



Long-term care billing and referral requirements

page 4

Inside this edition

ANNOUNCEMENTS

- AmeriHealth New Jersey seeks committee members

ADMINISTRATIVE

- Ambulance transport for Medicare Advantage HMO members receiving custodial and skilled nursing care
- Long-term care billing and referral requirements
- ▶ New radiology transparency program for New Jersey members
- Reminder: No referrals required for AmeriHealth New Jersey HMO Plus and POS Plus plans (NJ only)
- ▶ Cost-sharing for preventive and nonpreventive services

HIPAA 5010

- ▶ AmeriHealth follows CMS lead with second HIPAA 5010 90-day enforcement grace period
- ▶ HIPAA 5010 troubleshooting information

ICD-10

- ▶ ICD-10 Spotlight: Know the codes

NAVINET[®]

- ▶ Updated *Clinical Alerts Overview* is available
- ▶ NaviNet enhancement features new urgent care copayment (PA only)
- Use the Clinical Care Report to improve coordination of care

MEDICAL

- ▶ Policy notifications posted as of March 26, 2012
- ▶ Assessing the needs of high-risk Medicare Advantage HMO members
- ▶ Low-dose chest CT screening for individuals at high risk for lung cancer

PHARMACY

- CMS patient safety measures and how you can help

HEALTH AND WELLNESS

- Safe use of acetaminophen in infants and children
- Updated meningococcal vaccine/booster dose guidelines from the AAP
- Case management: Help for your patients when they need it

▶ Articles designated with an orange arrow include notice of changes or clarifications to administrative policies and procedures.



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Email sign-up: www.amerihealth.com/providers/email

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For articles specific to your area of interest, look for the appropriate icon:

P Professional

F Facility

A Ancillary



AmeriHealth HMO, Inc. has an accreditation status of *Commendable* from the National Committee for Quality Assurance (NCQA).



AmeriHealth 65[®] NJ HMO has an accreditation status of *Excellent* from NCQA.

AmeriHealth New Jersey seeks committee members

AmeriHealth New Jersey has openings available for physicians who are interested in participating on committees that focus on a variety of clinical topics. Specialty providers needed to participate vary from primary care to medical and surgical subspecialties.

The majority of the committee meetings will be conducted virtually via Web/teleconferences, and other meetings will be held in person at our new Cranbury, New Jersey, office. The frequency of the meetings will be based on the specific specialty and committee needs.

If you are interested in participating, please contact Dr. Lisa Blondin at lisa.blondin@amerihealth.com.



Ambulance transport for Medicare Advantage HMO members receiving custodial and skilled nursing care

This is a reminder that Medicare pays for limited ambulance transport services for Medicare Advantage HMO members receiving custodial and skilled nursing care.

For members in custodial care

Ambulance transport services are *not* a covered benefit for Medicare Advantage HMO members in custodial care when they are being transported to a provider's office.

For members receiving skilled nursing care

If a Medicare Advantage HMO member who is receiving covered inpatient skilled nursing care is being transported to a provider's office, ambulance transport services are covered only if transportation in any other vehicle could endanger the member's health.

Please refer to Claim Payment Policy #12.04.02b: Nonemergency Ambulance Transport Services at www.amerihealth.com/medpolicy for further information on Medicare requirements for ambulance transport services.

Long-term care billing and referral requirements

This is a reminder of the billing guidelines and referral requirements for professional providers when rendering services to members in long-term care (LTC) facilities. Please review the information below and be sure to adhere to these requirements when providing such services.

Place-of-service codes

Primary care physicians (PCP) often visit their patients while they are in an LTC facility. On a professional claim, participating PCPs are required to use the most accurate place-of-service code to specify where a service is rendered. Therefore, it is important to distinguish between skilled nursing care visits and custodial care visits and use the appropriate place-of-service code on professional claims.

- **Skilled nursing care:** Place-of-service code = “31”

Skilled nursing visits are intended for HMO, POS, and PPO members who need skilled or sub-acute care.

Skilled nursing visits are subject to the precertification requirements and benefits limitations of the member's plan. Admissions to a skilled nursing facility (SNF) are arranged by care coordinators and must be preapproved through the precertification process. These admissions are reviewed weekly, or more often if applicable, to ensure the appropriate use of benefits and promote optimal benefits coverage. SNF reviews may be on-site or by telephone or fax, depending on the arrangement with the individual facility.

- **Custodial care:** Place-of-service code = “32”

Many of the services provided by PCPs to members who have been admitted to an LTC facility are considered custodial care services. These services do not require precertification like skilled nursing care.

Referral requirements

We have established LTC panels for our PCPs who provide care in participating LTC facilities. PCPs with an LTC panel must issue referrals for any professional service or consultation that an LTC-panel member in long-term care receives, including:

- podiatry, physical therapy, and radiology services;
- consultation or follow-up with a specialist;
- ancillary services (note that LTC-panel members do not have capitation requirements for laboratory, physical therapy, radiology, or podiatry services).

PCPs should submit referrals for LTC-panel members in advance of the service being provided. Referrals can be submitted either by using the NaviNet[®] web portal or by calling the Provider Automated System at 1-800-275-2583, and they should be submitted in a timely manner to allow for appropriate claims processing. Claims will *not* be authorized for payment without a referral on file. In addition, consultants and ancillary providers are encouraged to provide the referral information with the claim to assist in processing.

Note: LTC-panel members do not need precertification for the services listed above. Precertification is required only for inpatient admissions for hospital care, skilled nursing care, short procedure unit cases, and outpatient ambulatory surgical center procedures. During an approved skilled nursing care admission, it is not necessary for the attending physician to issue a referral. However, all providers rendering care to the member should use the inpatient skilled nursing care authorization number on any claims during the dates of service within the skilled nursing inpatient stay.

New radiology transparency program for New Jersey members

AmeriHealth New Jersey, in collaboration with AIM Specialty Health (AIM[®]), is collecting information about the imaging capabilities of all AmeriHealth-contracted providers in New Jersey who perform the technical component of advanced diagnostic imaging services (CT/CTA, MRI/MRA, nuclear cardiology, and PET scans) for AmeriHealth New Jersey members.

Starting June 1, 2012, the information regarding imaging capabilities and average cost values for the combined professional and technical components will be made available to physicians who submit a request for an advanced diagnostic imaging service for their AmeriHealth New Jersey patients.

Ordering physician transparency

Ordering physicians can request precertification for advanced diagnostic imaging services through the NaviNet[®] web portal by selecting AIM from the Authorizations option in the Plan Transactions menu. Starting June 1, 2012, when ordering physicians request precertification online for AmeriHealth New Jersey members, a table like the example shown below will be presented and will include the scores and cost information for local imaging providers.

Facility Name	PPOE	Site Score	Address	City	State	Phone	Distance	Map
ABC RADIOLOGY	450.00	A	100 MAIN ST., STE 200	ANYTOWN	IN	017555-5555	1.81	View
IMAGING GROUP	650.00	A	20 N. HALE ST.	ANYTOWN	IN	017555-5555	8.99	View
AMERICAN IMAGING	1,300.00	A	350 OAK ST., STE 3C	ANYTOWN	IN	017555-5555	6.23	View
HOSPITAL IMAGING CENTER	400.00	B	1000 HOSPITAL DRIVE	ANYTOWN	IN	017555-5555	1.83	View
RADIOLOGY SPECIALISTS	700.00	B	210 TOWN HWY 30	ANYTOWN	IN	017555-5555	2.46	View
SPECIALIZED IMAGING	1,000.00	B	428 MINER	ANYTOWN	IN	017555-5555	9.3	View
DIAGNOSTIC IMAGING	400.00	C	4120 HITECHAVE	ANYTOWN	IN	017555-5555	5.99	View
ADAMS IMAGING	450.00	C	3065 MITCHELL LANE	ANYTOWN	IN	017555-5555	0.77	View
ACME DIAGNOSTIC GROUP	550.00	C	500 ACME DRIVE	ANYTOWN	IN	017555-5555	6.95	View
NATIONAL MEDICAL IMAGING	700.00	C	290 INDIANA STREET	ANYTOWN	IN	017555-5555	5.39	View
CENTER OF DIAGNOSTIC IMAGING	1,600.00	-	2041 CENTRAL AVE	ANYTOWN	IN	017555-5555	7.06	View
TRI-COUNTY IMAGING	1,400.00	-	300 COUNTY LINE ROAD	ANYTOWN	IN	017555-5555	8.95	View

Please note that this table will only be viewable to ordering physicians after they have reached the provider selection portion of the precertification request process. In addition, cost information or modality scores may not be available in some instances. When this occurs, a dash will be displayed in applicable columns.

Member engagement

Using the cost and facility data, AIM will also engage AmeriHealth New Jersey members in the site selection process. Once a precertification request has been received for advanced diagnostic imaging services, AIM specialists will proactively reach out to members to inform them of the imaging facility options available to them. During this outreach, members can potentially reduce their health care expenses (e.g., cost-sharing) by selecting a different facility that is high-quality and low-cost.

Please note that members will not be denied access to services if they do not choose a higher quality or lower cost option. Our goal is simply to provide them with information to make informed choices about their health care.

Registration and completion of the assessment can be done through OptiNet[®]

AIM uses an online assessment tool, called **OptiNet**, through which they collect modality-specific data, including facility qualifications, technologist and physician qualifications, accreditation, equipment, and technical registration. This information is used to assess compliance to industry-recognized standards, including those established by the American College of Radiology and the Intersocietal Accreditation Commission.

continued on the next page

New radiology transparency program for New Jersey members (continued)

We ask that all participating providers in New Jersey who perform the technical component of advanced diagnostic imaging services complete an online assessment through **OptiNet by May 31, 2012**. The data provided will become an important part of the information available to ordering physicians and members. If you are a servicing provider who performs advanced imaging services and you do not complete an assessment, your facility information will not be available to ordering physicians or patients.

The **OptiNet** assessment tool was designed with your convenience in mind:

- **OptiNet** is available online through NaviNet. Select *AIM* from the Authorization option in the Plan Transactions menu, then *Access Your OptiNet Registration*. Click on the green button to launch **OptiNet**.
- You can save your data as you go, which means you do not need to complete the assessment in one sitting.
- A checklist of the information required is available on the AIM **ProviderPortal**SM at www.aimspecialtyhealth.com/goweb. Select the *File Manager* tab and then *Forms*.
- After you complete the assessment, you can update your information at any time.

Please note that if you have already completed the assessment in **OptiNet** in connection with another health plan, you do not need to re-enter your information. Please review the information that has been prepopulated, make any necessary updates, and submit your information to register for AmeriHealth New Jersey.

Provider TIN	Site Name	Site Address	City	Status	Date	Reg Number	Score Card	Reg Summary	Actions
000000001	COMMUNITY HOSPITAL	123 N WIRE DR	SAMPLE	Complete	03/09/2012	00-0009			Edit Copy
000000001	COMMUNITY HOSPITAL	5 WAY AVE	SAMPLE						Register Site
000000001	FIRST HOSPITAL	1 S. PLACE DR	SAMPLE	Complete	03/02/2012	00-0008			Edit Copy
000000001	AREA	678 PLACE	SAMPLE	Complete	03/04/2012	00-0001			Edit

If you have multiple facilities, it is important that you complete an assessment for each one. However, you do not need to re-enter your information, as you can complete the **OptiNet** registration for one facility and copy your data for the others. To copy your data, select *Copy* from the Actions column on your site list and follow the steps when prompted.

If you have questions or need help completing the assessment, call AIM **OptiNet** Customer Service at 1-800-252-2021.

How the assessment information will be used

Upon the completion of the assessment, your responses will be evaluated using the **OptiNet** algorithm, and a modality score (represented by a letter grade) will be assigned to each of your facility's services based on the following scale:

- A = 88 – 100 points
- B = 76 – 87 points
- C = fewer than 76 points

Your facility's modality score, the average allowed payment amount (based on the professional and technical components of previously billed services), and the distance from members' homes will be shared with ordering physicians and their AmeriHealth New Jersey patients to assist them in making important health care decisions regarding advanced diagnostic imaging services.

Please be sure to review the score legend and the *Understanding Your Score Card* document, which are available at the top of your online score card. These reference documents outline the specific measures against which your site has been evaluated and will identify which areas may be deficient.

If you have any questions or concerns about this new transparency effort or about completing your assessment, please contact your Network Coordinator.



Reminder: No referrals required for AmeriHealth New Jersey HMO Plus and POS Plus plans (NJ only)

Members in AmeriHealth New Jersey HMO Plus and POS Plus plans do not need referrals to access care. Plus members can select a participating AmeriHealth New Jersey primary care physician (PCP) who can provide routine and preventive care services and assist members in finding physicians who can provide services such as laboratory, physical therapy, and radiology. With HMO Plus and POS Plus plans, members can visit any network PCP and pay the PCP copayment. Please remember that under the AIM Program, CT, MRI, PET scans, and nuclear cardiology services require precertification. In addition, effective June 1, 2012, echocardiography services will also require precertification.

POS Plus members receive the highest level of coverage by utilizing doctors and hospitals that participate in the AmeriHealth New Jersey network. When POS Plus members choose to visit providers who do not participate in the network, they are responsible for additional out-of-pocket costs.

Small Employer Health (SEH) and Large Group (51+) HMO Plus members must use in-network providers to access benefits.

Unlike a traditional HMO or POS plan, Plus members never need a referral to seek care. HMO Plus members may visit any AmeriHealth New Jersey participating provider directly without obtaining a referral from their PCP. ID cards for these members clearly state that no referrals are required.

If you have questions regarding AmeriHealth New Jersey HMO Plus or POS Plus products, please call Customer Service at 1-800-275-2583 or contact your Network Coordinator or Hospital/Ancillary Services Coordinator.

Cost-sharing for preventive and nonpreventive services



As previously communicated in *Partners in Health Update*, AmeriHealth announced there is no member cost-sharing (\$0) for certain preventive services provided to certain members. These new cost-sharing rules are mandated by the Federal Health Care Reform act known as the Patient Protection and Affordable Care Act of 2010.

The \$0 copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the member is experiencing a significant problem that requires a problem-focused service that could not be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, and follow-up at a shorter interval than would be normally anticipated, it would allow for cost-sharing.

For questions regarding member benefits, log on to the NaviNet® web portal and select *Eligibility and Benefits Inquiry* from the Plan Transactions menu. You can also use the Provider Automated System by calling 1-800-275-2583.



AmeriHealth follows CMS lead with second HIPAA 5010 90-day enforcement grace period

Consistent with the latest statement issued by the Centers for Medicare & Medicaid Services (CMS), AmeriHealth will observe a second 90-day grace period for enforcement of the new HIPAA 5010 transaction standards. This second grace period will expire on June 30, 2012.

The original rule from the U.S. Department of Health and Human Services (HHS) stipulated that any health care entity that submits electronic standard transactions must comply with HIPAA 5010 (errata version) by January 1, 2012. In late 2011, CMS issued a statement announcing a grace period of the enforcement of the new HIPAA 5010 transactions standards through March 30, 2012. CMS has issued a second statement extending the grace period to June 30, 2012.

AmeriHealth will comply with the HHS rule to move to 5010 standards. However, AmeriHealth will continue to accept and remit 4010A transactions through the recommended 90-day enforcement grace period, ending on June 30, 2012.

If you are not prepared to issue and accept HIPAA 5010-compliant transactions by June 30, 2012, you may be adversely affected by conversion activities initiated by AmeriHealth and/or your trading partner (clearinghouse/vendor). We encourage you to continue working with your trading partners to ensure your preparedness and to avoid any negative outcomes during this transition.

If you have any questions concerning your preparedness for the transition to 5010, please contact your trading partner (clearinghouse/vendor).

HIPAA 5010 troubleshooting information



As HIPAA 5010 claims submissions come in, AmeriHealth has been identifying the most common reasons for claims rejections. Please carefully review the examples below to avoid 5010 claims rejections.

Impacts 837P files only

When submitting Other Party Liability (OPL) claims, SBR09 not equal to "P", the new 5010 AMT segment must be submitted when AMT01 = "EAF".

Impacts both 837I and 837P files

- The description is required when submitting a non-specific procedure code. If this information is not present on the claim, the claim will fail compliance.

-837I 2400.SV202-7

-837P 2400.SV201-7

- REF segments are only allowed in the following loops when an NPI is submitted on the claim:

837P HIPAA 5010 Transaction	837I HIPAA 5010 Transaction
2010AA Billing Provider Name	2010BB Payer Name
2010BB Payer Name	2310A Attending Physician
2310A Referring Provider	2310B Operating Physician
2310B Rendering Provider	2310C Other Operating Physician
2310C Service Facility	
2420A Line Level Rendering Provider	

Note: If the subscriber is not the patient, please ensure that the patient's ID is submitted in 2010BA.NM109.

HIPAA 5010 Companion Guides can be found on the AmeriHealth website at www.amerhealth.com/edi. If you have any questions concerning your HIPAA 5010-compliant transactions, please contact your trading partner (clearinghouse/vendor).

ICD-10 Spotlight: Know the codes

ICD | 10

More codes • More detail • Improved accuracy™

Each month, this section will feature an example of how ICD-9 codes will translate to ICD-10 codes. We will present coding examples from different specialties and popular disease categories to demonstrate the granularity that the new ICD-10 code set will provide.

CONDITIONS: CENTRAL CORNEAL ULCER AND MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF FEMALE BREAST

“Laterality” (side of the body affected) is a new coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for conditions such as fractures, burns, ulcers, and certain neoplasms will require documentation of the side/region of the body where the condition occurs.

In ICD-10, laterality code descriptions include right, left, bilateral, or unspecified designations:

- Right side = character 1;
- Left side = character 2;
- Bilateral = character 3;
- Unspecified side/region = character 0 or 9 (depending on whether it is a 5th or 6th character).

The tables below compare the lack of specificity in ICD-9 to the greater level of specificity in ICD-10 when coding a corneal ulcer and female breast cancer.

Condition: Central Corneal Ulcer

ICD-9 coding table	ICD-10 coding table
<ul style="list-style-type: none"> • 370.03 Central corneal ulcer 	<ul style="list-style-type: none"> • H16.011 Central corneal ulcer, right eye OR • H16.012 Central corneal ulcer, left eye OR • H16.013 Central corneal ulcer, bilateral OR • H16.019 Central corneal ulcer, unspecified

Condition: Malignant Neoplasm of Lower-Outer Quadrant of Female Breast

ICD-9 coding table	ICD-10 coding table
<ul style="list-style-type: none"> • 174.5 Malignant neoplasm of lower-outer quadrant of female breast 	<ul style="list-style-type: none"> • C50.511 Malignant neoplasm of lower-outer quadrant of right female breast* AND/OR • C50.512 Malignant neoplasm of lower-outer quadrant of left female breast* OR • C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast

**If a bilateral code does not exist and the condition is bilateral, assign separate codes for both the left and right side.*

For additional information related to the AmeriHealth transition to ICD-10, please visit www.amerihealth.com/icd10.

Updated *Clinical Alerts Overview* is available

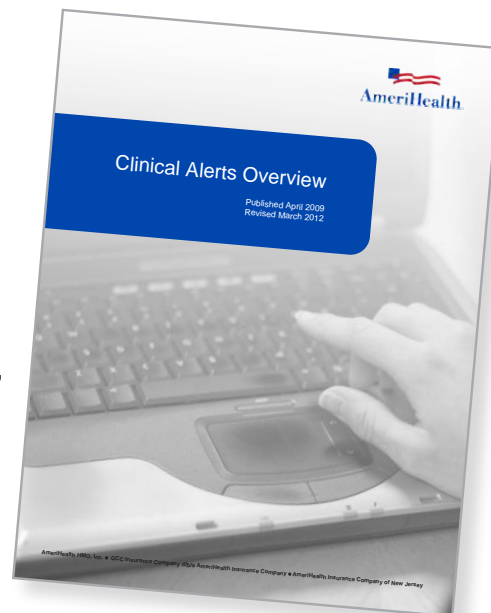
In 2009, Clinical Alerts were introduced as a tool to notify primary care physicians (PCP), OB/GYNs, cardiologists, and endocrinologists when their AmeriHealth patient has not received a recommended service or medication. These notifications are available on the NaviNet web portal through the Eligibility and Benefits Inquiry transaction.

Initially, 13 Clinical Alerts were introduced, including ones for missing mammograms and cholesterol screenings. Recently, the following new Clinical Alerts were added:

- bone mineral density test or drug to treat or prevent osteoporosis;
- HbA1c between 7% – 7.9% for patients with diabetes;
- HbA1c between 8% – 8.9% for patients with diabetes;
- HbA1c greater than 9.0% for patients with diabetes;
- cholesterol \geq 100 mg/dL for patients with diabetes;
- cholesterol \geq 100 mg/dL for patients with cardiovascular conditions.

The *Clinical Alerts Overview*, a user guide for how to access Clinical Alerts, has been updated to include these new alerts. The updated guide is available in the Administrative Tools & Resources section of AmeriHealth NaviNet Plan Central.

Note: PCPs are able to view all of a member's Clinical Alerts; however, specialists can view only those alerts pertaining to their specialty. Please refer to the *Clinical Alerts Overview* for a complete list of all alerts and the specialties they pertain to.



NaviNet enhancement features new urgent care copayment (PA only)

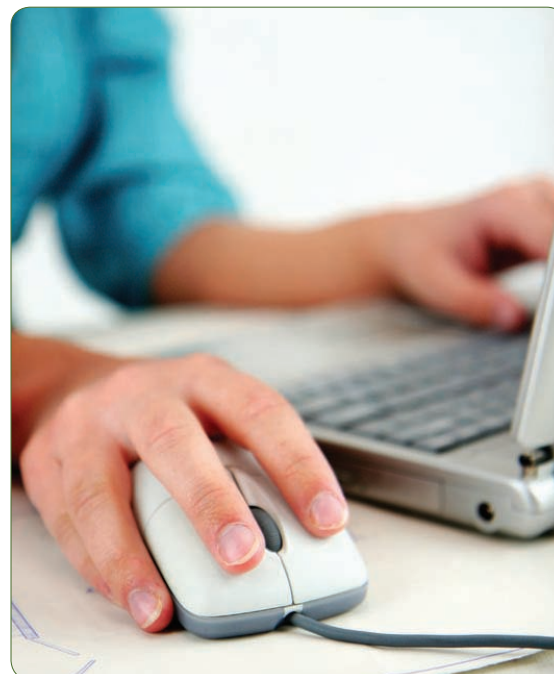
We have recently enhanced our Eligibility and Benefits Inquiry transaction on the NaviNet web portal to include copayment information for urgent care services.

To view the urgent care copayment for eligible members, select *Eligibility and Benefits Inquiry* from the Plan Transactions menu, enter the search criteria for the member, and hit *Select* next to the appropriate member. The urgent care copayment (if applicable) will be listed under *Copays*. The copayment, as well as any applicable coinsurance, will also appear on the *Additional Copays* screen. Please note that not all members are eligible for the urgent care benefit.

Only providers who are specifically credentialed and contracted with AmeriHealth as an urgent care provider can charge an urgent care copayment for urgent care services.

If you have questions related to the urgent care benefit, please contact Customer Service at 1-800-275-2583.

If you have any questions about viewing copayment information on NaviNet, please contact NaviNet Customer Service at 1-888-482-8057 or our eBusiness Provider Hotline at 215-640-7410.



Use the Clinical Care Report to improve coordination of care

The Clinical Care Report was introduced in 2011 to promote better coordination of health care for our members and physicians. Unless a member has opted out, this tool is accessible through the NaviNet web portal and offers participating physicians a snapshot view of care that their patients have received based on AmeriHealth-paid medical and prescription drug claims.

The Clinical Care Report is intended for viewing by the following participating health care providers:

- a member’s personal or primary care physician;
- a new physician with whom a member has an upcoming scheduled appointment;
- a physician who is addressing a current emergency medical need.

Information available in the Clinical Care Report

The information populated in the Clinical Care Report is derived from member claims data and includes the following information:

- disease conditions reported in the past two years;
- visits to the emergency room in the past year;
- hospital admissions in the past four years;
- outpatient procedures in the past two years;
- specialists seen in the past two years;
- prescriptions filled in the past six months;
- alerts by condition (i.e., gaps in care), if any;
- lab tests with results (when available);
- diagnostic imaging in the past two years;
- immunizations in the past four years.

Note: The Clinical Care Report is not a complete medical record of all services, tests, or products that a member may have received. It does not include data for sensitive health conditions such as mental/behavioral health, substance abuse, HIV/AIDS, sexually transmitted diseases, genetic testing, or for services for which AmeriHealth did not pay a claim.

How to grant or remove access to the Clinical Care Report

Initially, only the designated Security Officer(s) in each provider office has access to the Clinical Care Report, and he or she can control user access through the User Management transaction on NaviNet.

Therefore, in order for providers to access the Clinical Care Report, a designated Security Officer first must enable individual users or all users.

JANE Q. SAMPLE CLINICAL CARE REPORT

GENDER: F ADDRESS: 123 ANY STREET, ANY TOWN, PA 19000 DOB: 01/02/1934
 PHONE: 215-555-1234
 PRIMARY PHYSICIAN: ABC PHYSICIANS, 345 ANY STREET, ANY TOWN, PA
 PHONE: 215-555-5678; FAX: 215-555-9876

MEMBERSHIP INFORMATION
 MEMBER ID: 123456789
 PRODUCT: SAMPLE PRODUCT
 HMO
 MEMBER SINCE: 01/01/2011

IMPORTANT INFORMATION ABOUT THIS CLINICAL CARE RECORD
 This Clinical Care Report contains medical, pharmacy and certain lab tests and results based on paid claims data ("Claims Data") submitted to Plan over the past 4 years except for claims data relating to "sensitive health conditions." "Sensitive health conditions" Claims Data is Claims Data concerning mental or behavioral health, HIV/AIDS, sexually transmitted diseases, substance abuse, or genetic testing.

The Clinical Care Report contains confidential member protected health information. Only the primary care provider ("PCP") of the individual to whom the Claims Data relate ("Member") (or provider with a medically necessary reason) is authorized to access this information. Medically necessary reasons for a non-PCP accessing a Member's Clinical Care Report are limited to the following factors or circumstances: (a) the provider is addressing a Member's current emergency medical need; (b) the Member has an appointment with the Member. An "existing medical relationship" means that you have treated the Member within the prior 2 years.

The information contained in this Clinical Care Report must be handled in a manner that protects it at all times from any unauthorized use, access or disclosure and in compliance with HIPAA Privacy and Security Regulations and any other applicable state or federal laws. You agree to use all Clinical Care Report information and related materials solely for the purposes of identifying opportunities for improving clinical quality and outcomes in your medical practice for the Member whose information is included herein. A Clinical Care Report does not, and is not intended to, replace your professional clinical judgment. Please note that any information gaps in the Clinical Care Report may be the result of a number of factors, including, but not limited to: the Member receiving treatment from a provider who is not participating with Plan, the Member not submitting a claim to Plan for the identified service, or the Member having changed health plans thereby precluding Plan access to Claims Data from the other health plan. Please confer with the Member if you have questions about any information gaps.

DISEASE CONDITIONS IN PAST 2 YEARS

Completed Pregnancy With Complications
 Ectopic Pregnancy
 Major Symptoms, Abnormalities
 Monopurpura/Oth Neuro Conditn
 Other Endocrine/Metabolic/Nutritional
 Pelvic Inflamm/Oth Spec Fem Genital
 Post-Surgical States/Aftercare/Elective
 Screening/Observation/Special Exams
 Minor Symptoms, Signs, Findings
 Other Female Genital Disorders
 Miscarriages/Abortion
 Other Gastrointestinal Disorders
 Other Infectious Diseases

ER VISITS IN PAST 1 YEAR

PRIMARY DX CODE	DX DESCRIPTION	DATE	FACILITY NAME
462	ACUTE PHARYNGITIS	01/07/2011	ABINGTON MEMORIAL HOSPITAL
789.04	ABDOMINAL PAIN, LEFT LOWER QUADRANT	11/18/2010	ROXBOROUGH MEMORIAL HOSPITAL

HOSPITAL ADMISSIONS IN PAST 4 YEARS

PRIMARY DX CODE	DX DESCRIPTION	DATE	FACILITY NAME
047.83	OTH SPEC MATERNAL INF&PARASITIC DISEASE	01/17/2011	ALBERT EINSTEIN MEDICAL CENTER
664.81	ANTPRTM		
	OTHER SPECIFIED TRAUMA PERINEUMVULVA	03/23/2010	ABINGTON MEMORIAL HOSPITAL
	WIDELIVERY		

OUTPATIENT PROCEDURES IN PAST 2 YEARS

04/20/2011 11:00 AM Page 1

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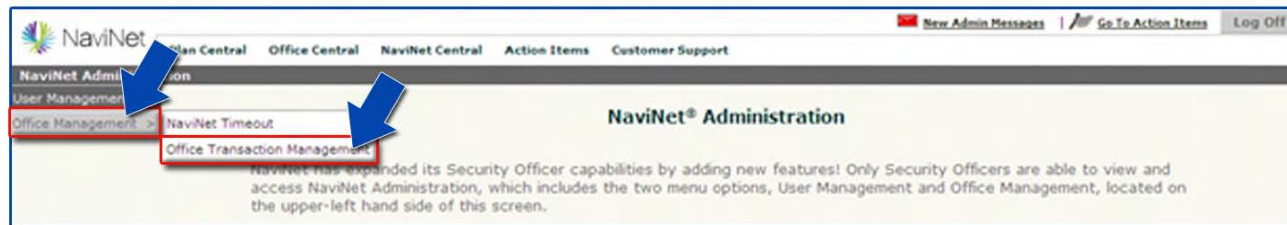
Use the Clinical Care Report to improve coordination of care (continued)

Granting access to all users within an office

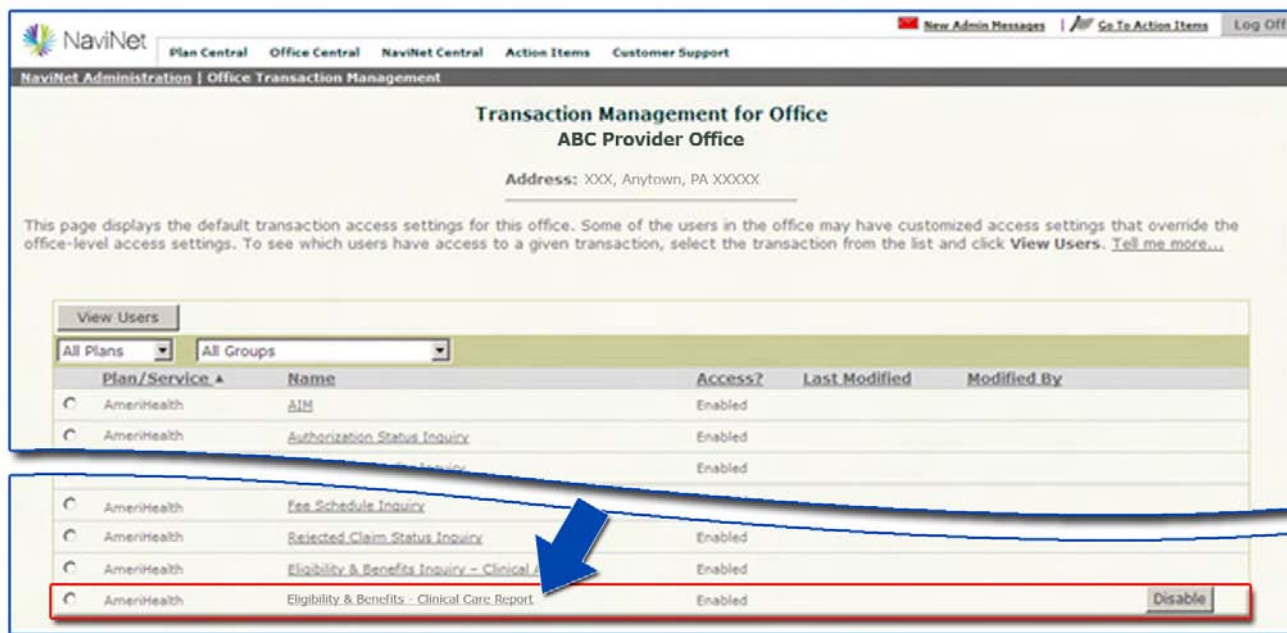
To update the settings to allow all users within an office access to the Clinical Care Report, the designated Security Officer must first select *NaviNet Administration* from the NaviNet Central menu.



Select *Office Management* from the drop-down menu on the left, and then select *Office Transaction Management*.



Scroll down the Transaction Management for Office screen until you find the transaction called *Eligibility & Benefits – Clinical Care Report* in the Name column. Click *Enable* to turn on access to all individuals in your office.



To turn off access for all users in your office, follow the same steps and click *Disable* instead.

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Use the Clinical Care Report to improve coordination of care (continued)

Granting access to only select individuals within an office

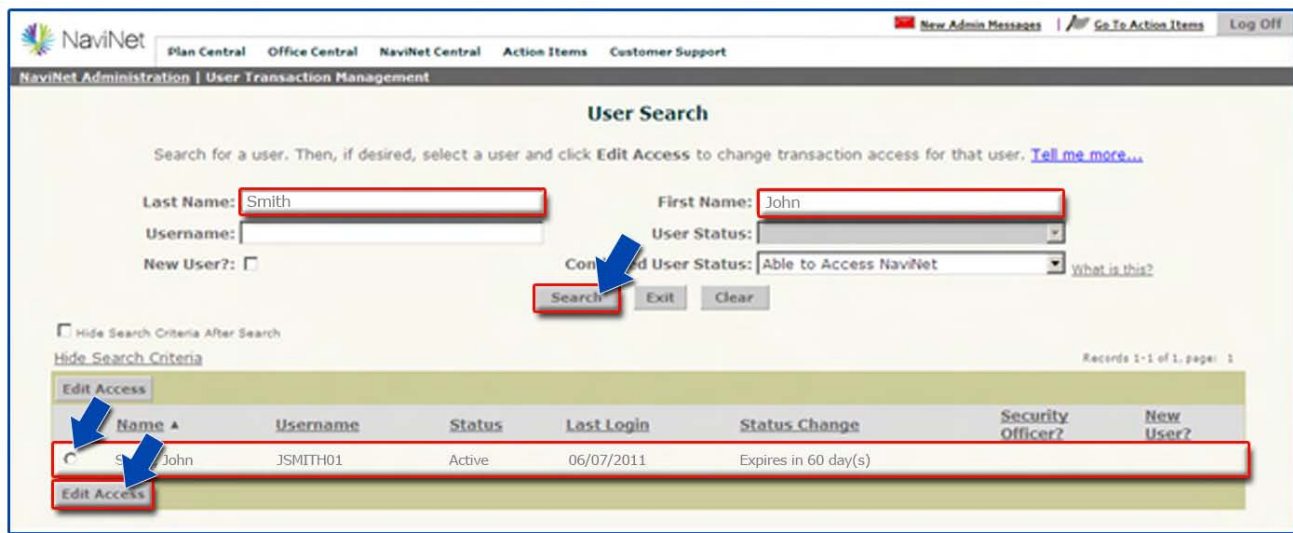
The designated Security Officer can also limit access to the Clinical Care Report to certain individuals within a provider office. To do so, first select *NaviNet Administration* from the NaviNet Central menu.



Select *User Management* from the drop-down menu on the left, and then select *User Transaction Management*.



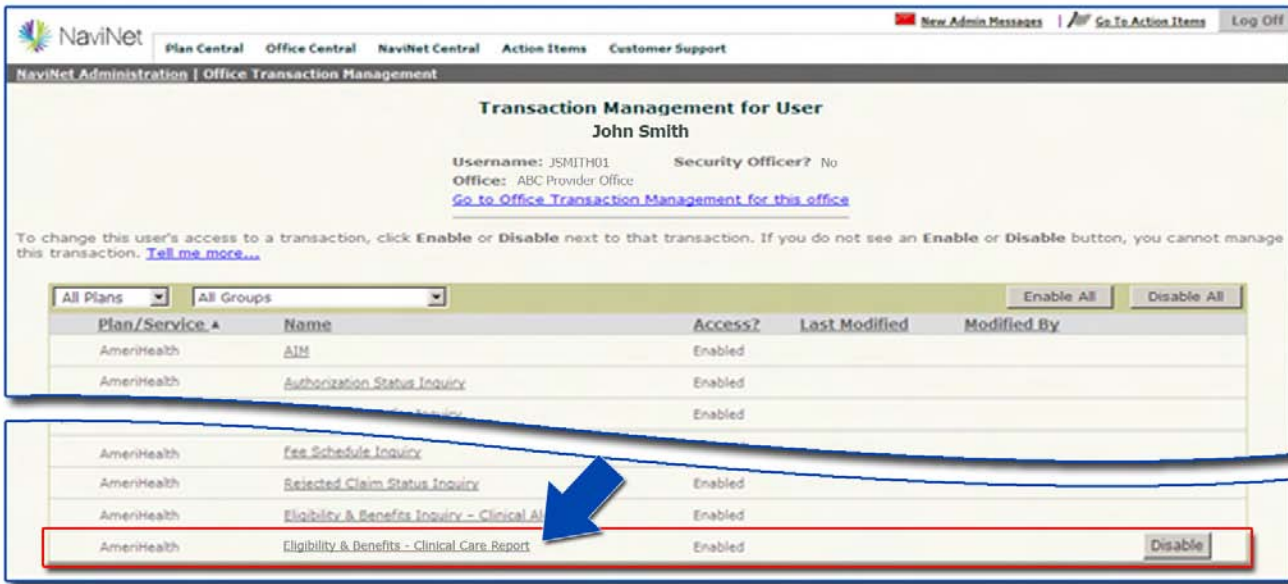
The designated Security Officer must search for the appropriate user by entering a last and first name and then clicking *Search*. Select the appropriate user from the list that populates, and then select *Edit Access* to view the list of transactions.



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Use the Clinical Care Report to improve coordination of care (continued)

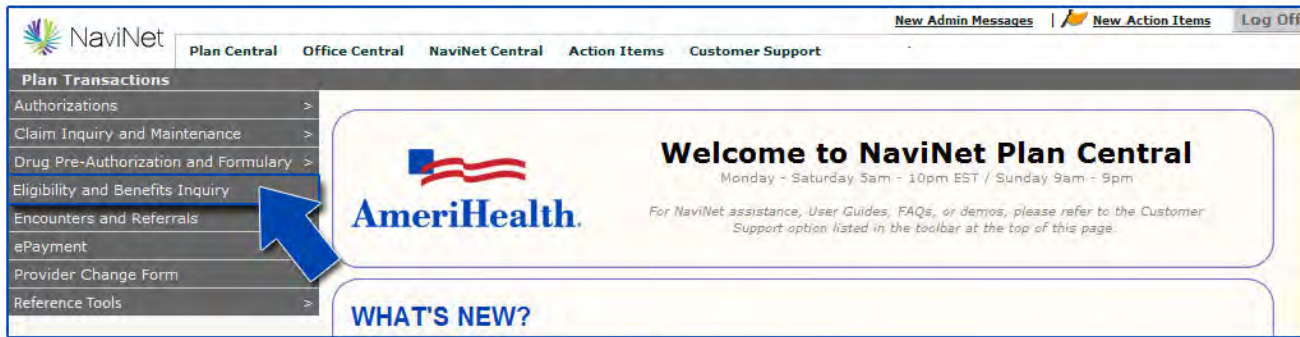
Scroll down the Transaction Management for User screen until you find the transaction called *Eligibility & Benefits – Clinical Care Report* in the Name column. Click *Enable* to turn on access to the individual.



To turn off access for certain individuals in your office, follow the same steps and click *Disable* instead.

How enabled users can view a member's Clinical Care Report

Once enabled, physicians can view the Clinical Care Report by selecting the *Eligibility and Benefits Inquiry* option from the Plan Transactions menu.



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Use the Clinical Care Report to improve coordination of care (continued)

To determine if a member has a Clinical Care Report, the user should enter the member’s information (either the member ID number or last name, first name, and date of birth) and select the *Search* button.

Member Eligibility and Benefits Inquiry

Please Note: Please use the full ID presented on the member’s current ID card or the member’s name and date of birth to search.

Member ID: Member DOB:

Member Last Name: Member First Name:

Date Of Service:

Search Add to List Clear All Fields Clear List

If the member has not opted out of the tool, there will be a flag in the column labeled “CCR”. The blue flag in that column indicates that the member’s Clinical Care Report is available for you to view once you have agreed to abide by the terms and conditions. Click the blue flag to view the report.

Member Eligibility and Benefits Inquiry

Eligibility as of 04/20/2011

Go to Search Screen New Search

Records 1-1 of 1, page: 1

Req ID	Member Name	Member ID	Product Name	DOB	Relationship	Status	Begin Date	End Date	Alert	CCR	R-Panel	DOS	
1	SAMPLE, JANE Q			01/02/1934								01/01/2011	
	SAMPLE, JANE Q	XYZ123456789	SAMPLE PRODUCT	01/02/1934	Subscriber	Active	01/01/2011				N		Select

We hope you’ll find this tool valuable as you care for your patients, our members. If you have questions regarding this tool, please call the eBusiness Provider Hotline at 215-640-7410 for providers in Pennsylvania or Delaware or at 856-638-2701 for providers in New Jersey.

If you are not yet NaviNet-enabled at your office location, register by going to www.navinet.net and selecting *Sign up* from the top right.

Policy notifications posted as of March 26, 2012

All policies are posted prior to their effective date. Below is a listing of the policy notifications that we have posted to our website as of March 26, 2012.

Policy effective date	Policy no.	Notification title	Notification issue date
March 20, 2012	11.08.03h	Lipectomy and Liposuction	December 21, 2011
March 21, 2012	10.01.01i	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Programs	January 18, 2012
March 30, 2012	07.00.14d	Cold Laser Therapy	February 29, 2012
March 30, 2012	07.03.05l	Sleep Disorder Testing	February 29, 2012
April 4, 2012	11.17.06h	Surgical and Minimally Invasive Treatments for Urinary Outlet Obstruction due to Benign Prostatic Hyperplasia (BPH)	January 5, 2012
April 4, 2012	10.06.01e	Speech Therapy	January 5, 2012
April 4, 2012	07.13.07e	Corneal Pachymetry Using Ultrasound	January 5, 2012
April 4, 2012	10.04.01j	Pulmonary Rehabilitation	January 5, 2012
April 4, 2012	11.08.12g	Surgery for Gynecomastia	January 5, 2012
April 4, 2012	05.00.09e	Bone Growth Stimulators	January 5, 2012
April 4, 2012	05.00.37d	Compression Garments	January 5, 2012
April 5, 2012	07.03.09h	Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)	January 6, 2012
April 5, 2012	07.03.18g	Nerve Conduction Studies (NCS) and Related Electrodiagnostic Studies	January 6, 2012
April 5, 2012	07.03.20	Surface Electromyogram	March 6, 2012
June 1, 2012	09.00.46f	High-Technology Diagnostic Radiology Services	March 2, 2012

To view the policy notifications, go to www.amerhealth.com/medpolicy, select *Accept and Go to Medical Policy Online*, and click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet[®] web portal by selecting *Reference Tools* from the Plan Transactions menu, then *Medical Policy*. Once these policies are in effect, they will be available by using the Search box on the Medical Policy homepage. Be sure to check back often, as the site is updated frequently.

Assessing the needs of high-risk Medicare Advantage HMO members

We are pleased to announce two outreach initiatives in 2012 for our high-risk Medicare Advantage HMO members: one for members who are currently in a contracted facility that provides skilled or custodial care (SNF program), and another for select high-risk members who reside at home (In-Home program). Through MedAssurant, local physicians, nurse practitioners, and physician assistants will conduct comprehensive health risk assessments for members either at the facility or in the member's home.

These programs provide face-to-face comprehensive medical assessments for high-risk Medicare Advantage HMO members with complex chronic conditions, at no cost to the member. These assessments will help support the care that primary care physicians (PCP) give to these Medicare Advantage HMO members and identify additional health risks and additional medical management opportunities.

As noted in communications to SNF and at-home members, a MedAssurant representative will contact applicable facilities and members to arrange these comprehensive health risk assessments and review charts as necessary with the members' consent. For

the SNF program, facilities are responsible for providing inpatient medical records and assisting in contacting members' PCPs for information to complete the health risk assessments.

Once the comprehensive health risk assessment is completed, a letter will be sent to the Medicare Advantage HMO members' PCP or other designated provider informing them that an assessment was performed, along with the results. As part of the SNF program, a copy of the comprehensive health risk assessment shall be placed in the patient's medical records in the facility. PCPs should file the comprehensive health risk assessment in their patients' charts and review the results with them during their next visit.

Last year, the comprehensive health risk assessments were well-received by both patients and the provider community. This year we look forward to serving the selected high-risk members and the provider community.

Please call Customer Service at 1-800-275-2583 if you would like more information about this initiative or if you have further questions.

Low-dose chest CT screening for individuals at high risk for lung cancer

As of March 23, 2012, AmeriHealth includes coverage of chest CT screening for our managed care members at high risk for lung cancer.

This decision was made based upon National Cancer Institute-sponsored research published by the National Lung Screening Trial Research Team, in addition to current clinical practice guideline recommendations. Results from the study illustrated a 20 percent reduction in overall lung cancer mortality among high-risk individuals who were randomized to the low-dose CT screening arm of the trial.

This benefit is available for members when all of the following are met:

- The patient has no signs or symptoms suggestive of underlying cancer.
- The patient is between 55 and 74 years of age.
- There is at least a 30 pack-year history of cigarette smoking (if former smoker, quit date is within the previous 15 years).

Providers are required to obtain precertification from AIM Specialty Health (AIM[®]), who is contracted with AmeriHealth to perform precertification for select diagnostic imaging services for our managed care members. Precertification can be requested through the AIM **ProviderPortalSM**, which is available on the NaviNet[®] web portal by selecting AIM from the Authorizations option in the Plan Transactions menu, or at www.aimspecialtyhealth.com/goweb. If you do not have Internet access, call 1-800-275-2583 to request precertification.

If you have any questions regarding this new benefit, please contact your Network Coordinator or Hospital/Ancillary Services Coordinator.

CMS patient safety measures and how you can help

The Centers for Medicare & Medicaid Services (CMS) uses performance and quality measures to help Medicare beneficiaries make informed decisions regarding medical and prescription drug programs. As part of this effort, CMS calculates and publicizes several patient safety measures, many of which are used to calculate ratings for health plans.

We are committed to working with our providers to improve outcomes on these patient safety measures. As a first step, we want to explain each measure as well as the role you can play to ensure that our Medicare Advantage HMO members are receiving care that is both safe and effective. The measures and their descriptions are listed below.

High-Risk Medication (HRM)

The HRM rate analyzes the percentage of Medicare Part D beneficiaries who are 65 and older and have filled prescriptions for medications with a high risk of serious side effects in the elderly. The list of medications that CMS defines as high-risk in the elderly was adapted from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and adapted and endorsed by the Pharmacy Quality Alliance (PQA). Go to www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_07.16.10.pdf (see pages 3-4) for the complete list. Providers should avoid prescribing these medications, when possible, to patients who are 65 and older.

Diabetes Treatment (DT)

The DT rate analyzes the percentage of Medicare Part D beneficiaries who are 18 and older and have filled a prescription for both diabetes and hypertension but did *not* fill a prescription for an ACEI or ARB medication. Providers who have diabetic patients who also need hypertension medications are encouraged to prescribe an ACEI or ARB and educate their patients about the importance of taking an ACEI or ARB in conjunction with treatment for diabetes and hypertension. A list of the diabetes and hypertension medications included in this measure is available at www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_07.16.10.pdf (see pages 5-6).

Drug-Drug Interaction (DDI)

The DDI rate analyzes the percentage of Medicare Part D beneficiaries who have filled a prescription for a targeted medication during the measurement period and who also filled a prescription for a contraindicated medication, either at the same time or subsequent to the initial prescription. Providers can view the list of targeted and contraindicated medications at www.cms.gov/PrescriptionDrugCovContra/Downloads/2010PtSafetyReportEnhan_memo_093010.pdf (see page 8) and should avoid prescribing these medications together.

Diabetes Medication Dosage (DMD)

The DMD rate analyzes the percentage of Medicare Part D beneficiaries who filled a prescription at a dose that was higher than the daily recommended dose for biguanide, sulfonylurea, and thiazolidinedione therapeutic classes of oral hypoglycemic drugs. Providers can view the maximum recommended adult doses for these drugs at www.cms.gov/PrescriptionDrugCovContra/Downloads/2010PtSafetyReportEnhan_memo_093010.pdf (see pages 5-7) and are encouraged to prescribe them within the recommended dose range.

Part D Medication Adherence (ADH)

The ADH rates assess the extent to which Medicare Part D beneficiaries adhered to their prescribed medications in the following drug classes/therapeutic areas: antiretrovirals, cholesterol (statins), hypertension (ACEI or ARB), and oral diabetes medications. Providers are encouraged to educate their patients who have been prescribed these medications about the importance of taking and refilling their prescriptions.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).





Safe use of acetaminophen in infants and children

Since 2011, manufacturers of infant's and children's liquid acetaminophen products (e.g., Tylenol®) have changed the amount of acetaminophen to one standard amount to help eliminate dosage confusion among parents and guardians who administer these medications. Providers who see infants and children should make parents and guardians aware of this change to avoid an accidental overdose of acetaminophen.

More information is available at www.fda.gov/Drugs/DrugSafety/ucm284756.htm.



Updated meningococcal vaccine/booster dose guidelines from the AAP

In December 2011, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the American Academy of Pediatrics (AAP) updated recommendations for the meningococcal vaccine and booster dose.¹

Updated recommendations include vaccinating adolescents at 11 or 12 years with the quadrivalent meningococcal vaccine and administering a booster dose at age 16 with the objective of protecting adolescents and young adults between 16 and 21 years when meningococcal disease rates peak.

The article with the complete list of updated guidelines is published in the journal *Pediatrics*, available online at <http://pediatrics.aappublications.org/content/early/2011/11/22/peds.2011-2380.full.pdf+html>.

www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a4.htm?s_cid=mm6040a4_e%0d%0a



Case management Help for your patients when they need it

Sometimes members need extra support. Registered nurse case managers from AmeriHealth are available to provide telephone support and information to your patients who are experiencing complex health issues or are facing challenges in meeting health care goals. Consider making a referral to case management if any of your patients need help with the following:

- ▶ wound care
- ▶ cancer treatment education
- ▶ complications of pregnancy
- ▶ adherence to treatment plan
- ▶ community resource information
- ▶ coordination of home care services
- ▶ complex pediatric medical conditions
- ▶ socioeconomic support (medications)
- ▶ investigation of benefits for medical equipment
- ▶ chronic condition with multiple comorbid conditions

The case manager will work with your office to find out how best to support the member in following your treatment plan.

To refer a patient to case management, call 1-800-313-8628, or complete an online referral form at www.amerihealth.com/case_mgmt_ref_form.

IMPORTANT RESOURCES

AmeriHealth Direct Ship Injectable Program (medical benefits)	www.amerihealth.com/directship
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.amerihealth.com/antifraud
Care Management and Coordination	
Case Management	1-800-313-8628
Baby FootSteps®	215-241-2198 1-800-598-2229
ConnectionsSM Health Management Programs	
Connections SM Health Management Program Provider Support Line	1-866-866-4694
Connections SM Complex Care Management Program	1-800-313-8628
Credentialing	215-988-1413
Credentialing Violation Hotline	www.amerihealth.com/credentials
Credentialing and recredentialing inquiries (NJ only)	1-866-227-2186
Customer Service/Provider Services	
<ul style="list-style-type: none"> • Provider Automated System (eligibility/claims status/referrals) • Connections Health Management Programs • Precertification/maternity requests <ul style="list-style-type: none"> – Imaging services (PA and DE only) (CT, MRI/MRA, PET, and nuclear cardiology) – Authorizations 	1-800-275-2583
Provider Services user guide	www.amerihealth.com/providerautomatedsystem
eBusiness Help Desk	215-241-2305
FutureScripts® (pharmacy benefits)	
Prescription drug prior authorization	1-888-678-7012
Fax	1-888-671-5285
Direct Ship Specialty Pharmacy Program	1-888-678-7012
Fax	1-888-671-5285
Mail order program toll-free fax	1-877-228-6162
Blood Glucose Meter Hotline	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.amerihealth.com/rx
FutureScripts® Secure (Medicare Part D)	1-888-678-7015
Formulary updates	www.amerihealthmedicare.com
Mail order program toll-free fax	1-877-344-1318
Imaging services (NJ only) (CT, MRI/MRA, PET, and nuclear cardiology)	1-800-859-5288
Medical Policy website	www.amerihealth.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.amerihealth.com/providersupplyline



AmeriHealth

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