A Message to

Business Office Managers

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MEMORANDUM

TO: Directors of Utilization Review, Medical Records, Business Office, and Managed Care of **AmeriHealth** Participating Hospitals in New Jersey

FROM: Kathleen Sullivan RN
Director, Hospital & Ancillary Contracting

DATE: **May 26, 2004**

SUBJECT: RETROSPECTIVE REVIEW PROCESS FOR "LATE PICK-UP" CASES

The purpose of this Memorandum is to describe the AmeriHealth Retrospective Review Process for those inpatient, emergent and/or elective cases where you discovered later (i.e. days after admission, or even post-discharge) that a patient is an eligible AmeriHealth Member. These are instances in which you may have incorrectly classified the AmeriHealth Member under another insurance or as a self-pay patient.

These Retrospective Review, "late pick-up" cases are not appropriate for the Provider Appeals Department. The Provider Appeals Department reviews only those cases that have been reviewed, concurrently but may have denied for reasons pertaining to medical necessity or appropriateness. "Late pick-up" cases have not been denied for questions of medical appropriateness-- there is no medical information in the system at all. **The Hospital's telephone call to Care Coordination & Management is necessary to fill in the medical information, and is an important part of the claim payment process. The claim processing system requires that a medical review notification and record be in place so that the claim can pay.**

PLEASE USE THIS PROCESS FOR LATE IDENTIFICATION SITUATIONS:

(1) **NOTIFY AmeriHealth---Call Care Coordination & Management at 1-800-227-3116**

Even if the patient has already been dischaged, CALL Care Coordination & Management
Whenever possible, call prior to sending the UB92 claim to the AmeriHealth Service Center or sending via Electronic Data Interchange (EDI) for processing. A designated Hospital Associate, whether from Utilization Review or the Business Office, must contact Care Coordination & Management at 1-800-227-3116 to notify AmeriHealth of the admission. If you send the claim for processing prior to such notification, you will receive a denial message that no precertification is on file.

(2) Provide Demographic Information

The Hospital can explain to Care Coordination & Management that there has been a "late pick-up" and that this patient has AmeriHealth coverage. At that time, Care Coordination & Management will ask for the following demographic information:

- Name of Patient
- Name of Member (if different)
- Insurance Identification Number
- Group Number
- Member Demographics
- Physician Name
- Date of Admission

After providing this demographic information, the case is pended until the clinical information is provided to the appropriate AmeriHealth nurse reviewer.

(3) Provide Clinical Information

The designated Hospital Associate should then alert his/her Utilization Review Department in order to provide the following clinical information:

- Diagnosis and Procedure/Treatment
- Signs, Symptoms, and Clinical Findings
- Functional Status (if applicable)
- Previous Treatments or Admissions (if known)

At the time of initial telephonic review the hospital will be asked to provide the initial "face sheet" to verify that the patient was initially classified under another insurance, or as a self-pay patient. This can be faxed to Care Coordination & Management. The fax number will be provided during the review.

(4) Provide Access to Medical Records

The entire medical record may need to be provided to the concurrent review nurse.

- **For Telephonic Review:** At Care Coordination & Management's discretion, the case will be reviewed over the phone or, depending on the length of the case, will request medical records. If written copies of medial records are requested, the AmeriHealth reviewer will have 30 days in which to complete the review and provide the Hospital with the determination.

- **For On-Site Review**: If AmeriHealth has an on-site review nurse at your Hospital, please make the medical records available for the on-site designated person. AmeriHealth will advise Hospital of the review determination on the daily log, as well as by formal written communication. .

- AmeriHealth will send both verbal and written notification on the medically approved or denied days to the Hospital's Utilization Review Department. If there are days medically approved, then the claim should be mailed to the AmeriHealth Service Center or sent via EDI for payment.

  * If the hospital had previously submitted the claim and received a denial, (for lack of pre-authorization) at this point, you may request AmeriHealth Provider Services to adjust the claim.. Reference the authorization number in the adjustment request.

If you have any questions regarding this Retrospective review process, please call Care Coordination & Management (800-227-3116) or your New Jersey Hospital Services Coordinator, 856-778-6500- South NJ counties, or 732-726-6700- North, Central & shore counties)

Thank you for your attention and cooperation.