT HAS BEEN MET FOR THIS BENEFIT
EXH7	INFO-BN-FAMILY MAXIMUM DOLLAR AMOUNT HAS BEEN MET FOR THIS BENEFIT
EXH8	INFO-BN-THIS PAYABLE SERVICE WAS APPLIED TO EMERGENCY ROOM COPAYMENT
EXH9	INFO-CL-SERVICE WAS NOT PRE AUTHORIZED, RESULTING IN A BENEFIT REDUCTION
EXHA	INFO-THIS EX NAME CAN BE USED/NOT ATTACHED
EXHB	INFO-CB-BENEFITS COORDINATED WITH PRIMARY INSURANCE CARRIER

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXHC	INFO-PR-SERVICE COVERED UNDER CAPITATION
EXHD	INFO-CL-THIS AMOUNT EXCEEDS THE SEMI PRIVATE ROOM RATE
EXHE	INFO-CL-PERSONAL COMFORT ITEM(S) NOT COVERED
EXHF	INFO-CL-NON COVERED ITEM(S)
EXHG	INFO-CL-VITAMINS AND NUTRITIONAL SUPPLEMENTS ARE NOT COVERED
EXHH	INFO-CL-PAID ACCORDING TO AVMED GUIDELINES FOR SERVICES PERFORMED BY PCP
EXHI	INFO-CL-AMOUNT PAID REPRESENTS AV-MED FEES **DO NOT BILL PATIENT**
EXHJ	INFO-CL-SERVICE PROCESSED ACCORDING TO CONTRACTUAL AGREEMENT WITH AVMED
EXHK	INFO-CL-ALLOWANCE DETERMINED BY MEDICAL REVIEW
EXHL	INFO-CL-COLLECTION AND HANDLING OF SPECIMEN TO OUTSIDE LABORATORY
EXHM	INFO-CL-PAID ACCORDING TO AVMED'S BENEFIT FOR SECOND OPINION BY A NONPAR
EXHN	INFO-CL-THIS IS AN ADDITIONAL PAYMENT TO A PREVIOUSLY PROCESS CLAIM
EXHO	INFO-CL-COLL./HANDLING OF SPECIMEN MUST BE BILLED WITH APPROPRIATE CODE.
EXHP	INFO-CL-PROCEDURE CODE WAS CHANGED DUE TO MEDICAL REVIEW DETERMINATION
EXHQ	INFO-CL-PROCEDURE CODE CHANGED IN ACCORDANCE TO YOUR AV-MED AGREEMENT
EXHR	INFO-CL-ALLOWANCE DETERMINED BY CLAIMS DIRECTOR REVIEW
EXHS	INFO-CL-ALLOWED AMT IS THE LIMITING CHARGE SET BY MEDICARE FOR THIS SERV
EXHT	INFO-CL-CLAIM HAS BEEN PAID, WE WILL CONTINUE TO PURSUE OTHER INSURANCE
EXHU	INFO-CL-UNDER MEDICARE PD.AMT. IS THE MAX.DUE TO YOU. DO NOT BILL MEMBER
EXHV	INFO-CS-CLAIMS SERVICE REVIEW
EXHW	INFO-CL-ADDITIONAL PAYMENT BASED ON REVIEW BY CLAIMS SERVICE DEPT.
EXHX	INFO-CL-SERVICES NOT COVERED BY MEDICARE
EXHY	INFO-CL-CLAIM PROCESSED UNDER INDEMNITY PLAN DUE TO SERVICE NOT AUTH.
EXHZ	INFO-CL-PROCESSED ACCORDING TO AVMED GUIDELINES
EXIA	DENY-PLEASE REFILE CLAIM WITH HORIZON BEHAVIORAL SERVICES
EXIB	INFO-CL-PROCESSED ACCORDING TO AVMED GUIDELINES
EXIC	INFO-UNDER MEDICARE LAW, ALLOWABLE AMOUNT IS MAXIMUM DUE.
EXID	INFO-MEMBER CAN BE BILLED FOR COINS, DED AND OTHER NON COVERED SERVICES
EXIE	INFO-PLEASE SUBMIT MEDICAL RECORDS TO PATIENT'S PCP
EXIF	INFO-CL-CLAIM HAS BEEN RECEIVED AND IS IN OUR SYSTEM FOR PROCESSING
EXIK	INFO-CB-BENEFITS COORDINATED WITH AUTO INSURANCE CARRIER
EXIN	INFO-FN - FREEZE/THAW
EXIO	INFO-TOTAL AMOUNT PAID MAY INCLUDE INTEREST PAID TO THE SERVICE PROVIDER
EXIP	PAY-CL-CODE BILLED DOES NOT MATCH CODE AUTHORIZED / PAID UPON REVIEW
EXIR	DENY-CL-CODE BILLED DOES NOT MATCH CODE AUTHORIZED. DO NOT BILL MEMBER.
EXIU	DENY-CL-CODE BILLED DOES NOT MATCH CODE AUTHORIZED.
EXK1	PAY-PR-ALLOWABLE CHARGES
EXK2	PAY-AU-APPROVED FOLLOWING MEDICAL DIRECTOR REVIEW
EXK3	PAY-AU-SERVICE AUTHORIZED
EXK4	PAY-CL-AMOUNT REFLECTS MULTIPLAN'S AGREEMENT. DO NOT BILL MEMBER
EXK5	PAY-CL-AMOUNT PAID REFLECTS DRG CALCULATION. DO NOT BILL MEMBER
EXK6	PAY-CL-AMOUNT CHARGE FOR THE SERVICE EQUALS ZERO
EXK7	PAY-PR-OVERRIDE TO CAPITATION
EXK8	PAY-CL-AMOUNT REFLECTS OUTLIER AGREEMENT. DO NOT BILL MEMBER
EXK9	PAY-CL-PAID IN ACCORDANCE TO LIFETRACT CONTRACT

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXKA	PAY-CL-ACCORDING TO AV-MED GUIDELINES
EXKB	PAY-CB-NON COVERED BENEFIT PAID OUT OF CREDIT BANK
EXKC	PAY-CB-BENEFIT PAID OUT OF CREDIT BANK
EXKD	PAY-CR-OUTDATED CODE REPLACED WITH NEW CURRENT PROCEDURE CODE
EXKE	PAY-CR-SERVICE REPLACED DUE TO CURRENT PROCEDURE CODING GUIDELINES
EXKF	PAY-AU-PAY CONTRACTED RATE-TERTIARY RATE NOT APPROVED
EXKG	PAY-AU-PCP AFFILIATION NOT FOUND
EXKH	PAY-CL-PAYMENT REFLECTS CHARGE ADJUSTMENT DUE TO AUDIT
EXKI	DENY-AU-DENIAL MAINTAINED BY FMQAI
EXKJ	PAY-CL-AMOUNT PAID REFLECTS NEGOTIATED AGREEMENT.
EXKN	PAY-CL-AMOUNT REFLECTS NPPN AGREEMENT. DO NOT BILL MEMBER
EXKO	PAY-AU-DENIED INITIALLY,OVERTURNED ON APPEAL
EXKP	XX-PAY-CASE MANAGEMENT
EXKQ	XX-PAY-CASE MANAGEMENT
EXKR	XX-PAY-CASE MANAGEMENT
EXKS	XX-PAY-DISCHARGE PLANNING
EXKT	PAY-CL-AMOUNT PAID REFLECTS DRG TRANSFER CALCULATION
EXKU	PAY-AU-CLAIM PAID AFTER PHYSICIAN REVIEW
EXKV	PAY-AU-DENIED INITIALLY/APPROVED BASED ON ADDITIONAL INFORMATION
EXKW	DENY-CR-OUTDATED CODE REPLACED WITH NEW CURRENT PROCEDURE CODE
EXKX	PAY-AU-OVERTURNED BY FMQAI
EXKZ	DENY-PR-NO ADDITIONAL PAYMENT DUE PER CONTRACT AGREEMENT
EXL6	PAY-PR-ALLOWABLE CHARGES
EXLC	PAY - AU - PAID ACCORDING TO AVMED GUIDELINES
EXLG	PAY-CL-PROCESSED ACCORDING TO UMBH CONTRACT
EXLI	PAY-CL-PROCESSED ACCORDING TO PSYCHCARE CONTRACT
EXLM	DENY-PR-MEMBER NOT IN YOUR PANEL
EXLO	DENY-PR-PCP CONSULTS ARE ONLY PAYABLE FOR PRE-OP EXAM.DO NOT BILL MEMBER
EXLP	PR-ANESTHESIA CLAIM-UCR
EXLT	DENY-PR-CLAIM PROCESSED ACCORDING TO CAPITATION AGREEMENT
EXLV	PAY-PR-LEVIED PROVIDER-PAYMENT HAS BEEN FORWARD TO THE IRS
EXLX	DENY-CL-SERVICE INCLUDED IN APC GROUPE REIMBURSEMENT
EXM1	AU-DISEASE MANAGEMENT
EXM2	DENY-CB-MANUAL-INFO REGARDING SPOUSE'S INSURANCE COVERAGE NOT RECEIVED
EXM4	DENY-MEMBER NOT ELIGIBLE FOR GLOBAL REIMBURSEMENT
EXM6	DENY-CB-MANUAL-INFO ON ACCIDENT DETAILS & SPOUSE INSURANCE NOT RECEIVED
EXM7	DENY-CB-MANUAL-INFO ON SLIP & FALL/AUTO/ACCIDENT DETAILS NOT RECEIVED.
EXM8	DENY-CB-MANUAL-INFO REGARDING OTHER INSURANCE COVERAGE NOT RECEIVED.
EXMF	DENY-CB-RECEIVE DATE EXCEEDS 90 DAYS FROM PRIMARY CARRIER DETERMINATION
EXMG	DENY-PR- THIS SERVICE INCLUDED IN MATERNITY FEE
EXMI	PAY-PHCS PREFERRED PAR PROVIDER BENEFIT APPLIED,NOT BILLABLE TO PATIENT
EXML	DENY-PR-ONLY MEDICARE APPROVED ASC PROCEDURES WILL BE REIMBURSED
EXMN	MBR-PEND MEMBERS WITH "A" ASSIGNED MBR NUMBER
EXMR	PAY-PR-DEBARRED PROVIDER
EXMT	PR-DENY YOU MUST FILE A CLAIM WITH PSYCHCARE HEALTH NETWORK

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXMU	DENY-PR-YOU MUST FILE A CLAIM WITH UM BEHAVIORAL HEALTH NETWORK
EXMV	DENY-CL-MBR IN HOSPICE, SVC NOT RELATED TO TERM COND, BILL MEDICARE
EXMX	PAY-PR-MAXIMUM ALLOWANCE REACHED. NO ADDITIONAL PAYMENT DUE PER CONTRACT
EXN1	AU-CASE MANAGEMENT
EXN2	AU-PEND CL/PAY AU-MED BENEFIT EXCEPTION TO CONTRACT, REVIEW AUTH REMARKS
EXN6	DENY-PR-CREDENTIALING DENIED, NO PAYMENT DUE, DO NOT BILL MEMBER
EXNA	BN-MANUAL INTERVENTION REQUIRED TO CHECK ACCURACY OF AUTH
EXNE	DENY-MB MEMBER TERMED AS NEVER EFFECTIVE
EXNG	DENY-PR-NO ADDITIONAL PAYMENT DUE - INCLUDED IN GLOBAL PAYMENT
EXO3	INFO-CL-FAILED TO RESPOND TO CONTESTED CLAIM IN 45 DAYS. PROCESS OFFSET
EXOF	INFO-CL-PROVIDER FAILED TO RESPOND IN 35 DAYS PROCESS OVERPAYMENT OFFSET
EXOX	ZY-BN-BENEFITS CONFIGURATION ERROR *
EXOZ	INFO-CL-PROVIDER APPROVAL RECEIVED TO OFFSET OVERPAYMENTS
EXQX	DENY-CR-PROCEDURE REPLACED DUE TO CURRENT PROCEDURE CODING GUIDELINES
EXRC	PAY-CL-HOSPITAL PAYMENT BASED ON USUAL & CUSTOMARY CHARGES FOR LOCATION
EXS9	DENY-PR-SERVICE INCLUDED IN PER DIEM
EXSO	DENY-PR-SERVICE NOT BILLABLE PER MEDICAID
EXT1	ADJ-CL-HOSPITAL OBSERVATION REIMBURSEMENT ADJUSTMENT
EXT3	ADJ-CL-CLAIM REVIEWED- DENIAL UPHELD
EXT4	PAY-PR-SERVICE PAYABLE ONCE PER DAY
EXT6	DENY-PR-SERVICE ALREADY PAID FOR MEMBER
EXT7	PAY-PR-MEMBER CHOICE-BILL MEMBER FOR CHARGES ABOVE AVMED'S PAYMENT
EXTA	ADJ-CL-APPEALS EXCEPTION FOR TIME LIMIT
EXTB	ADJ-CL-APPEALS RETROAUTHORIZATION
EXTC	ADJ-CL-INSURANCE DIVISION EXCEPTION
EXTD	ADJ-CL-ADMINISTRATIVE DECISION FOR TIME LIMIT
EXTE	ADJ-CL-ADMINISTRATIVE DECISION RETROAUTHORIZATION
EXTF	ADJ-CL-SPECIAL PROJECTS
EXTG	ADJ-CL-NON-PAR LAB EXCEPTION
EXTH	ADJ-CL-OUTPATIENT HOSPITAL LAB EXCEPTION
EXTI	ADJ-CL-MEMBER/DEPENDENT NOW COVERED
EXTJ	ADJ-CL-MANUAL CHECK
EXTK	ADJ-CL-PAR REFERRING PHYSICIAN'S NAME SUBMITTED
EXTL	ADJ-CL-AUTHORIZATION ADJUSTMENT
EXTM	ADJ-CL-SPECIAL AGREEMENT/HOSPITAL CONTRACT ADJUSTMENT
EXTN	ADJ-CL-GLOBAL FEE EXCLUSIONS
EXTO	ADJ-CL-PCP REVIEW ADJUSTMENT
EXTP	ADJ-CL-SPECIALTY CAPITATION EXCLUSION ADJUSTMENT
EXTQ	ADJ-CL-DENY-REVIEW REQUESTED BEYOND REVIEW FILING LIMIT
EXTR	ADJ-CL-NUMBER OF UNITS ADJUSTMENT
EXTS	ADJ-CL-COPAYMENT/DEDUCTIBLE ADJUSTMENT
EXTT	ADJ-CL-REVIEW REQUESTED BUT CLAIM WAS CHANGED TO A DIFFERENT DENIAL CODE
EXTU	ADJ-CL-CONSULT REPORT ADJUSTMENT
EXTV	ADJ-CL-OPERATOR AUDIT ADJUSTMENT
EXTW	ADJ-CL-SYSTEM AUDIT ADJUSTMENT

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXTX	ADJ-CL-AN ADJUSTMENT HAS BEEN MADE TO YOUR CLAIM
EXTY	ADJ-CL-CORRECTED BILL/LATE CHARGE
EXTZ	ADJ-CL-HOSP.PROFESSIONAL COMPONENT/AUTOMATIC AUTHORIZATION
EXU1	ADJ-VOID-PER NM REVIEW
EXU2	ADJ-VOID-AVMED NO LONGER ACT AS TPA FOR GROUP
EXU3	ADJ-VOID-CLAIM RETURNED TO PROVIDER FOR SUBMISSION TO CORESOURCE
EXU4	ADJ-VOID-DISPUTED CLAIM FOR LUMP SUM SETTLEMENT
EXUA	ADJ-REF-REFUNDED BY COLLECTION AGENCY
EXUB	ADJ-REF-INCORRECTLY PROCESSED, ADJUSTMENT TO ORIGINAL CLAIM
EXUC	ADJ-REF-THIS IS AN ADJUSTMENT TO A PREVIOUSLY PROCESSED CLAIM
EXUD	ADJ-REF-SERVICE(S) NOT RENDERED BY PROVIDER
EXUE	ADJ-REF-WRONG PAYEE
EXUF	ADJ-REF-DUPLICATE PAYMENT
EXUG	ADJ-REF-LATE CREDIT
EXUH	ADJ-REF-HOSPITAL AUDIT
EXUI	ADJ-REF-COMMERCIAL INSURANCE PRIMARY
EXUJ	ADJ-REF-MEDICARE PRIMARY
EXUK	ADJ-REF-SUBROGATION SETTLEMENT
EXUL	ADJ-REF-PHYSICIAN OVERPAYMENT
EXUM	ADJ-REF-HOSPITAL OVERPAYMENT
EXUN	ADJ-REF-WORKER'S COMPENSATION
EXUO	ADJ-REF-TERMINATED MEMBER
EXUP	ADJ-REF-OVERPAYMENT TO MEMBER
EXUQ	ADJ-REF-SYSTEM ERROR-PAID INCORRECTLY
EXUR	ADJ-REF-WRONG CODE/INCORRECTLY BILLED,ADJUSTMENT TO ORIGINAL CLAIM
EXUS	ADJ-VOID-WRONG PAYEE
EXUT	ADJ-VOID-DUPLICATE PAYMENT
EXUU	ADJ-VOID-INVALID ADDRESS
EXUV	ADJ-VOID-STALE DATED CHECK
EXUW	ADJ-VOID-MEMBER DECEASED
EXUX	ADJ-VOID-MEMBER REQUEST
EXUY	ADJ-VOID-PER PPO/FINANCE DEPARTMENT
EXUZ	ADJ-VOID-VOID
EXV1	ADJ-VOID-VOID PER PROVIDER
EXV2	ADJ-OVP-SERVICE (S) NOT AUTHORIZED
EXV3	ADJ-OVP-WRONG PAYEE
EXV4	ADJ-OVP-DUPLICATE PAYMENT
EXV5	ADJ-OVP-DISENROLLED - BILL MEDICARE
EXV6	ADJ-OVP-MEMBER CHANGED OB AS PCP
EXV7	ADJ-OVP-HOSPITAL AUDIT
EXV8	ADJ-OVP-WORKER'S COMPENSATION CLAIM
EXV9	ADJ-OVP-LATE CREDIT
EXVA	ADJ-OVP-PRE-EXISTING CONDITION
EXVB	ADJ-OVP-OVERPAYMENT MADE TO PHYSICIAN
EXVC	ADJ-OVP-OVERPAYMENT MADE TO HOSPITAL

PAYMENT AND DENIAL CODE EXPLANATIONS (CONT.)

EXVD	ADJ-OVP-MEDICARE INTERMEDIARY PAID
EXVE	ADJ-OVP-SERVICE(S) INCLUDED IN CAPITATION
EXVF	ADJ-OVP-MEMBER PAID CLAIM IN FULL
EXVG	ADJ-OVP-SERVICE(S) INCLUDED IN CARDIAC GLOBAL FEE
EXVH	ADJ-OVP-OVERPAYMENT DUE TO COMMERCIAL INSURANCE PAYMENT
EXVI	ADJ-OVP-OVERPAYMENT DUE TO MEDICARE PAYMENT
EXVJ	ADJ-OVP-OVERPAYMENT DUE TO SUBROGATION
EXVK	ADJ-OVP-MEMBER TERMINATED- DEDUCTED PER INSURANCE DIVISION INSTRUCTION
EXVL	ADJ-OVP-SERVICE(S) INCLUDED IN MATERNITY GLOBAL FEE
EXVM	ADJ-OVP-OVERPAYMENT MADE TO MEMBER
EXVN	ADJ-OVP-BENEFIT PAYABLE UNDER INDEMNITY
EXVO	ADJ-OVP-AV-MED NOT PRIMARY PAYOR
EXVP	ADJ-OVP-OVERPAYMENT DUE TO MULTIPLE TAX ID
EXVQ	ADJ-OVP-OVERPAYMENT DUE TO AUTH. FEE
EXVR	ADJ-OVP-PAID SUBMITTED FEES TO PARTICIPATING PROVIDER
EXVS	ADJ-OVP-SERVICES INCLUDED IN GLOBAL FEE
EXVT	ADJ-OVP-BENEFITS TERMINATED, BILL MEMBER
EXVU	ADJ-OVP-OVERPAYMENT - MEMBER TERMINATED
EXVV	DENY-PR-DENY BREVARD COUNTY MEMBERS
EXVW	ADJ-CL-DENY-CORRECTED CLAIM-PROCEDURE CODE HAS BEEN REMOVED
EXVY	ADJ-REF-OVERPAYMENT ADJUSTMENT/REFUND CHECK RECEIVED
EXW1	INC-AU-CLOSED/MEDICAL INFORMATION NOT RECEIVED
EXW2	DENY - AU - INSUFFICIENT INFORMATION RECEIVED/NO AUTHORIZATION ON FILE
EXW3	DENY-PR-AVMED CONTRACT TERMINATED. DO NOT BILL MEMBER
EXW7	DENY-BN-NOT PAYABLE BASED ON MBR'S EMPLOYER'S DEFINITION OF SERVICE AREA
EXWD	PAY-CL-CLAIM REVIEWED. OVERPAYMENT REQUEST WITHDRAWN.
EXWG	PAY-CB-\$10,000 PIP ASSUMED. AWAITING PIP PAYOUT.
EXWH	PAY-PAYMENT BASED ON USUAL AND CUSTOMARY CHARGES FOR YOUR LOCATION
EXWI	PAY-PAID ACCORDING TO GROUP SPECIFIC SCHEDULE OF BENEFITS
EXWJ	DENY-AU-SERVICING PROVIDER MISREPRESENTED ON CLAIM
EXWK	DENY-CL-NDC IS MISSING / INVALID OR DOES NOT MATCH DRUG DOSAGE BILLED
EXWL	PAY-CB-PAYMENT BASED ON ANTICIPATED PRIMARY PAYMENT
EXWM	DENY-CL-WRONG MEMBER ID NUMBER-TO BE REPROCESSED UNDER CORRECT MEMBER ID
EXWN	DENY - SERVICE NOT BILLABLE PER MEDICAID
EXWP	DENY-CL-WRONG PAYEE-TO BE REPROCESSED TO CORRECT PROVIDER OF SERVICE
EXWQ	DENY-CL-REBILL WITH VALID / APPROPRIATE HCPC CODE
EXWW	DENY-PR-SERVICE NOT BILLED ACCORDING TO YOUR CONTRACTUAL AGREEMENT
EXXZ	DENY-CL-MATERNITY SERVICES FOR DEPENDENT CHILDREN NOT A COVERED BENEFIT
EXYC	PAY-CL-FACILITY PAYMENT BASED ON APC REIMBURSEMENT
EXZR	DENY-PR-TRANSPLANT CASE: RE-SUBMIT CLAIM TO SRIZURICH
EXZY	DENY-PR-YOU MUST FILE A CLAIM WITH PSYCHCARE
EXZZ	DENY-PR-YOU MUST FILE A CLAIM WITH HORIZON BEHAVIORAL SERVICES

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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

Type of Request	Case Determination	Provider Notification - Approvals/Denials
Emergent/Urgent/Concurrent – All necessary information received at time of initial request	Within 2 hours	Within 24 hours of approved case determination Within 72 hours of denied case determination
Expedited Pre-Service (i.e., ongoing ambulatory services, such as therapy or home healthcare) – All necessary information received when extension requested	Within 72 hours	Within 24 hours of approved case determination Within 72 hours of denied case determination
Standard (fax)	Within 14 calendar days (Medicare) Within 15 calendar days (Commercial)	Within 24 hours of case determination

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.

SERVICES REQUIRING AUTHORIZATION

The Authorization Platform

The services listed below require authorization by AvMed and must be requested on an Authorization Request Form via fax (see sample found in this chapter), telephonically, any emergent; or by using AvMed's automated authorization tools for select services:

- Inpatient hospitalization (acute, observation, preclears, newborn, skilled nursing, vent and rehabilitation admissions) mental health must be rendered through our capitated Providers
- Outpatient and in-office complex radiological procedures (CT, MRI, MRA, PET scans, CT angiography and nuclear/cardiac imaging)
- Outpatient surgery in an ambulatory surgery center or hospital setting; procedures, excludes specific surgical CPT 4 codes that can be found online at **AvMed.org** using your Provider number (including cardiac catheterizations and PTCA procedures)*
- Outpatient drug infusions/injections performed in an outpatient facility or infusion suite*
- In-office drug administration (specific codes available at **AvMed.org** using your Provider number)
- Integrated Health Care for Home Health and DME services (except for Tampa area); BayCare in the Tampa area, Hillsborough, Hernando, Pasco and Pinellas counties
- Wound care/hyperbaric oxygen therapy (HBO; when service provided outpatient or at a wound care center)
- Hemodialysis services
- Transplant services
- Non-participating Provider services
- Pain management

*There is no authorization required for home healthcare for Miami-Dade County/Jackson Health System Members.

ELECTIVE INPATIENT ADMISSIONS

Elective surgery admission requests should be submitted via AvMed's Authorization Request Form. It is important that the requesting Provider submit all pertinent medical notes to support the appropriateness of the surgical intervention. Unnecessary delays may occur if submitted requests are not accompanied by documentation to confirm the clinical appropriateness of the service.

COMPLEX RADIOLOGICAL PROCEDURES

National Imaging Associates (NIA) now processes these procedures. Providers may initiate routine authorizations by accessing NIA's website **RadMD.com**. For expedited or retrospective review, Providers should call **1-866-663-8387** (CPT 4 codes and forms available on **AvMed.org** using your Provider ID).

Complex radiological procedures are defined as:

- Computerized tomography (CT scans)
- CT angiography
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET scans)
- Nuclear tests* and nuclear cardiac imaging (myocardial perfusion imaging and cardiac blood pool imaging)

Complex radiological procedures planned in the office, or for an outpatient hospital setting and/or a hospital-affiliated diagnostic facility, cannot be processed using AvMed's automated authorization tools and must be submitted via National Imaging Associates' website. It is important that the requesting Provider submit all pertinent medical notes to support the appropriateness for the complex radiological procedure. Unnecessary delays may occur if submitted requests are not accompanied by documentation to confirm the clinical appropriateness of the service requested.

AvMed's claim adjudication procedure will require the authorized CPT code to match the billed CPT code in order for the claim to pay. For example, if the referring Physician has requested a CT of the chest **without** contrast, CPT code 71250, and the claim is submitted for a CT of the chest **with** contrast, CPT code 71260, the claim will be denied.

When appropriate, referring Physicians are encouraged to consider utilizing in-Network freestanding diagnostic facilities when prescribing complex radiological procedures. Freestanding diagnostic facilities are routinely the most cost-effective and convenient (extended hours and spacious parking amenities) setting to perform complex radiological diagnostic procedures.

For a listing of in-Network freestanding diagnostic facilities, log on to AvMed's website at **AvMed.org** or contact AvMed's Physician Services.

*Miami Dade County/Jackson Health System Members **DO NOT** require authorization for nuclear medicine studies. However, nuclear cardiology studies **DO** require authorization. Please submit Authorization requests for Individual plan Members to AvMed directly at **1-800-552-8633**.

OUTPATIENT SURGICAL PROCEDURES

These include cardiac catheterization and percutaneous transluminal coronary angiography (PTCA).

Outpatient surgical procedures defined by surgical current procedural terminology (CPT) codes together with cardiac catheterizations and percutaneous transluminal coronary angiography (PTCA) procedures require prior authorization.



Surgical procedures planned for an outpatient hospital setting and/or a hospital-affiliated ambulatory surgery center cannot be processed using AvMed's automated authorization tools and should be submitted via AvMed's Authorization Request Form. It is important that the requesting Provider submit all pertinent medical notes to support the appropriateness for the prescribed surgical intervention. Unnecessary delays may occur if submitted requests are not accompanied by documentation to confirm the clinical appropriateness of the service.

When appropriate, referring Physicians are encouraged to consider utilizing in-Network freestanding ambulatory surgical centers when prescribing outpatient surgical interventions. Freestanding ambulatory surgical facilities are routinely the most cost-effective and convenient (extended hours and spacious parking amenities) setting to perform outpatient surgical procedures.

For a listing of in-Network freestanding ambulatory surgical centers, log on to AvMed's website **AvMed.org** using your Provider number or contact AvMed's Provider Service Center.

OUTPATIENT FACILITY DRUG ADMINISTRATION/INFUSION

Therapeutic, diagnostic, hydration and/or chemotherapy drug administration by infusion, intravenous push and injection in an outpatient facility setting require prior authorization.

When these services are provided in an in-office setting, an authorization is not required.¹

Requests for outpatient facility drug administration/infusion should be submitted via AvMed's Authorization Request Form. It is important that the requesting Provider submit all pertinent medical notes to support the appropriateness for the prescribed outpatient drug administration. Unnecessary delays may occur if submitted requests are not accompanied by documentation to confirm the clinical appropriateness of the service.

INTEGRATED HOME CARE SERVICES

Integrated Home Care Services should be used for home health and DME services (except for Tampa area); BayCare in the Tampa area, Hillsborough, Hernando, Pasco, Pinellas and Polk counties. Visits require prior authorization.*

Coverage is contingent on the Member's benefit (including visit limitations), confirmation that the Member's condition prohibits travel, and that the prescribed treatment plan includes service(s) that must be performed by a registered nurse or licensed practical (vocational) nurse.

Requests for home healthcare services cannot be processed using AvMed's automated authorization tools and should be submitted on AvMed's Home Health Authorization Request Form via fax. It is important that the requesting Provider submit all pertinent medical notes to support the appropriateness for prescribed home healthcare services.

Unnecessary delays may occur if submitted requests are not accompanied by documentation to confirm the clinical appropriateness of prescribed care. Custodial care services are not a covered benefit.

¹ This is excluding specific medications defined by the In-Office Medication Administration subsection.

*No authorization required for Miami-Dade County/Jackson Health Members.

DIALYSIS SERVICES

AvMed has an ESRD/CKD Department staffed with experienced dialysis nurses, and supported by AvMed Medical Directors. The department is responsible for authorizing all dialysis requests and vascular access procedures related to dialysis. Authorization can be requested via telephone at **1-800-346-0231**, extension 40518 or 40683, or fax **1-352-337-8511**.

TRANSPLANT SERVICES

AvMed's Transplant Management Department is staffed by registered nurses and supported by AvMed Medical Directors. The department is responsible for managing all potential transplant referrals (solid organ and bone marrow), and coordinating benefits and services through appropriate transplant Providers. The department reviews and processes all authorization requests for transplant services. Authorization requests can be made directly by phone. Please call **1-800-346-0231**, extension 40506 during business hours. The fax number is **1-352-337-8511**.

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**.

WOUND CARE

Wound care services performed in an outpatient facility or contracted freestanding facility require authorization.

- An authorization is required for all wound care delivered in the home setting
- Debridement/wound care provided in the in-office setting **does not** require authorization

* Wound care supplies are covered in accordance with CMS coverage, clinical guidelines and monthly quantity limitations. Advanced Care Solutions, AvMed's preferred Provider, should be contacted to coordinate the delivery of prescribed wound care supplies.³

² Emergency medical services and care means medical screening, examination and evaluation by a Physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an emergency medical condition exists and if it does, the care and treatment prescribed by a Physician deemed necessary to relieve or eliminate the emergency medical condition. In-area emergencies do not include elective or routine care, treatment related to minor illness or care that could reasonably be sought and obtained from the Member's treating Physician. Out-of-area emergencies do not include care for conditions for which a Member could reasonably have foreseen the need for such care before leaving the service area or care that could safely be postponed until their prompt return.

³ If prescribed quantity exceeds defined CMS monthly limitation, Advanced Care Solutions, on behalf of the prescribing Physician, will submit a request to AvMed for quantity benefit exception.

PAIN MANAGEMENT *(Conditional authorization required)*

Several factors must be considered to determine if a prior authorization is required for pain management procedures/services:

- Pain management services that are identified within a specific CPT code range require authorization in an outpatient facility setting.
- Pain management provided in the in-office setting does not require prior authorization with a contracted Physician. All implants, trial and pain pumps require prior authorization.

SERVICES NOT REQUIRING AUTHORIZATION

Simple Referrals (Specialist Consultations)

Most product offerings recognize the Primary Care Physician as the “Care Coordinator.” Most simple referrals/consultations to an AvMed specialist must be arranged through the Member’s PCP.

AvMed does not require formal authorizations for simple referrals / consultations to participating specialists however, a professional referral from PCP to specialist is required for a majority of AvMed’s products and supports the expectation that the PCP will continue to play an integral role coordinating medical care for AvMed Members.

Members are afforded direct access to the following:

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

If a Member needs to be admitted to an inpatient facility on an emergent/urgent basis, either from the Physician’s office or an emergency room, please call AvMed’s Clinical Coordination Department at **1-888-ER-AvMed (1-888-372-8633) Monday through Friday 8 am-5:30 pm. After hours, holidays and weekend requests must be faxed to **1-800-339-3554**. Forms are available at **AvMed.org**

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.

REFERRAL GUIDELINES AND EXCEPTIONS INFORMATION

Requirements

1. Referrals are required to see most Physician specialties*
2. Referrals are required for most specialty evaluation and management services, and other services provided in the Physician's office
3. Referrals can only be created by PCPs, for their eligible Medicare Members
4. Specialists can only view (check status of) a referral
5. Number of referral visits can range from one to nine
6. Subsequent visits are created by PCP (Member is not required to be present)
7. Referrals have a validity period of 90 days from the date of creation
8. NO service will require BOTH a referral and an authorization

*Note: Referrals are exclusive to service location 11, and specialties delineated in file titled "Referral Specialties List.xls."

Exceptions (do not require referral)

1. Ancillary services (e.g., diagnostics, etc.)
2. Services requiring prior authorization, as defined by AvMed's UM processes
3. Preventive services (on the next page)
4. Services with a state or federal open access requirement (listed on the next page)
5. Physician specialties excluded from the "Referral Specialties List.xls" due to the following:
 - Specialty designated as Primary Care
 - Specialty designated as NEVER requiring referral (e.g., chiropractic, dermatology, mental health, vision, etc.)
 - Specialty designated as pediatric and/or hospital-based

Preventive Services

The following services are excluded from the referral process. In the event that a claim is received for a service that matches one or more of the below referenced descriptions, it will be treated as an exception by the AvMed referral system and will NOT be denied.

1. Routine women's healthcare, including breast exams, screening mammograms (X-rays of the breast), Pap tests and pelvic exams (as long as they are obtained from a Network Provider)
2. Flu shots and pneumonia vaccinations (as long as they are obtained from a Network Provider)
3. Colonoscopy screenings
4. Spirometry testing post COPD diagnosis
5. Routine eye exams

State/Federal Mandatory Open Access

The following specialties are excluded from and/or have specific open access "annual" visit requirements defined by state or federal regulation, and in accordance with AvMed's Medicare benefits :

1. Dermatology services (as long as they are obtained from a Network Provider)
2. Chiropractic services (as long as they are obtained from a Network Provider)
3. Podiatry services, one visit for routine foot care every 60 days without a referral (as long as they are obtained from a Network Provider)
4. Optometry services



Please note that in accordance with Centers for Medicare & Medicaid Services (CMS) quality of care guidelines, services are subject to change by AvMed.

Specialist Responsibilities

After a Member has been referred to and seen by a specialist, the specialist must contact AvMed directly if and when services prescribed require authorization. The authorization must be obtained prior to performing tests or procedures. This requirement is the responsibility of the specialist, not the PCP. If a specialist determines a referral is required to the same-specialty or subspecialty peer, then the specialist should initiate the professional referral. If a specialist determines a referral to an alternative specialty is appropriate, then the PCP must be notified to support coordination of the Member's care.

Durable Medical Equipment (DME)

An authorization is no longer required for prescribed durable medical equipment except for high-cost DME, such as but not limited to wound vac, insulin pump, feeding pump, hospital beds, prosthetics, electric wheelchairs, etc., when delivered by a Network DME Provider. It is important to note that the DME benefit is generally limited to a maximum dollar value per calendar year. Furthermore, coverage of DME is dependent on clinical appropriateness as it is defined by CMS and/or AvMed's coverage explanations.

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.

BEHAVIORAL HEALTH

Outpatient behavioral health services are contractually limited to a number of visits per calendar year for most AvMed products. Generally, diagnostic testing and treatment related to mental retardation or deficiency, learning disabilities, behavioral problems, developmental delay and/or attention deficit disorder are not covered.

You can contact Magellan Case Management at **1-800-741-5044**, between 8:30am and 5pm for assistance with screening patients for co-occurring depression and substance abuse. Magellan also offers Case Management support for Members with complex behavioral health problems. The following methods may be used to refer your patients to Magellan's Case Management programs:

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

HOW TO OBTAIN AN AUTHORIZATION

The Link Line and web authorization modules have been modified to support the authorization process. PCPs and specialists are encouraged to utilize tools to view authorizations and to check Member benefits and eligibility.

AvMed accepts fax and telephonic requests for authorization.

Important Contact Information

Hours of Operation	6 am-10 pm	Automated system is available 7 days a week
	8 am-5:30 pm	Monday through Friday for coordinator-assisted authorizations

Provider Authorizations

Requests/Confirmations:	1-800-816-LINK	Member Confirmation:	1-800-80MEMBER
	1-800-816-5465		1-800-806-3623

Clinical Coordination Fax:	1-800-55AVMED	Pharmacy Fax:	1-877-535-1391
	1-800-552-8633		

For additional assistance using the AvMed Link, please contact the Provider Service Center at **1-800-452-8633**.

Fax

Routine requests for services requiring authorization should be submitted, via fax, on AvMed's Authorization Request Form (see sample found in this chapter). Routine requests will be processed within 10 calendar days.⁴

To impact the efficiency of the fax authorization process, the Authorization Request Form must be legible and complete. **When requesting an authorization, it is imperative that your office submits on the Authorization Request Form, accurate ICD 10 code(s), CPT/HCPCS code(s), Provider number(s), Member information and supporting medical records.** Providing all required elements when requests are submitted enables the Clinical Coordination Department to promptly process your submitted request.

If the submitted request excludes required information, the request for authorization will be faxed back to the Provider for completion.

Telephone

For an **emergent or urgent request**, please contact AvMed's Clinical Coordination Department at **1-800-816-5465** for immediate review and processing.

If a telephone request fails to support an emergent/urgent or urgent/concurrent condition, the Provider will be asked to submit the requested service by following the fax process. An emergent condition is supported by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

⁴ The 10-day turnaround time is contingent upon receipt of a complete Authorization Request Form and clinical data to support the requested service(s).

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

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

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).

Q. Do screening mammograms and EKGs need authorization?

A. No. The patient should be referred to a participating facility with a prescription.

Q. Is authorization needed for emergency room services?

A. No. You do not need prior approval to refer to the emergency room.

Q. Is a separate authorization required for inpatient consults and procedures?

A. No. Most services on authorized admissions are covered under the original authorization. Only AvMed-participating consultants should be used when available.

Q. Should the PCPs obtain all authorizations?

A. No. It is the responsibility of the prescribing Physician's office to contact the Clinical Coordination Department to authorize all services requiring authorization.

Q. Can a specialist refer to another specialist?

A. If a specialist determines a referral is required to the same-specialty or a subspecialty peer, then the specialist should initiate the professional referral. If a specialist determines a referral to an alternative specialty is appropriate, then the PCP must be notified to support coordination of the Member's care.

Q. When should the prescribing Physician secure a prior authorization for physical, speech and occupational therapy?

A. An authorization is no longer required for rehabilitation services delivered by Network Providers; however, therapy is generally limited to a specified number of visits per calendar year, and coverage is isolated to acute conditions for which therapy will provide significant improvement. An acute phase of a chronic condition may be covered; however, long-term physical, occupational or speech therapy for a chronic condition in general is not contractually covered.

When physical, occupational or speech therapy services are provided in the home, an authorization is required and visits are contractually limited as defined by the Member's therapy benefit.

Q. Does durable medical equipment require authorization?

A. Yes. AvMed utilizes Integrated Home Care Services for Home Health and DME services (except in Tampa area); BayCare in the Tampa area, Hillsborough, Hernando, Pasco and Pinellas counties. Visits require prior authorization.

Q. Is there an authorization requirement for diabetic teaching?

A. 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.

Q. What happens if a service is rendered and it is later determined to be contractually excluded?

A. It is important to educate Members that a service or supply is not a covered service simply because it is furnished or prescribed by a Physician or healthcare professional. Provider and Member education is emphasized in an effort to alleviate cumbersome authorization requirements.

A covered health service or supply is defined by the following criteria:

- It is supported by national medical standards of practice, the Centers for Medicare & Medicaid Services' coverage guidelines and/or the health plan's coverage procedures
- It is a service or supply that is described under the headings Schedule of Basic Benefits and Limitations of Basic Benefits
- It does not exceed a benefit limitation
- It is not excluded under the Exclusions from Basic Benefits
- It is a service or supply that is provided to a covered Member while the plan is in effect and prior to the date that any individual termination condition set forth in the Group Medical and Hospital Services Contract is executed

CLINICAL COORDINATION DEPARTMENT

The Clinical Coordination Team is responsible for admissions to an inpatient facility on an emergent/urgent basis either from the Physician's office or an emergency room.

Clinical Coordination can be contacted at **1-888-ER-AVMED** (1-888-372-8633), 8 am- 5:30 pm, Monday through Friday (TTY 711). Clinical Coordination is staffed by registered nurses, licensed practical nurses and non-clinical support staff, and supported by AvMed Medical Directors. When you call, the following options are available (Providers, press 2):

- Option 1:** Authorization for admission originating in the emergency room, observation to inpatient admission or direct admission
- Option 2:** Authorization verification
- Option 3:** Member eligibility
- Option 4:** Claims reviews or services
- Option 5:** Utilization Management, regarding facility admission or to speak to a UM representative
- Option 6:** Repeats message

Note: If your call is regarding after-hours urgently needed services, other than an emergent/urgent admission, please select option 2.

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 is located in Gainesville and 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**, under **Quick Links, Drug List**.

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 Healthy Living

The AvMed Healthy Living programs staffed with registered nurses, licensed by the State of Florida, encompass both Care Management and Disease Management.

AvMed’s Care Management programs include the following: Complex Case, High-Risk Pregnancy, Chronic Kidney Disease and Transplant. Disease Management programs include: Congestive Heart Failure, Asthma/Chronic Obstructive Pulmonary Disease, Diabetes and Coronary Artery Disease. For assistance contact AvMed’s Care Management Department **1-800-972-8633**.

Criteria and Denial Determination and Notification

Medical benefit coverage decision determinations are evaluated using criteria and/or guidelines based on reasonable medical evidence. Procedures are in place for applying benefit coverage criteria based on the needs of the Member and the characteristics of the local delivery system.

Medical benefit coverage decision determinations for requested services may also be based on additional criteria, including but not limited to, the individual Member’s benefits, the participating status of the Provider, the location of the service, and review of criteria related to the specific service requested. Evidence-based criteria may be applied when a coverage determination is required based on medical judgment. **These criteria are available to AvMed’s Members and/or Participating Physicians upon request.**

UM decisions are made in a timely manner. The timeliness and documentation are consistent with regulatory and accreditation guidelines/standards.

Only an AvMed Medical Director may make an adverse coverage determination based on medical judgment or clinical appropriateness that could result in an adverse determination. Notification to Members of their appeal rights, as well as other required information, is included in the adverse determination notice. **Providers are copied on this correspondence.**

If you wish to speak to a Medical Director regarding a medical necessity denial, please call **1-800 346-0231, extension 40513**.

PROVIDER SATISFACTION **Satisfaction With the UM Process**

On an annual basis, AvMed measures Member and Provider satisfaction with the UM process. Questions specific to the UM program are

included on both survey instruments. Changes to the UM process may be driven based on areas of reported dissatisfaction and when opportunities for improvement are identified through these sources.

Physician Satisfaction

AvMed surveys PCPs and specialists on at least an annual basis to measure satisfaction.

Emergency Care

Emergency care initiated by Members, Physicians and/or AvMed does not require authorization.

Affirmation Statement on Incentives

All staff who have the ability to impact a Utilization Management decision, including authorization of services or making an adverse determination, will do so based solely on reasonable medical criteria/guidelines, state statutes, federal regulations and/or contractual limitations. All Employees are required to refrain from the acceptance of any gratuity or personal incentive, either monetary or otherwise, to influence a medical determination.

Access to UM Staff

AvMed provides access to UM staff for Members and Providers who are seeking information about the UM process and the authorization of care. There is designated staff available at all regional offices to assist with communication during normal business hours. You may call **1-888-372-8633, option 3**.

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 on the back of 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**.

AVMED AUTHORIZATION REQUEST FORM

Clinical Coordination Department



Medical Prior Authorization Request Form

Phone: 1-800-816-5465

Fax: 1-800-552-8633

- Standard:** Submit requests 10-15 days prior to the anticipated date of service
- Expedited:** Call when MD orders care to be performed within 72 hours.
- Post Service:** Submit via Fax within 5 days of service date

- **All fields are REQUIRED.** An incomplete request form will delay the authorization process.
- Most authorization requests are considered standard unless care is medically necessary in 72 hours or less.
- **Definition of STAT/Expedited/Urgent requests:** must be supported by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected in any of the following:
 - Serious jeopardy to the health of the patient, including pregnant women or her fetus.
 - Serious impairment to bodily functions; serious dysfunction to any organ or body part.

Member Information			
Last Name		First Name	ID # A
Date of Birth		Gender F <input type="checkbox"/> M <input type="checkbox"/>	Date of Service
Requesting Provider Information (Primary Care or Specialist)			
Name	Provider #	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 #	Tax ID	
		NPI	
Telephone/Ext	Fax	Contact Person	
Requested Service - Please Include supporting chart notes, Diagnostic tests & Lab Values when appropriate.			
<input type="checkbox"/> In Patient Admission	<input type="checkbox"/> Out Patient Surgery	<input type="checkbox"/> Specialty Lab	<input type="checkbox"/> Non Par Provider
<input type="checkbox"/> Observation	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Predetermination	<input type="checkbox"/> Non Par Facility
<input type="checkbox"/> Wound Care (Facility)	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Other
<input type="checkbox"/> Wound Care (WTN)	<input type="checkbox"/> Admin. of Medication	<input type="checkbox"/> Transplant	
<input type="checkbox"/> Clinical Trial	<input type="checkbox"/> Medicare	<input type="checkbox"/> Commercial	No Auth. required for CMS approved clinical trials –Medicare only.
Diagnosis: ICD Code and Description			
Code	Code	Code	
Description	Description	Description	
Procedure: CPT Code and Description			
Code	Description		
Code	Description		
Code	Description		
Provide additional information or changes to be made to an existing authorization below			



HOME HEALTHCARE REQUEST FORM

Clinical Coordination Department



Home Health Prior Authorization Request Form

Urgent Phone: 1-800-816-5465

<input type="checkbox"/> Discharge orders Fax: 305-671-4712	<input type="checkbox"/> Standard/Expedited Fax: 1-844-439-5382
--	--

- All fields are REQUIRED. An incomplete request form will delay the authorization process.
- **Definition of STAT/Expedited/Urgent requests:** must be supported by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected in any of the following:
 - Serious jeopardy to the health of the patient, including pregnant women or her fetus.
 - Serious impairment to bodily functions; serious dysfunction to any organ or body part.

Member Information				
Last Name	First Name	ID # A		
Date of Birth	Gender F <input type="checkbox"/> M <input type="checkbox"/>	Start of Care Date:		
Requesting Provider (Primary Care or Specialist)				
Name	Provider #	Tax ID	NPI	
Telephone/Ext	Fax	Contact Person		
Service Provider				
Name:	Provider #	Tax ID	NPI	
Telephone	Fax	Contact Person		
Requested Service - Please include MD Orders, Plan of Care and supporting documentation when appropriate.				
<input type="checkbox"/> Nurse	<input type="checkbox"/> Therapy	<input type="checkbox"/> DME		
<input type="checkbox"/> RN	<input type="checkbox"/> PT <input type="checkbox"/> OT	<input type="checkbox"/> Supplies		
<input type="checkbox"/> LPN	<input type="checkbox"/> ST	<input type="checkbox"/> Enteral		
<input type="checkbox"/> HHA	<input type="checkbox"/> RT	<input type="checkbox"/> Misc.		
<input type="checkbox"/> Other				
Diagnosis: ICD Code and Description				
Code	Code	Code		
Description	Description	Description		
Procedure: HCPC Code and Units				Frequency of visits
Code	Units			
Code	Units			
Code	Units			
Code	Units			
Changes to be made to an existing authorization.				
Authorization #	Date of Service	Facility	ICD/CPT Code	Other
Instructions:				

Home Health_Prior_Auth_Request_Form_July_2015

HOME HEALTHCARE REQUEST FORM (CONT.)



Member Name: _____ ID: A
Date of Request: _____ Agency: _____

LPN: Care/services to be rendered (specify in detail):	
CPT Code: _____	CPT Description: _____
From (date): _____	To (date): _____
Total # weeks: _____	Total # visits per week: _____
Physical Therapist: Care/services to be rendered (specify in detail):	
1. Evaluation Request: CPT Code: _____ CPT Description: _____ From (date): _____ To (date): _____	2. Additional Services: CPT Code: _____ CPT Description: _____ From (date): _____ To: _____ Total # weeks: _____ Total # visits per week: _____
Occupational Therapist: Care/services to be rendered (specify in detail):	
1. Evaluation Request: CPT Code: _____ CPT Description: _____ From (date): _____ To (date): _____	2. Additional Services: CPT Code: _____ CPT Description: _____ From (date): _____ To: _____ Total # weeks: _____ Total # visits per week: _____
Speech Therapist: Care/services to be rendered (specify in detail):	
1. Evaluation Request: CPT Code: _____ CPT Description: _____ From (date): _____ To (date): _____	2. Additional Services: CPT Code: _____ CPT Description: _____ From (date): _____ To: _____ Total # weeks: _____ Total # visits per week: _____
Home Health Aide: may only be requested in correlation with, and during the same timeframe as, authorized professional services. Care/services to be rendered (specify in detail):	
CPT Code: _____	CPT Description: _____
From (date): _____	Total # hours per day: _____
Total # weeks: _____	
Medical Social Worker: Care/services to be rendered (specify in detail):	
CPT Code: _____	CPT Description: _____
From (date): _____	Total # hours per day: _____
Total # weeks: _____	



HOME HEALTHCARE REQUEST FORM (CONT.)



Member Name: _____ ID: A
Date of Request: _____ Agency: _____

ADDITIONAL DOCUMENTATION REQUIRED FOR SUBMISSION:

- Clinical documentation: Yes
- Agency's *Plan of Care*: Yes
- Optional Supporting documentation: Yes No

ATTESTATION:

I hereby acknowledge that the data submitted on this form accurately represents information submitted to the Agency by the requesting independent practitioner:

- The detailed, written, and signed orders of the treating physician -OR- the optional *Physician Request for Home Health Care Services* (for Commercial Members);
OR
- The required *CMS Physician Certification* (for Medicare Members);
AND
- The services are "reasonable and necessary" as supported by clinical documentation;
- Member is "confined to home";
- Service is requested on an "intermittent/part-time" basis;
- Home Health Aide services, if indicated, are specifically requested in writing and are to be rendered in correlation with, and during the same timeframe as, authorized professional services.

Agency Clinical Representative (print name, title)
Title: _____

Signature of Agency Clinical Representative
Date: _____

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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 preferred medication lists (PML) on the AvMed website at AvMed.org.

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 **1-877-535-1391**.

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 **1-877-535-1391**.

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.

Brand Additional Charge – Some AvMed Members have benefits that will charge them an additional amount 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. In order to avoid the additional amount we encourage you to consider prescribing generic medications when available.

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 Copay (lowest-cost option)** – These are typically list-specific, plan-generic medications and are the lowest out-of-pocket expense.
- **Tier 2 Copay (midrange-cost option)** – These are typically brand-name medications and are in the middle range for out-of-pocket expense.
- **Tier 3 Copay (higher-cost option)** – These are non-preferred, brand-name medications and are in the higher range for out-of-pocket expense. Often times there are alternatives available in Tier 1 or Tier 2 that may be less expensive yet still appropriate for treatment.
- **Tier 4 Copay (high-cost medications)** – These are generally self-injectable medications, excluding insulin, and are typically the highest out-of-pocket expense.

Commercial 5-Tier Formulary

- **Tier 1 Copay (lowest-cost option)** – These are typically list-specific, plan-generic medications and are the lowest out-of-pocket expense.
- **Tier 2 Copay (midrange-cost option)** – These are typically non-preferred generic medications and are in the low to mid-range for out-of-pocket expenses.
- **Tier 3 Copay (midrange-cost option)** – These are typically preferred brand-name medications and are in the middle to higher range for out-of-pocket expense. Often times, there are alternatives available in Tier 1 or Tier 2 that may be less expensive yet still appropriate for treatment.
- **Tier 4 Copay (high-cost medications)** – These are typically non-preferred, brand-name medications and are in the higher range for out-of-pocket expense. Often times, there are alternatives available in Tier 1, Tier 2 or Tier 3 that may be less expensive yet still appropriate for treatment.
- **Tier 5 Copay (high-cost medications)** – These are generally self-injectable medications, excluding insulin, and are typically the highest out-of-pocket expense.

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.
- Replacement prescription drug products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill.
- 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.
- Compounded prescriptions, except pediatric preparations.
- 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 **1-877-535-1391**.

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 with a Tier 3 or Tier 4 designation for up to one (1) year within the established quantity limit for each drug. You will be notified via fax of the approval determination.

If the Member fails to meet the above criteria, he or she will be mailed a letter of an adverse determination via USPS. The letter will include, but not be limited to, the medication denial, Member Appeal Rights and the process for filing an appeal. Notification of an adverse determination for urgent requests will be sent within 72 hours of receiving all the supporting documentation required. For routine non-urgent requests, notification will be sent within 14 calendar days of receiving all the supporting documentation required.

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 **Tools** (left side of screen)
2. Select **Guidelines and Standards**
3. Select **Pharmacy Coverage Guidelines**

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 CVS Specialty 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.

CVS specialty currently administers an optional drug delivery program for some specific medications. Participation in this optional program requires completion of a brief enrollment form. Upon receipt of the enrollment form, the claims payment system will be configured to indicate participation. Since payment is made to CVS for the medication, AvMed's Claims Processing system will be configured to pay CVS specialty directly. All though providers will not be able to bill for the medication they will continue to be reimbursed for the administration of the medication when appropriate.

MEDICARE FORMULARY

Beneficiaries enrolled in AvMed's Medicare product have a medication benefit included with their medical coverage. The benefit is annual, with a five-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 five tiers:

1. Preferred Generics
2. Generics
3. Preferred Brands
4. Non-preferred Drugs
5. Specialty

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](https://www.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

COMMERCIAL MEDICATION EXCEPTION REQUEST FORM

Date of Submission: _____



For a complete list of list of all medications that require a prior authorization, please visit AvMed' website at <https://www.avmed.org/web/guest/preferred-medication-lists>

- For medications administered in the in the physician's office, participating facility or in the home by a healthcare practitioner please select the "[PA Requirements – Office, Facility, Home Health](#)" link
- For medication obtained at the pharmacy please select the appropriate formulary based on the member's enrollment.

PATIENT INFORMATION			
Member ID	A	Date of Birth	Is Member Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member Name		Height	Weight
Diagnosis		Diagnosis (ICD-10) Code	
DELIVERY – ADMINISTRATION INFORMATION			
<input type="checkbox"/> In-office (MD to supply and administer) <input type="checkbox"/> Retail pharmacy Pickup <input type="checkbox"/> Home Health Provider		If you are requesting medication delivery to your office, enrollment in the CVS Specialty Medication Delivery Program is required. Please choose below: <input type="checkbox"/> CVS Specialty – Patient delivery (self-administered specialty meds) <input type="checkbox"/> CVS Specialty – MD office delivery CVS Specialty can be reached at : Phone: 866-638-8311 Fax:800-323-2445	
<input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Infusion Suite Name of Facility/Suite: _____ Facility/Suite Provider Number: _____			
ADDITIONAL MEDICATION INFORMATION FAX 877-535-1391			
Please attach all Office Notes and Current Lab Results Incomplete forms and/or inadequate documentation may result in a denial			
Drug Name		Quantity	
Directions for Use		<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy	
If Continuation of Therapy, indicate the member's therapeutic response:			
Duration of Therapy		Procedure Code	
Reason for Request			
PHYSICIAN INFORMATION			
Prescriber Name		Prescriber Specialty	
Form Completed By		AvMed Provider Id #	
NPI #		Office Number	Ext
Contact Name		Fax Number	

Please remember to review and complete all fields on this form and include appropriate Office Notes and Labs with all requests

Fax completed form to AvMed at 1-877-535-1391

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.
MP-3160 Rev012018



MEDICARE MEDICATION EXCEPTION REQUEST FORM

MEDICARE MEDICATION PRIOR AUTHORIZATION REQUEST FORM



Date of Submission: _____

For a complete list of list of all medications that require a prior authorization, please visit AvMed' website at <https://www.avmed.org/web/quest/preferred-medication-lists>

- For medications administered in the in the physician's office, participating facility or in the home by a healthcare practitioner please select the "[PA Requirements – Office, Facility, Home Health](#)" link
- For medication obtained at the pharmacy please select the appropriate formulary based on the member's enrollment.

PATIENT INFORMATION			
Member ID	A	Date of Birth	Is Member Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member Name		Height	Weight
Diagnosis		Diagnosis (ICD-10) Code	

Delivery – Administration information	
<input type="checkbox"/> Retail Pharmacy Pickup	<input type="checkbox"/> Hospital – Outpatient Facility:
<input type="checkbox"/> In-office (MD to supply and administer)	<input type="checkbox"/> Non-Hospital Facility - Infusion Suite:
<input type="checkbox"/> In-Office Delivery (Specialty Delivery Program Forms) note: If you are requesting medication delivery to your office, enrollment in the Specialty Delivery Program is required	

ADDITIONAL MEDICATION INFORMATION		FAX 305-671-0189
Please attach all Office Notes and Current Lab Results		
Incomplete forms and/or inadequate documentation may result in a denial		
Drug Name		Quantity
Directions for Use		<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy
If Continuation of Therapy, indicate the member's therapeutic response:		
Duration of Therapy		Procedure Code
Reason for Request		

PHYSICIAN INFORMATION			
Prescriber Name		Prescriber Specialty	
Form Completed By		AvMed Provider Id #	
NPI #		Office Number	Ext
Contact Name		Fax Number	

Please remember to review and complete all fields on this form and include appropriate Office Notes and Labs with all requests

Fax completed form to AvMed at 1-877-535-1391 or 305-671-0189

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.
MP-3160 Rev012018

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.

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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**.

MEMBER BENEFITS

STANDARD COMMERCIAL CARDS



Health Plan (80840) 7811990044 [Open Access-Self Refer to Specialist]
[HSA Qualified Plan]
[POS-In and Out of Network Benefits]

Member: [Member Name]
ID#: [A0000000-00]
Group Name: [Division] Group # []
RxBIN 004336
RxGrp RX1548

MEMBERS Call 1-[]
PROVIDERS Call 1-800-452-8633
Date Issued: 00/00/0000

IMPORTANT INFORMATION FOR MEMBERS

- Co-payments or other applicable charges are due at the time of service.
- AvMed Member Services [] or visit www.avmed.org (TTY 711)
- Automated Member Authorization Confirmation Line 1-800-806-3623 (24/7)
- AvMed Nurse on Call: 1-888-866-5432 (24/7)

IMPORTANT INFORMATION FOR PROVIDERS

- This card does not guarantee coverage. For eligibility, benefits verification and
- Pre-authorization of services, call 1-800-452-8633 or visit www.avmed.org
- For admissions, call 1-888-372-8633 (24/7)
- PHCS Healthy Directions network is available for covered emergent and/or urgent services outside the AvMed service area. For provider listing call AvMed or visit www.avmed.org
- Send claims to: AvMed, P.O. Box 569000, Miami, FL 33256-9000
- Pharmacy Help Desk: 800-364-6331



STANDARD MEDICARE CARDS

AvMed Embrace better health.

Health Plan (80840) 7811990044 **AvMed Medicare Choice**

Member Name:
[First Name Last Name] [Dual Eligible Copays May Apply]

Member ID:
[Axxxxxxxx00]

Group # 092001 [County]

RxBin 004336
RxPCN MEDDADV
RxGrp RX8551

MedicareRx
Prescription Drug Coverage

Date Issued: 00/00/0000 CMS H1016 [County Code]

CONTACT INFORMATION

For Members:

- Member Services: 1-800-782-8633
- Nurse On Call: 1-888-866-5432
- Hearing Impaired Line: TTY-711
- Delta Dental: 1-800-693-2601

For Providers:

- Eligibility, benefits verification,
and pre-authorization: 1-800-816-5465
- Admissions: 1-888-372-8633

Send claims to: AvMed, P.O. Box 569000, Miami, FL 33256

visit us at www.AvMed.org

MEMBER BENEFITS

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 important 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.

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].

MEMBER BENEFITS

HOW DO YOU REQUEST A FAST APPEAL?

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

AvMed Member Relations

P.O. Box 749

Gainesville, FL 32602

Phone: 1-800-782-8633

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.

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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, option 1**; 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, option 2**
Fax: **1-800-452-3847**

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

For questions regarding Member benefits:

- **Member Engagement – North (Gainesville, Jacksonville, Orlando, Tampa and Tallahassee)**
Phone: **1-800-882-8633**
Fax: **1-352-337-8612**
State of Florida: **1-888-762-8633**
Small Group, Commercial: **1-800-376-6651**
- **Member Engagement – South (Miami-Dade, Broward, West Palm Beach and Southwest)**
Phone: **1-800-882-8633**
Fax: **305-671-4736**
IU65: **1-800-477-8768** (Monday-Friday, 8 am-6 pm only)
MDC/JHS: **1-800-682-8633**
Medicare: **1-800-782-8633**

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

Ophthalmology:

For questions regarding benefits, eligibility and authorization:

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

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:

- **Magellan Healthcare**

1-800-424-4810

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**



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 Training

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.

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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.

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

- \$1,000,000/\$3,000,000: 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 practitioner 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.

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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
- VP Care Management
- 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
- Manager of Credentialing
- Director of Case Management

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 Connections
- Network 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 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	<p>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.</p> <p>For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.</p>	<p>MET: For patients seen three or more times the medical record contains information as prescribed by the standard</p> <p>Not MET: Evidence exists that patients seen three or more times do not have information in the medical record as prescribed by the standard</p> <p>N/A: Patient not seen by PCP at least three times</p>	
7	<p>The reason for the visit/chief medical complaint is documented on each visit.</p>	<p>MET: Evidence exists in the medical record that the reason of the visit/ chief complaint is documented on each visit.</p> <p>Not MET: No evidence exists in the medical record that the reason of the visit/chief complaint is documented on each visit.</p> <p>N/A: No exceptions</p>	
8	<p>A summary of Significant surgical procedures, past and current diagnoses illnesses and medical conditions are indicated on the problem list (EMR) or in the office notes.</p> <p>This includes any chronic or acute co-morbidity that have occurred in the Member's medical history.</p>	<p>MET: 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</p> <p>Not MET: 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</p> <p>N/A: No exceptions</p>	
9	<p>All Medications prescribed are indicated on the Medication/Problem list (EMR) or in the office notes.</p>	<p>MET: Evidence of a completed medication prescribed is found in the medical record.</p> <p>Not MET: No evidence medications are documented when prescribed.</p> <p>N/A: No exceptions</p>	
10	<p>The evaluation of the patient includes a pertinent history and physical exam.</p>	<p>MET: 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)</p> <p>Not MET: No evidence exists of how or when symptoms or the injury occurred, and/or, The physical exam is not relevant to the complaint</p> <p>N/A: No exceptions</p>	

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

QUALITY ACTIVITY

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

Follow-Up Appointment

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

Wait Time In Office

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

PRIVILEGED AND CONFIDENTIAL

NOT A PART OF THE MEMBER FILE

V. WITNESSES	
NAME & TITLE	CONTACT INFORMATION & PHONE NUMBER

VI. ANALYSIS (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

<input type="checkbox"/> S = SURGICAL	<input type="checkbox"/> N = NONE	<input type="checkbox"/> ALERT QI
<input type="checkbox"/> D = DIAGNOSTIC	<input type="checkbox"/> T = TEMPORARY	<input type="checkbox"/> FOLLOW UP WITH CREDENTIALING
<input type="checkbox"/> A = ANESTHESIA	<input type="checkbox"/> P = PERMANENT	<input type="checkbox"/> FOLLOW UP WITH CONTRACTING
<input type="checkbox"/> E = EMERGENCY CARE	<input type="checkbox"/> D = DEATH	<input type="checkbox"/> ALERT SUBROGATION
<input type="checkbox"/> M = MEDICATION	<input type="checkbox"/> U = UNKNOWN	<input type="checkbox"/> TRACK & TREND
<input type="checkbox"/> O = OTHER		

X. RISK MANAGER'S ANALYSIS:

PRACTICE GUIDELINES AND STANDARDS

CHAPTER 9 CONTENTS PRACTICE GUIDELINES AND STANDARDS

AVMED CLINICAL GUIDELINES AND STANDARDS	2
AVMED COVERAGE GUIDELINES	2
PHARMACY COVERAGE GUIDELINES	2
PREVENTIVE SERVICES	2



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**

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MEDICARE HEALTH OUTCOMES SURVEY (HOS)	3
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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 47 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 **Pediatric 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**.

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

- 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
- Options for retrieving and receiving medical records with EMR (electronic medical record) systems are available

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.









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

