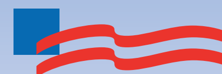
PARTNERS

Health



AmeriHealth

UPDATE

WORKING TOGETHER FOR QUALITY HEALTHCARE

January 2004

www.amerihealth.com

Important Pharmacy Updates Effective February 2004

PAXIL® (PAROXETINE) AND EFFEXOR® (VENLAFAXINE) AGE EDITS

There is a growing concern with the use of Paxil® (paroxetine) and Effexor® (venlafaxine) in children or adolescents for major depressive disorder (MDD). These antidepressants are not FDA approved in the pediatric population.

The FDA issued a warning in June 2003 about the use of Paxil® and Effexor® due to the increased risk of suicidal thoughts and attempts in children under the age of 18. Therefore, Paxil® and Effexor® will require a prior authorization for use in children under the age of 18. Prescriptions will be grandfathered for those children already using Paxil® and Effexor®. **This age edit will be effective in February 2004.**

EMEND® (APREPITANT) QUANTITY LIMITS

Emend® (aprepitant) is a unique medication that was recently FDA approved for acute (0 to 24 hours) and delayed (25 to 120 hours) nausea and vomiting in patients receiving highly emetogenic chemotherapy agents, such as Cisplatin. Emend® should be used in combination with other antiemetic agents, such as Zofran® (ondansetron) and Decadron® (dexamethasone).

The recommended dose of Emend® is 125 mg orally one hour prior to chemotherapy on day one, and 80 mg orally once daily in the morning on days two and three. Emend® will have a quantity level limit of one 125 mg tablet and four 80 mg tablets per 21 days (3 weeks). **This quantity edit will be effective in February 2004.**

SMART PRIOR AUTHORIZATION FOR SINGULAIR® (MONTELUKAST)

Singulair® (montelukast), approved for allergic rhinitis and asthma, already requires prior authorization but will soon be part of the Smart Prior Authorization program, **effective in February 2004.** Smart Prior Authorization is an enhancement to the Prior Authorization process that will automatically screen patient profiles for at least one trial of an antihistamine [e.g. Clarinex® (desloratadine), Zyrtec® (cetirizine), Allegra® (fexofenadine)] or an intranasal steroid [e.g. Flonase® (fluticasone), Nasacort® (triamcinolone), Vancenase® (beclomethasone)]. The Smart Prior Authorization program will identify whether the patient has tried at least one antihistamine or intranasal steroid in the past 6 months and, if so, will automatically approve Singulair®. However, if the patient has not tried the recommended agents, the regular Prior Authorization process will be required.

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A New Design for A New Year

AmeriHealth is pleased to present this newly designed *Partners in Health Monthly Update*. As always, we strive to provide timely information and resources that will help you facilitate the highest quality health care for our members.

You will continue to find important information on administrative processes, medical updates, pharmacy services, preventive health updates, and other news and announcements. In this new format, information will now be easier to read, with articles clearly identified to highlight effective dates, first-time announcements, and helpful reminders. Also new on the back cover, "Important Resources" lists both key phone numbers and online resources at *www.amerihealth.com* for quick reference.

This monthly publication delivers timely news and information in concert with our quarterly *Partners in Health Newsletter*, *Coding Guidelines and Policy Update*, Provider Manual Updates, NaviNet℠, Web site, and other mailings. We welcome your feedback on this new design and on all our provider communications.

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Announcements

Health Resource Center Expands to Improve Service to Providers and Members

The Health Resource Center (HRC) currently provides call center support for our many AmeriHealth Healthy Lifestyles℠ programs, such as our Smoking Cessation and Weight Management programs. As part of our continued efforts to streamline processes and improve service to both our members and providers, HRC operations will be expanded. **Effective January 1, 2004**, the majority of Care Management and Coordination (previously Patient Care Management) functions, including but not limited to precertification of inpatient and outpatient services, will be supported by the expanded HRC team. This transition should be seamless to you and your office staff.

For more information, please contact Susanne Ford, Director, Health Resource Center at (610) 225-9543.

Important Information Regarding Radiology Services For New Jersey Members

As communicated in a mailing you received in December, AmeriHealth has contracted with American Imaging Management, Inc. (AIM) to implement a new Radiology Quality Initiative (RQI) for outpatient diagnostic imaging services for New Jersey AmeriHealth members.

Effective for dates of service on or after February 1, 2004, ordering physicians for New Jersey AmeriHealth members must contact AIM to obtain an RQI number for the non-therapeutic or interventional imaging services listed below when performed in an office, outpatient hospital (excluding emergent and inpatient services), or free-standing imaging center:

- **CT**
- **MRI**
- **MRA**
- **Nuclear Cardiac studies**
- **PET Scans** (Note: The AIM RQI process will satisfy the existing precertification requirement for New Jersey AmeriHealth members.)

A PCP referral will no longer be required for New Jersey AmeriHealth members receiving these tests. The ordering physician should write the RQI number on prescriptions for the imaging studies listed. The performing provider should document the RQI number on claims submissions for the imaging studies listed.

AmeriHealth will implement these changes to outpatient diagnostic imaging services for New Jersey members of AmeriHealth HMO, POS, PPO, CMM, and Medicare. This program applies only to AmeriHealth-NJ business. This program does NOT apply to members of AmeriHealth affiliates in PA and DE. In early 2004, New Jersey AmeriHealth members will receive new ID cards with AIM's contact information on the reverse side. The member should also know if they are covered by AmeriHealth-NJ. For more detailed information on this new initiative, please refer to the AIM mailing.

New University of Pennsylvania ID Card

Patients who are employees of the University of Pennsylvania have a new PENNCare identification card Their benefit program provides for three levels of coverage: PENNCare Network* benefits, Personal Choice® Network benefits, and out-of-network benefits. Copayments for PENNCare and Personal Choice Network physicians are displayed on the patient's ID card.

*PENNCare physicians must also be Personal Choice Network participating physicians.

Get Connected

Retrieve Primary Care Physician (PCP) and PCP-Capitated Site Data Online with NaviNet℠

Network providers equipped with NaviNet℠, the Web-based HIPAA-compliant connectivity solution offered by NaviMedix®, Inc., are able to connect with our back-end systems to streamline various administrative tasks, including the retrieval of member eligibility and benefits information, and, for HMO members, PCP and PCP-capitated site data.

Using the NaviNet℠ Member Eligibility and Benefits feature, you may view member plan type, coverage dates, copayments, PCP, PCP-capitated sites, and even coordination of benefits and pre-existing condition clause information (when applicable). PCP-capitated site data includes the names, addresses, telephone numbers and 10-digit HMO group identification numbers of the PCP's selected Laboratory, Physical Therapy, Podiatry, and Radiology for their patient's care.

For AmeriHealth NJ Providers: Please note, however, that New Jersey law affords members a choice of specialists among participating network providers following an authorized referral subject to the specialist's availability to accept new patients. If your patient chooses to receive services from a participating provider or facility outside the PCP-capitated site, please issue a referral and call AmeriHealth to pre-authorize the procedure.

Other NaviNet℠ features include, but are not limited to: Referral Submission and Inquiry; Drug Pre-Authorization Submission; Claims Status Inquiry; Pre-Authorization Submission and Inquiry; Encounter Submission; Procedure and Diagnosis Code Inquiry; Emergency Room Notification and the Provider Change Form.

We encourage you to consider the advantages of this comprehensive application. For additional information or to register for NaviNet℠, contact the eCommerce Provider Inquiry Line in Delaware at (302) 661-6111/ in New Jersey at (856) 638-2701, or complete an Online Inquiry Form at *www.amerihealth.com/providers*.

Billing Tips

Improve Claims and Encounter Submission with NaviNet Claims℠

With NaviNet Claims℠, offered by NaviMedix®, Inc., network providers may submit HMO, PPO, and POS claims and encounters to AmeriHealth electronically, free of charge. In addition to converting all non-HIPAA-compliant claims to HIPAA-compliant versions, submission through NaviNet Claims℠ is simple and helps minimize claims rejections.

NaviNet Claims℠ can work with a provider's practice management system or can be supplied as desktop software for use with a PC and a modem or Internet access.

Editing features allow for fast and simple correction of errors before claims are submitted, resulting in reduced payer rejections and administrative concerns. Reporting features enable claims to be tracked from the moment of submission through receipt by the health plan.

For additional information or to register for NaviNet Claims℠, contact NaviMedix®, Inc., at (888) 482-8057 or complete an Online Inquiry Form at *www.amerihealth.com/providers.*

Investors in NaviMedix®, Inc. include an affiliate of AmeriHealth, which has a minority ownership interest in NaviMedix®, Inc.

AmeriHealth to Cover FluMist™ for the 2003-2004 Flu Season

As previously communicated in a separate mailing, in response to the reported shortage of injectable flu vaccines, AmeriHealth will expand its coverage of flu vaccine for the remainder of this flu season to include the nasal spray FluMist™ (intranasal), a live trivalent nasally administered vaccine intended for active immunization for the prevention of influenza. This is an update to the AmeriHealth coverage position previously detailed in the October 2003 *Partners in Health Update*. AmeriHealth has expanded its flu vaccine coverage to enhance the availability of flu vaccine injections for high-risk individuals by allowing for coverage of an alternative vaccine for others, as noted below.

Effective immediately, this special accommodation will apply to those individuals for whom FluMist™ is indicated by the U.S. Food and Drug Administration (FDA). The Centers for Disease Control and Prevention (CDC), following indications approved by the FDA, has recommended the use of FluMist™ as an option for healthy children and adults between the ages of 5 and 49.

According to the FDA, sufficient data does not yet exist to establish whether FluMist™ is safe and effective for use by people ages 50 and older, or by people with a medical condition that places them at high risk for complications from the flu. This includes people with chronic heart or lung disease, diabetes, kidney failure, and similar chronic conditions; and includes persons with weakened immune systems or those on medications that weaken a person's immune system (e.g. chemotherapy and immunosuppressives).

This AmeriHealth initiative applies to all dates of service beginning with December 11, 2003, and for the remainder of the 2003-2004 flu season. As noted above, the special accommodation applies only to those individuals for whom FluMist™ is indicated. As such, at this time, this accommodation will not routinely apply to Medicare members.

FluMist™ contains live attenuated influenza virus reassortants of the strains recommended by the U.S. Public Health Service for the 2003-2004 season.

For more information on this year's flu season and on flu vaccines, visit the CDC's Web site at *www.cdc.gov/flu/*.

Preventive Health Service Group Update For New Jersey Providers

In 2002, AmeriHealth conducted the Preventive Health Services Study to assess the delivery of preventive care and adherence to guidelines for preventive health services among enrolled members. More specifically, plan staff reviewed 11,422 records in the 425 primary care physician (PCP) offices.

Preventive Health Guidelines Indicators for 2 Year Olds

Rates of growth chart use and screening for passive smoking remain essentially unchanged. Counseling for child car safety seats, general nutrition and safe storage of drugs, toxic substances, firearms and matches also did not show significant changes remaining at or above 70%.

Preventive Health Guidelines Indicators for 3-10 Year Olds

Documentation for the following indicators demonstrated significant increases:

- Growth chart use (74.2% to 77.4%).
- Screening for passive smoking (45.1% to 47.8%).
- Child car safety (56.5% to 62.2%).
- General nutrition (70.3% to 72.8%).
- Regular physical activity (64.4% to 67.1%).
- Bicycle helmets (55.2% to 57.5%).
- Safe storage of drugs, toxic substances, firearms and matches (55.3% to 60.4%).

Preventive Health Guidelines Indicators for 19-64 Year Olds

Documentation for the following indicators demonstrated significant increases:

- Blood pressure measurement (95% to 96.2%).
- Screening for cholesterol in 40-64 year olds (81.4% to 83.3%).
- Screening for colorectal cancer (31.9% to 43.1%).
- Assessment of alcohol use (71.1% to 71.8%).

However, significant decreases were noted in the following areas:

- Screening for cholesterol in 19-39 year olds (51.7% to 47.7%).
- Assessment for physical exercise (56.9% to 54.9%).
- Sexual activity/risk for STDs (55.9% to 53.5%).

Preventive Health Guidelines Indicators for Members 65 Years and Older

Documentation for the following indicators demonstrated significant increases:

- Height measurement (73.4% to 79.8%).
- Colorectal cancer screening (43.9% to 57%).
- Counseling for advance directives (37.7% to 46.1%).
- Assessment of alcohol use (76.9% to 78.6%).

AmeriHealth remains committed to encouraging the use of age appropriate preventive health services. To this end, the plan will maintain or enhance provider and member focus programs designed to improve adherence to preventive guidelines.

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Important Claims Reminder:
Effective January 1, 2004, Providers Are Required to Report ICD-9 Diagnosis Codes to Highest Degree of Specificity

As previously communicated, **effective January 1, 2004**, AmeriHealth and its affiliates will require that all practitioners report diagnosis codes to the highest degree of specificity, according to the most current ICD-9-CM coding manual. This requirement applies to all claims and encounters. It reflects 1) the need for better diagnostic information for quality and medical management, 2) the decision to make our coding policy more consistent with that of Highmark Blue Shield and other major carriers, and the Center for Medicare and Medicaid Services (CMS) ICD-9-CM coding guidelines, and 3) the decision by CMS to determine Medicare+Choice premiums based on the severity of illness of enrolled members.

The following are guidelines for diagnosis coding:

- Most ICD-9-CM codes require the fourth or fifth digits. There are only about 100 valid three-digit codes.
- Most ICD-9-CM coding manuals include a color-coded system to designate diagnosis codes that require additional digits beyond the basic three digits. Please refer to your ICD-9-CM coding manual for specific instructions.
- Always include the fourth or fifth digit when indicated in the ICD-9-CM coding manual.
- Always report with the highest level of specificity possible for an individual patient.

Exceptions: The following providers are not required to report ICD-9-CM diagnosis codes to the highest degree of specificity: home health agencies, independent laboratories, independent physiological laboratories, general dentists, orthodontists, endodontists, pedodontists, pharmacies, durable medical equipment suppliers, ambulance services, orthotic and prosthetic suppliers, and home infusion providers.

For examples of valid and invalid ICD-9-CM codes, please refer to the article published in November Update. If you have any questions about how to report diagnosis codes, please contact Provider Services.

Important Reminder Regarding:
Protected Health Information (PHI) and E-mail

As previously communicated, AmeriHealth has installed new software that secures outbound e-mail containing Protected Health Information (PHI). Beginning in December, e-mail sent to you with PHI is now secured so that it is unintelligible to unauthorized parties. Instead of receiving an e-mail with member PHI directly in your inbox, you will receive an e-mail stating that AmeriHealth has a secured message waiting for you on a secure server. A link will take you, via a secure browser, to that server, where you will receive instructions for opening the e-mail.

We have implemented this Secure E-mail system to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA). While this process requires some extra steps, we are making every effort to ensure that there is no significant disruption to your communications with us. We appreciate your cooperation in helping us safeguard member PHI.

If you have any questions concerning our new electronic messaging security policies and procedures, please visit the Privacy Information (HIPAA) page at our Web site, *www.amerihealth.com/providers.*

Important Reminder Regarding:
HIPAA-Compliant Transactions

AmeriHealth applauds those providers who have achieved compliance with the HIPAA Transactions and Code Sets (TCS) requirements, and those providers whose efforts are nearing completion. While communications with our trading partners indicated that a large majority of practices would meet HIPAA requirements, a significant number of providers and vendors were not ready by the mandated compliance date of October 16, 2003.

In view of this reality and in recognition of the serious potential for disruption of service on October 16, 2003, AmeriHealth announced that it would invoke its HIPAA TCS contingency plans.

As previously communicated:

- AmeriHealth will continue to accept and process non-compliant electronic formats* for providers and for their trading partners until **February 29, 2004**.
- AmeriHealth will accept ASC X12N version 4010A1 electronic formats from trading partners that **may not be data content compliant**, while working with the trading partner to achieve compliance, until February 29, 2004.
- AmeriHealth will continue to make testing opportunities available to those contracted providers and their trading partners to assist in reaching HIPAA transaction compliance.
- AmeriHealth will reassess national guidelines, provider readiness, and vendor readiness prior to February 29, 2004 to determine how long the contingency plan should remain in place.

*Please note that AmeriHealth does not currently accept or process ASC X12N version 4010 transactions.

For testing and conversion assistance to the HIPAA-compliant claims transaction (837), please contact the NaviMedix®, Inc. HIPAA Conversion Team at (866) 877-6284. Updates to these contingency plans will be communicated on our Web site at *www.amerihealth.com/edi.*

Policy

New Credentialing Compliance Hotline and Web Page

Our provider credentialing policy requires that our members receive health care services only from fully credentialed practitioners. As noted in your Professional Provider Agreement, *non-credentialed practitioners may not see our members on an in-network basis.* Therefore, we need your assistance in identifying credentialing noncompliance.

Our Credentialing Compliance Department has launched a new Hotline telephone number and Web page. If you suspect any violations of our practitioner credentialing policies, please proceed with one of the following options:

1. Call the *confidential* Credentialing Corporate Compliance Hotline toll-free at (866) 282-2707.
2. Submit an online Credentialing Noncompliance Referral Form available at *www.amerihealth.com/credentials.*

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Billing Reminders:
10-Digit HMO Provider ID Number and Performing Provider ID Number (PIN #) Required

As previously communicated, effective January 1, 2003, the **10-digit HMO provider ID number** is required on all HMO claims submissions, encounters, referrals, and related correspondence. HMO claims submitted without the 10-digit HMO provider ID number are being rejected as non-clean claims. Both your group provider ID number and the Performing Provider ID Number (PIN #) need to reflect the new 10-digit numbers.

The Performing Provider ID Number must be recorded on all claims. This is a **required** data element in conjunction with HIPAA compliance and other requirements. HMO, POS, and PPO claims submitted without the identification number of the physician or other professional provider performing the procedure or service are being rejected and returned as non-clean claims and must be resubmitted with the necessary information. The Performing Provider ID Number should be reported in section 33 of the CMS 1500 claim form in the "PIN #" field.

When submitting HIPAA-compliant **electronic claims** through Electronic Data Interchange (EDI) transmission, the Performing Provider ID Number should be entered in the rendering provider ID number field, located in the **REF02** data element, either in loop **2310B** (at the claim level) or loop **2420A** (at the line level). The referring physician's provider ID number should be reported in the **2310A** loop in the **REF02** data element. The applicable group provider ID number should be reported in the secondary billing provider segment, located in the **REF02** data element, in loop **2010AA**. For more information on EDI transmission of electronic claims, please consult the 837P HIPAA Transaction Companion Guide on our Web site at *www.amerihealth.com/edi.*

As always, the provider ID numbers entered on electronic and paper-based claims should directly reflect the member's benefit plan. **Please enter your 10-digit HMO provider ID number on all HMO and POS (referred and self-referred) claims submissions, encounters, referrals, and related correspondence**. Enter your PPO provider ID number on all PPO claims and related correspondence.

Please note the following:

- The requirements above apply to **paper** *and* **electronic claims submissions.**
- With the October 27, 2003 transition of POS self-referred claims processing to MHS, our managed care information system, you should enter your 10-digit HMO provider ID number on all POS claims (referred and self-referred).
- The updated EDI electronic claims instructions outlined above are compliant with HIPAA Transactions and Code Set rules, which require a transition from the National Standard Format (NSF) to the HIPAA 837P transaction when submitting electronic claims. The compliance deadline for HIPAA Transactions and Code Sets was October 16, 2003. For testing and conversion assistance to the HIPAA-compliant claims transaction (837), please contact the NaviMedix®, Inc. HIPAA Conversion Team at (866) 877-6284.
- The provider ID numbers that you currently use for AmeriHealth Personal Choice® services are not affected and continue to be valid for AmeriHealth Personal Choice claims and related correspondence.
- Physical therapists and labs which have not been assigned a specific Performing Provider ID Number should submit their group provider ID number in both the "Grp #" and "PIN #" fields of box 33 on the CMS 1500 form. When submitting electronic claims, physical therapists and labs that have not been assigned a specific Performing Provider ID Number should report their group provider ID number in both the **2010AA** loop *and* either the **2310B** loop (at the claim level) or **2420A** loop (at the line level) in the **REF02** data element. **Claims submitted without information in both of these fields are now being rejected as non-clean claims and must be resubmitted with the necessary information.**

IMPORTANT RESOURCES

PROVIDER INFORMATION and TOOLS WEB PAGE
www.amerihealth.com/providers

PROVIDER CLINICAL PRACTICE GUIDELINES WEB PAGE
www.amerihealth.com/guidelines

PROVIDER MEDICAL POLICY WEB PAGE
www.amerihealth.com/medpolicy

PROVIDER ELECTRONIC DATA INTERCHANGE SERVICES WEB PAGE
www.amerihealth.com/edi

PROVIDER SERVICES
Policies/Procedures/Claims

HMO
(800) 821-9412-NJ
(800) 888-8211-DE

PPO
(800) 595-3627

CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT
Anti-Fraud and Corporate Compliance Hotline
(866) 282-2707
www.amerihealth.com/anti-fraud

CREDENTIALING COMPLIANCE HOTLINE
(866) 282-2707
www.amerihealth.com/credentials

PHARMACY SERVICES

Prescription Drug Authorization
(888) 671-5280

Toll-Free Fax
(888) 671-5285

Direct Ship Injectable
(267) 402-1711
(888) 671-5280

(215) 761-9165 Fax

Blood Glucose Meter Hot Line
(888) 494-8213 (option 2)

HEALTH RESOURCE CENTER
AmeriHealth Healthy Lifestyles℠
(800) 275-2583

Precertification
(800) 227-3116

CARE MANAGEMENT AND COORDINATION (formerly Patient Care Management)

HMO Commercial
(800) 888-8211 DE
(800) 227-3116 NJ

PPO
(800) 373-4455

Case Management/Ancillary
(800) 373-4455 DE
(800) 332-2566 NJ

THE SUPPLY LINE
(800) 858-4728

The AmeriHealth Partners in Health Monthly Update is a publication of the Provider Communications department for the exchange of information and ideas among the Amerihealth Provider community. Suggestions and contributions are welcome.

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