HOSPITAL MANUAL

1/21/2009

For Participating Hospitals, Ancillary Facilities, and Ancillary Providers

AmeriHealth® NEW JERSEY

All content current as of January 21, 2009, unless otherwise indicated.

AmeriHealth HMO Inc. • AmeriHealth Insurance Company of New Jersey

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Hospital Manual

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Introduction

Introduction

This *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers (Hospital Manual*) is part of your Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement), as applicable, with AmeriHealth and its Affiliates (collectively referred to as "AmeriHealth" or "Plan" throughout this *Hospital Manual*). It provides you with pertinent policies, procedures, and administrative processes relevant to the Covered Services your facility provides to our Members. Please note that capitalized terms not defined in the *Hospital Manual* have their meanings identified in your current Agreement. In addition to the information contained in this *Hospital Manual*, we will provide your facility with regular updates to AmeriHealth policies and procedures through the following resources:

- *Partners in Health Update*: our monthly newsletter that includes news and announcements on various topics such as administrative processes, medical policies, and other important information
- NaviNet® eBusiness portal: an online gateway that allows real-time transactions between AmeriHealth and its providers
- Facility and ancillary bulletins: valuable resources that provide information about policies and procedures that are essential to participating providers
- Website: *www.amerihealth.com/providers*

Note: All information is current as of January 21, 2009.

Who is "Plan"?

The term "Plan" used throughout this *Hospital Manual* refers to AmeriHealth's managed care subsidiaries and Affiliates, including, but not limited to, AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO, Inc., which offer the following managed care benefits plans:

Health Maintenance Organization (HMO)/Point-of-Service (POS)

- AmeriHealth POS
- AmeriHealth POS Plus
- AmeriHealth HMO
- AmeriHealth Small Employer Health (SEH) POS
- AmeriHealth SEH HMO
- AmeriHealth 65® (Medicare Advantage HMO/POS)

Preferred Provider Organization (PPO)

- AmeriHealth PPO
- AmeriHealth SEH PPO

Traditional

- AmeriHealth SEH Comprehensive Major Medical

Finding information quickly and easily

This *Hospital Manual* is available online as an Adobe Acrobat® Portable Document Format (PDF) file. PDFs are universally accessible via standard web browsers and provide simple navigation, making finding information quick and easy.

Use the keyword search function

Every word in the *Hospital Manual* can be found by conducting a keyword search. There are several simple ways to start a search. Each of these methods will produce the same results:

- Choose *Edit/Search* from the main menu drop-down.
- Press CTRL and F.
- Type directly into the "Find" field that may already appear on your toolbar.
- Right-click your mouse, and choose *Search*.

Use the Table of Contents

A hyperlinked Table of Contents is provided at the beginning of each section. Just click on a topic of interest and you will be taken directly to that section.

Use the reference links

For your ease of reading and navigation, many sections of the *Hospital Manual* reference a particular page or section within the manual where additional information is located. These references are displayed in *green*. Whenever you come across one of these references, simply click the *green* text to view the page or section indicated.

Example: Please refer to the *General Information* section for additional contact information.

Use the websites

All websites mentioned in the *Hospital Manual* are hyperlinked. If the *Hospital Manual* refers to a website — either an AmeriHealth or third-party website — you can just click the *italicized* web address, and the website will open in your default web browser. All links are current as of the date indicated at the bottom of each section.

Note: You must have an Internet connection to view these sites.

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General Information

Member eligibility

It is important to properly identify the Member's type of coverage. All Member ID cards contain information such as name, ID number, alpha prefix, coverage type, and copayments. The information on the card may vary based on the Member's benefits plan. Eligibility is not a guarantee of payment. In some instances, the Member's coverage may have been terminated.

How to check Member eligibility

- Always check the Member's ID card before providing service.
- If a Member is unable to produce his or her ID card, ask if the Member has a copy of his or her Enrollment/Change Form or temporary insurance information printed from the amerihealthexpress.com Member portal. This form provides Members temporary identification and can be used as an accepted proof of coverage until the actual ID card is issued.
- Participating facilities are encouraged to use either the NaviNet® portal or the Interactive Voice Response (IVR) system for all Member eligibility inquiries.

AmeriHealth has no obligation to pay for services provided to individuals who are not eligible Members on the date of service.

AmeriHealth New Jersey products

Please refer to the Eligibility Detail screen on NaviNet to obtain Member eligibility information. You may also call Customer Service for specific product information. The following tables outline the products offered through AmeriHealth. The alpha prefix found on the Member's ID card will assist you in quickly identifying our Members.

AmeriHealth New Jersey

Products	Alpha prefix
Point-of-Service (POS) and Small Employer Health (SEH) POS	Any of the following prefixes: ▪ Q1A ▪ Q1P
Preferred Provider Organization (PPO)	Q1B
Health Maintenance Organization (HMO) and SEH HMO	Q1C
SEH Comprehensive Major Medical (CMM)	Q1H
AmeriHealth 65® HMO (Medicare Advantage)	Q1N
AmeriHealth 65® POS (Medicare Advantage)	Q1N
SEH PPO	Q1S
Traditional Medical	Q1T

Note: AmeriHealth Administrators uses the suffix TPA. It does not use an alpha prefix.

Capitation

Under the HMO benefits program, select services are capitated for HMO Members. The following specialties include a capitated program:

- laboratory
- radiology*
- rehabilitative therapy*
- behavioral health

Members must be referred to their Primary Care Physician's (PCP) designated site for these capitated services. If the PCP's capitated site cannot perform a capitated study/service, that site is responsible for subcontracting with a participating AmeriHealth provider. To use a site other than the designated site or their subcontractor, the PCP must Precertify the service, which includes providing a clear medical rationale for selection of a site other than the designated site.

Hospitals that are contracted as a capitated provider should only accept Referrals from those PCPs that have selected their facility as their designated site for capitated services. Hospitals that are not contracted as a capitated provider should accept Referrals for capitated services only if the Referral has a subcontracting confirmation or per the Member's request with a valid Referral from AmeriHealth. Hospitals contracted as a capitated provider will be compensated in accordance with their Agreement.

**These services apply to southern New Jersey only which includes the following counties: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.*

The northern New Jersey counties include the following: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren.

Behavioral health services

Behavioral health services are capitated to Magellan Behavioral Health, Inc. However, PCPs do not have designated behavioral health providers. Eligible members can self-refer to any Magellan Behavioral Health, Inc. contracted provider.

Preapproval/Precertification

Preapproval/Precertification is required for certain services prior to services being performed. Examples of these services include planned or elective Inpatient Admissions and select Outpatient procedures. Preapproval/Precertification requirements vary by benefits plan; please reference *Appendix A* for specific requirements.

Note: Preapproval/Precertification is not required for Emergency Services.

For detailed information on Preapproval/Precertification, please see the *Care Management and Coordination* section of this Manual.

eConnectivity

The NaviNet® portal

The NaviNet portal is the HIPAA*-compliant, web-based connectivity solution (offered by NaviMedix®, Inc.) that streamlines administrative tasks, provides a wealth of time-saving electronic transactions, and provides you with news, announcements, and other valuable communications.

** HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability and continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations stated within the Act.*

Plan Central

"Plan Central" is AmeriHealth's dedicated news and information section, designed to keep you up to date with publications, important effective dates, product details, new programs, administrative tools and resources, and much more.

Plan Central content and links

- provider news
- *Partners in Health Update*
- NaviNet billing tips
- contact information
- third-party links

Inquiries and submissions

The NaviNet portal provides connectivity for both transaction inquiries and submissions. The following transactions apply to hospitals, ancillary facilities, and ancillary providers. Exceptions are indicated using the following key: Hospital (H); Ancillary (A).

Inquiries

- Accepted Claims Status Inquiry
- Authorization Status Inquiry
- Claims INFO Adjustment Inquiry
- Diagnosis Code Inquiry
- Eligibility and Benefits Inquiry
- ePayment – Online SOR Inquiry
- Procedure Code Inquiry
- Referral Inquiry
- Rejected Claim Status Inquiry
- Report Inquiry
- View A/R Aging Report

Submissions

- Cardiac Rehab Authorization – Facility-based (H)
- Chemotherapy/Infusion Authorization
- Request A/R Aging Report
- Claims INFO Adjustment Submission
- DME Authorization (A)
- ER Admission Notification (H)

- Home Health Authorization (A)
- Home Infusion Authorization (A)
- Drug Preauthorization
- EFT Registration
- Encounter Submission
- Medical/Surgical Authorization – Acute Care and Ambulatory Surgery Centers
- OB/GYN Referral Submission
- Provider Change Form
- Pulmonary Rehab Authorization – Hospital-based (H)
- Referral Submission
- Sleep Studies
- Speech Therapy – Speech Therapy providers and Facility-based Speech Therapy departments
- User Permission Manager (Security Officer Only) – EFT and SOR Registration

Featured resources

The following information is available to all NaviNet-enabled providers:

- **Access to Medical Policy via NaviNet** – View medical, claim payment, and pharmacy policies.
- **American Imaging Management, Inc. (AIM) Radiology Precertification** – Follow the NaviNet link to AIM's website to view online Precertification requests, or call AIM at 1-800-859-5288. *Note:* All providers must register with AIM prior to using the AIM website.
- **Authorization – Authorization Status Inquiry** – View Inpatient, Outpatient, and concurrent authorizations. When applicable, edit admission or service dates for approved authorizations.
- **Authorization Submission** – Submit authorization requests for selected services. You can authorize medical or surgical procedures at an acute-care facility or ambulatory surgical center.
- **Benefits Snapshot** – View a summary of benefits with copayments.
- **Claims A/R Aging –** Retrieve claims data in a report format, which can be exported to Microsoft® Excel, for service dates up to two years prior to the date of your search. You may retrieve claims data by using your provider number or tax identification number (TIN).
- **Claim INFO Adjustment Submission** – View existing claim detail for service dates up to two years prior to the date of your search and submit requests to AmeriHealth for claim adjustments, retractions, and late charges.
- **Claim Inquiry and Maintenance** – Search for and retrieve up to two years of historic claims data (including paid, rejected, denied, remit cycle, and in-process/pended claims) by using your TIN or group provider ID number.
- **Drug Formulary** – Obtain the list of the U.S. Food and Drug Administration-approved medications chosen for their medical effectiveness, safety, and value.
- **ePayment – Electronic Fund Transfer (EFT) and Online Statement of Remittance (SOR)** – Register and maintain your EFT account and receive claim payments electronically by viewing the ePayments screen. Once registered, use this feature to view all remittances issued to you and to search for an SOR using your facility's internal patient account number. SOR information can be viewed for a 13-month rolling calendar. *Note:* The NaviNet portal security officer can enable the above options by using the user permissions manager.
- **Member Eligibility and Benefits Inquiry** – Confirm Member ID, product, date of birth, relationship to the insured, coverage status, copayment, and Coordination of Benefits (COB) information.
- **Referral Inquiry** – View all Referrals (generated via NaviNet or the IVR system) to your facility.

- **Referral Submission** – PCPs and OB/GYNs must submit Referrals electronically to AmeriHealth and to NaviNet-enabled facilities and specialists. There are also fax and print options available via NaviNet.
- **Additional functionality** – View aging reports, procedure and diagnosis code inquiries, report inquiries, and user permissions manager.

Electronic Data Interchange claims submission

Electronic Data Interchange (EDI) claims submission is the most effective way to submit your claims. EDI claims submission reduces payor rejections and administrative concerns and increases the speed of claims payment by submitting HMO, PPO, and POS claims electronically. For information and inquiries about electronic submissions, please contact the eBusiness Help Desk at 215-241-2305 or through email at *claims.edi-admin@amerihealth.com*. Additional EDI billing information can be viewed online at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html*. Providers without electronic connectivity should contact Customer Service at 1-800-275-2583, prompt 2 for Provider Services.

Contact information

In addition to NaviNet and *www.amerihealth.com*, the list of resources provided below is available for your reference.

Important telephone numbers

American Imaging Management Call for CT/CTA, MRI/MRA, PET, and nuclear cardiology Precertification requests	1-800-859-5288
AmeriHealth Administrators **Provider Relations** (Direct all inquiries or issues directly to AmeriHealth Administrators)	1-800-841-5328 *provrelations@amerihealth-tpa.com*
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707
Baby FootSteps® Perinatal case management Nurse on call 24 hours a day	1-800-598-BABY
Care Management and Coordination Case Management (For Precertification/Preapproval, please see "Health Resource Center") HMO/PPO (Medicare Advantage and commercial) Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-313-8628 or 856-778-6374
Connections℠ Health Management Programs Call for disease management and decision support Connections℠ Health Management Program Connections℠ AccordantCare™ Program	 1-866-866-4694 1-866-398-8761
Credentialing violation hotline	215-988-1413

Customer Service AmeriHealth HMO/PPO Hours: Mon. – Fri., 8 a.m. – 6 p.m. AmeriHealth 65 Hours: Mon. – Sun., 8 a.m. – 8 p.m. TTY/TDD	 1-800-275-2583 1-800-645-3965 1-888-857-4816
Electronic Data Interchange (EDI)	215-241-2305 *claims.edi-admin@amerihealth.com*
FutureScripts® Prescription drug Preauthorization Hours: Mon. – Fri., 9 a.m. – 5 p.m. **FutureScripts® Secure** Medicare Part D prescription drug Preauthorization Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pharmacy appeals Blood glucose meter hotline	1-888-678-7012 1-888-678-7015 Toll-free fax: 1-888-671-5285 NJ appeals: 1-877-585-5731, prompt 2 1-877-585-5731 (prompt 2) 1-888-678-7012 (prompt 2)
Health Resource Center AmeriHealth Healthy Lifestyles℠ Hours: Mon. – Fri., 8 a.m. – 6 p.m. Precertification Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-275-2583
Interactive Voice Response (IVR) system	1-800-275-2583, prompt 2
Mental Health/Substance Abuse Magellan Behavioral Health, Inc. Member Services/Precertification Hours: 24 hours a day, 7 days a week	1-800-809-9954
NaviMedix®	1-888-482-8057
NaviNet® portal registration and questions	856-638-2701
Provider Services	1-800-275-2583, prompt 2
Provider Supply Line	1-800-858-4728

Claims mailing addresses

AmeriHealth Administrators
720 Blair Mill Road
Horsham, PA 19044

Note: Submit AmeriHealth Administrators new claims or adjustment requests directly to AmeriHealth Administrators. Do not submit AmeriHealth Administrators claims to the AmeriHealth HMO/POS, PPO claims addresses. Reference the back of the member ID card for specific claim mailing instructions.

AmeriHealth Processing Center
P.O. Box 41574
Philadelphia, PA 19101-1574

This address is for all HMO/POS and PPO claims and Magellan Behavioral Health, Inc. claims for the following products: Self-Referred (Out-of-Network) POS, New Jersey without the National Access Rider Standard and Flex PPO, and CMM.

Magellan Behavioral Health Claims Submission
Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958

This address is for the following claims: HMO/Referred (In-Network) POS, POS Plus with the National Access Rider, and New Jersey with the National Access Rider (In-Network and Out-of-Network).

Appeals mailing addresses

Member Medical Necessity Appeals – NJ
AmeriHealth New Jersey Appeals Unit
8000 Midlantic Drive, Suite 333 North
Mount Laurel, NJ 08054-1560

Member Administrative Appeals – NJ
Member Appeals Department
8000 Midlantic Drive, Suite 333 North
Mount Laurel, NJ 08054-1560

Inpatient Facility Appeals – NJ
P.O. Box 13985
Philadelphia, PA 19101-3985

Medicare Advantage HMO Member Appeals
Medicare Member Appeals Unit
P.O. Box 13652
Philadelphia, PA 19101-3652

Provider Claims Appeals – NJ (HMO/PPO)
Claims Payment Appeals Unit
P.O. Box 7218
Philadelphia, PA 19101

General mailing addresses

Claim Payment/Overpayment Refunds (AmeriHealth HMO and PPO)
P.O. Box 15075
Newark, NJ 07192-5075

Provider Services

Provider Services can serve as a valuable resource to you. The role of Provider Services is to:

- educate providers;
- facilitate effective communications by providing timely, accurate responses to telephone inquiries;
- identify service problems and their root causes and develop solutions.

To reach Provider Services, please call Customer Service at 1-800-275-2583, prompt 2.

Hospital and Ancillary Service Coordinators

Hospital and Ancillary Service Coordinators play an important role in educating our participating providers on policies, procedures, and specific billing processes. In an effort to build and sustain a strong working relationship with you, these coordinators will contact you regularly to:

- resolve issues
- review clinical and claim payment policies
- discuss new policy implementation
- explain new products and programs
- investigate and assist in resolution of inquiries

If you are unsure who your coordinator is, please contact Customer Service at 1-800-275-2583, prompt 2 for Provider Services, to obtain the name and contact information for your Hospital and Ancillary Service Coordinator.

Claims submissions

Clean Claim: A Clean Claim is a claim for payment for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by AmeriHealth or substantiating documentation or a particular circumstance requiring special handling or treatment, which prevents timely payment on the claim.

The following information is generally required for a Clean Claim:

- patient's full name
- patient's date of birth
- valid Member ID number including prefix
- statement "from" and "to" dates
- diagnosis codes
- facility bill type
- revenue codes
- procedure codes (e.g., CPT® at the line level for outpatient claims, ICD-9 CM at the claim level for Inpatient claims)
- charge information and units
- service provider's name, address, and National Provider Identifier (NPI)
- provider's TIN

Missing or incomplete information will result in a claim being returned to you. Returned claims must be corrected and resubmitted within the time frame specified in your Agreement with AmeriHealth in order to be eligible for payment.

Claims submission requirements

Institutional and Professional Loop and Data Elements

For information on Institutional and Professional Loop and Data Elements, refer to the NPI Toolkit located at *www.amerihealth.com/providers/npi*. To view our 837P and 837I companion guides, visit *www.amerihealth.com/providers/claims_and_billing/edi/forms.html*. AmeriHealth recommends that you share our electronic billing requirements and updates with your billing vendor.

UB-04 data field requirements

A description of how to complete a paper UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*. Providers who bill electronically should bill according to their specifications. Failure to use the UB-04 form will result in the claim being returned to you or claim denial.

CMS-1500 field requirements

The CMS-1500 form should only be used by ancillary providers, such as home infusion, durable medical equipment, ambulance, and private duty nursing.

Providers who bill electronically should bill according to their specifications. Failure to use the CMS-1500 form will result in the claim being returned to you or claim denial. A description of how to complete a paper CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Coordination of benefits/Other party liability

Where AmeriHealth is determined to be the secondary Payor, AmeriHealth will reimburse for any *remaining* patient liability, not paid by the primary carrier, *only* up to and including its own fee schedule or contracted rate, excluding applicable deductibles, copayments, and coinsurance. As a result, the total of the primary carrier's payment plus any balance paid by AmeriHealth will never exceed the contracted rate of payment.

Motor vehicle accident

All claims, up to the appropriate auto benefits amount related to the motor vehicle accident (MVA), are coordinated with the auto insurance carrier.

- To expedite payment, the provider should bill the auto insurance carrier first.
- When the auto insurance carrier sends notice that the applicable auto benefits have been exhausted, the provider should submit an exhaust letter with each claim form that is submitted to ensure prompt payment and to avoid a timely filing denial.
- Members should not be billed or be required to pay before MVA-related services are rendered.

Workers' compensation

If a claim is related to a workers' compensation accident, the provider must bill the workers' compensation carrier first. If the workers' compensation carrier denies the claim, the provider should submit the bill to AmeriHealth with a copy of the denial letter attached to the claim.

To expedite payment, include the following information when filing a workers' compensation claim:

- Member's name
- Member's ID number
- date of accident
- name and address of workers' compensation carrier

Coordination of benefits for dependents

AmeriHealth processes COB claims for dependents of Members with different coverage plans according to the "birthday rule." If both parents have family coverage with two different health plans, the parent whose birthday falls nearest to January 1 is the primary insurance carrier.

Example: If the mother's birthday is January 30 and the father's birthday is March 1, the mother's plan is primary.

Exceptions to the "birthday rule" may apply under certain conditions, including but not limited to, where required by divorce decree, child custody, or other court order.

Claims inquiries and follow-up

NaviNet is an available resource for claims status and adjustment requests. This option is outlined in detail in the *eConnectivity* section. If NaviNet is unavailable, you should contact Customer Service. The unit's hours of operation are 8 a.m. to 5 p.m., Monday through Friday. Inquiries regarding claims status should be directed to 1-800-275-2583, prompt 2 for Provider Services.

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Care Management and Coordination

Overview

The Care Management and Coordination (CMC) department is comprised of health care professionals whose objective is to support and facilitate the delivery of quality health care services to our Members. This is accomplished through several activities, including Precertification of elective health care services, medical review, facilitation of discharge plans, and case management.

Utilization Review process and criteria

Utilization Review overview

Utilization Review is the process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Member's benefits plan.

In order for a health care service to be covered or payable, it must be eligible for coverage under the benefits plan, and it must be Medically Necessary. To assist us in making coverage determinations for certain requested health care services, we use established AmeriHealth medical policies and medical guidelines based on clinical evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting where the services are to be performed is also part of the Utilization Review.

It is not practical to verify Medical Necessity on all procedures on all occasions. Therefore, certain procedures may be determined by AmeriHealth to be Medically Necessary and automatically approved based on the following:

- the generally accepted Medical Necessity of the procedure itself
- the diagnosis reported
- an agreement with the provider performing the procedure

For example, certain services received in an emergency room (ER) are automatically approved by AmeriHealth. The approval is based on the procedure having met Emergency criteria and on the severity of the diagnosis reported (e.g., rule out myocardial infarction or major trauma). Other requested services, such as certain elective Inpatient or Outpatient Services, may be reviewed on a case-by-case basis in which the specific procedure and setting are considered.

Utilization Review generally includes several components that are based on the timing of the review itself. When review is required before a service is performed, it is called a *Preapproval*/*Precertification Review*. Reviews occurring during a hospital stay are called *Concurrent Reviews*. Those reviews occurring after services have been performed are called either *Retrospective* or *Post-Service Reviews*. AmeriHealth follows applicable State and Federally required standards for the time frames in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval. Only an AmeriHealth Medical Director may deny coverage for a procedure based on Medical Necessity. The evidence-based clinical protocols are used to evaluate the Medical Necessity of specific procedures, the majority of which are nationally recognized, standardized guidelines. Information provided in support of the request is entered into a computer-based system and evaluated against the clinical protocols. The nurses review applicable policies and procedures in the benefits plan, taking into consideration the individual Member's condition and applying sound professional judgment. When the clinical criteria are not met, the given

service request is referred to an AmeriHealth Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. If a procedure is denied for coverage based on lack of Medical Necessity, a letter is sent to the requesting provider and Member notifying them of the denial and appeal rights in accordance with applicable law.

AmeriHealth's Utilization Review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing physicians with direct access to AmeriHealth Medical Directors to discuss coverage of a case. The nurses, AmeriHealth Medical Directors, other professional providers, and independent medical consultants who perform Utilization Review services are not compensated or given incentives based on their coverage review decisions. AmeriHealth Medical Directors and nurses are salaried; contracted external physicians and other professional consultants are compensated on the basis of the number of cases reviewed, regardless of the coverage determination. AmeriHealth does not specifically reward or provide financial incentives to individuals performing Utilization Review services for issuing denials of coverage. There are no financial incentives that would encourage Utilization Review decisions that result in underutilization.

Clinical criteria, guidelines, and resources

The following clinical criteria, guidelines, and other resources are used to help make Medical Necessity and appropriateness coverage decisions:

InterQual®: The InterQual clinical decision-support criteria model is based on the evaluation of intensity of service and severity of illness.

Covered Services for which InterQual criteria may be applied include, but are not limited to, the following:

- elective-surgery settings for Inpatient and Outpatient procedures
- Inpatient hospitalizations
- Inpatient rehabilitation
- home health care
- skilled nursing facility (SNF)
- long-term acute care
- observation

Centers for Medicare & Medicaid Services (CMS) Guidelines: CMS adopts and publishes a set of guidelines for coverage of services by Medicare (for Medicare Advantage Members). CMS guidelines are also used to help determine coverage for durable medical equipment (DME) services for all products.

AmeriHealth Medical Policies: AmeriHealth internally develops a set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services. AmeriHealth medical policies may be applied for Covered Services including, but not limited to, the following:

- nonemergency ambulance transports
- infusion therapy
- speech therapy
- DME
- review of potential cosmetic procedures
- review of potential experimental or investigational services

Delegation of Utilization Review activities and criteria

Independence Healthcare Management is responsible for the Utilization Review process and is a state-licensed Utilization Review entity. In certain instances, AmeriHealth has delegated Utilization Review activities to entities with an expertise in medical management of a certain membership population, such as neonates/premature infants, or type of benefits, such as mental health/substance abuse. A formal delegation and oversight process is established in accordance with applicable law and with nationally recognized Utilization Review and quality assurance accreditation body standards. In such cases, the delegate's Utilization Review criteria are generally used, with AmeriHealth approval.

Facility Preapproval/Precertification Review

For services requiring Preapproval/Precertification, facilities are encouraged to contact AmeriHealth at least **five business days prior** to the scheduled date of the procedure to ensure documentation of timely Precertification. Preapproval/Precertification can be obtained by either calling the Health Resource Center (HRC) or by accessing NaviNet®. To reach the HRC, call 1-800-275-2583, prompt 2, then prompt 3. HRC representatives are available Monday through Friday, 8 a.m. to 5 p.m. Providers may also obtain the status of an authorization by calling the HRC or by accessing NaviNet.

After business hours, a nurse is on call to assist with Preapproval inquiries regarding urgent services and discharge planning needs or to help direct Members or providers to appropriate settings. The after-hours on-call nurse can be reached by calling 1-800-275-2583, prompt 2, then prompt 3.

At the time of Preapproval/Precertification Review, the following information will be requested:

- name, address, and phone number of Member
- relationship to Member
- Member ID number
- group number
- physician name and phone number
- facility name
- diagnosis and planned procedure codes
- indications for Admission: signs, symptoms, and results of diagnostic tests
- past treatment
  - date of Admission or service
  - estimated length of stay (SNF and rehabilitation only)
  - current functional level (SNF and rehabilitation only)
  - short- and long-term goals (SNF and rehabilitation only)
  - discharge plan (SNF and rehabilitation only)

If the required Preapproval/Precertification is not requested and the Member is already admitted, the facility should contact the HRC following Admission, either by phone or through NaviNet, to initiate approval of the remaining Inpatient days. If AmeriHealth approves the Admission, the day of the Admission review will be considered the first day of Admission, and all prior Inpatient days of the Admission will be denied.

Certain products have specialized Referral and Preapproval/Precertification Review requirements.

- A list of current Preapproval/Precertification requirements by product is available in *Appendix A*.
- A list of certain diagnostic procedures exempt from Precertification is available in *Appendix B*.
- Certain infusion drugs require Preapproval/Precertification when provided in all settings for most HMO, PPO, and POS plans. A list of these drugs is available in *Appendix C*.

Note: Infusion drugs that are newly approved by the U.S. Food and Drug Administration during the term of a facility contract are considered new technology and will be subject to Preapproval/Precertification requirements, pending notification by AmeriHealth.

Please check with Provider Services for information pertaining to individual membership benefits.

Providers registered with NaviNet may submit authorization requests for services rendered by a home health provider, infusion therapy provider, prosthetics provider, or DME provider.

Nonemergency ambulance transport

Nonemergency medical ambulance transport services require Preapproval/Precertification when such a transport meets *all* of the following criteria:

- It is a benefit as outlined in the Member contract.
- It is a means to obtain Covered Services or treatment.
- It meets requirements associated with transport origin, destination, and Medical Necessity.

Our Nonemergency Ambulance Transport Services policy can be viewed on our website at *www.amerihealth.com/medpolicy*.

Obstetrical Admissions

Preapproval/Precertification for a maternity Admission for a routine delivery is not required. However, through our Baby FootSteps® prenatal program, obstetricians are encouraged to notify AmeriHealth of future deliveries through a maternity questionnaire.

Hospital notification

Hospitals must notify CMC of Members' obstetrical admissions within 48 hours or the next business day, whichever is later.

The delivery information provided to AmeriHealth needs to include the type of delivery and condition of the newborn baby (e.g., if the baby was put in a NICU or transferred to another facility).

Penalties for lack of Preapproval/Precertification

It is the network provider's responsibility to obtain Preapproval/Precertification for certain services. Please refer to *Appendix A* for more details. Members are held harmless from financial penalties if the network provider does not obtain prior approval.

Concurrent Review

Concurrent Review is the review of continued stay in the hospital after an Admission is determined to be Medically Necessary/Appropriate. Our Concurrent Review program consists of both onsite and telephonic review, based on the Agreement with the individual hospital.

- Concurrent Review is performed where the reimbursement is based on per diem reimbursement.
- Where payment is based on a per-case or diagnosis related group (DRG)-based arrangement, a determination is made whether the Admission meets criteria guidelines, both in elective and Emergency scenarios, and no further Concurrent Review is performed.
- Under DRG reimbursement, hospitals must provide AmeriHealth with requested clinical updates for Members who remain Inpatient at the following checkpoints: 5 days, 10 days, 17 days, and weekly

thereafter. The clinical updates will assist in making appropriate discharge planning arrangements and case management referrals.

- In certain situations, based on diagnosis, procedure, or where an Agreement with the hospital does not support the review, Concurrent Review may not be performed.

Onsite Concurrent Review process

- When onsite Concurrent Review is performed, the hospital provides the onsite review nurse with a daily census report of all Members who are admitted to or are currently Inpatients at that facility.
- The Members' charts will be reviewed by the onsite review nurse on or before the Member's last covered day using InterQual criteria.
- If all pertinent information is available on the chart for approval, an expected length of stay is assigned. If information is not available, the case will be pended until information is available, or AmeriHealth may contact the Member's physician or hospital case manager to obtain additional information.
- Upon review of all available information, the review nurse may determine that Inpatient criteria are not being met. A Medical Director will then review the Admission or continued stay and may authorize the entire stay or a portion of the stay. A determination will be rendered within one business day.
- Throughout the Concurrent Review process, the care coordinator is continually assessing the potential for discharge needs and communicating with the physician and hospital Discharge Planning department to facilitate discharge as appropriate.
- Notification of determinations to the facility's Utilization Review department occurs according to established standards. If the determination involves a continued stay denial, the notification includes contractual basis and the clinical rationale for the denial and an explanation of the appeals process. Written confirmation of denials is sent according to applicable law and AmeriHealth policy. Facilities may not hold the Member financially liable for denials issued under the Concurrent Review process.

Telephonic Concurrent Review process

- The hospital is required to initiate Concurrent Review on or before the last covered day. The information provided must include:
  - current medical information for the days being reviewed
  - a treatment plan
  - current progress on goals
  - an estimated length of stay
  - a discharge plan update
- If all pertinent information is provided and the days are Medically Necessary/Appropriate utilizing InterQual criteria, the determination will be made and verbally communicated to the hospital contact at the time of the review.
- If sufficient information is not available, the case will be pended until the necessary information is obtained from the hospital.
- If the telephone review nurse is unable to approve additional days, the case will be referred to an AmeriHealth Medical Director for physician review. The AmeriHealth Medical Director will review all information and render a determination within one business day.
- The telephone review nurse will verbally notify the appropriate hospital contact of the determination the same day the decision is rendered. Determination letters are generated for the hospital and attending physician within one business day.

- If a case has been denied for all forward days, it is the hospital's responsibility to inform AmeriHealth of any change in condition and to reinitiate Concurrent Review.
- Should AmeriHealth decide to transition its review program from an onsite to telephonic basis, hospitals will be given 30 days notice.

Retrospective/Post-Service Review

Retrospective/Post-Service Review is a review of a case after services have been provided in order to determine coverage or eligibility for payment. This may occur when:

- charts were unavailable at the time of Concurrent Review;
- Precertification was not performed as required or was unavoidably delayed.

A request for Retrospective/Post-Service Review is made to the hospital/facility's Medical Records department either by telephone or onsite. Review of the case and notification of the determinations will be made no later than 30 days after all supporting information that is reasonably necessary to perform the review is received. Failure of the hospital/facility to provide records for Retrospective/Post-Service Review might result in administrative denial of payment to the hospital/facility. Please note the following:

- When a hospital/facility is not made aware of insurance coverage at the initiation of service, it is the responsibility of the hospital/facility to seek Preapproval/Precertification Review as soon as the information is obtained.
- If the hospital/facility discovers post-discharge that a Member is an eligible Member but was incorrectly classified under another insurance program, it must provide CMC with the "face sheet," when reviewed by telephone, verifying this fact. It is expected that the hospital/facility will verify eligibility in a timely fashion.
- The entire medical record is to be provided to the Concurrent Review nurse (whether onsite or telephonic). Medical Appropriateness will be based upon the information that was reasonably available to the hospital at the time of Admission. At AmeriHealth's discretion, the case may be reviewed by telephone (depending on the length of the case). If it is an onsite review, once all information is received, the onsite reviewer will have 30 days to complete the review and provide the hospital with the determination via the onsite log.
- Hospitals/facilities may not bill Members for services that are determined to be not Medically Necessary following Retrospective/Post-Service Review.

Discharge planning coordination

Discharge planning is the process by which AmeriHealth care coordinators, after consultation with the Member, his or her family, the treating physician, and the hospital care manager, do the following:

- assess the Member's anticipated post-discharge problems and needs;
- assist with creating a plan to address those needs;
- coordinate the delivery of Member care.

Discharge planning may occur by telephone or onsite at the hospital.

All requests for placement in an alternative level of care setting/facility (such as acute or subacute rehab or SNF) will be reviewed for Medical Necessity. Hospitals must provide the requested information to CMC to determine whether placement is appropriate according to InterQual guidelines.

When appropriate, alternative services, such as home health care and Outpatient physical therapy, will be discussed with the Member or his or her family, the attending physician, and the hospital discharge planner or social worker.

Once alternative placement is authorized, the approval letter is sent to the Member, the hospital, and the attending physician. If the request does not meet the criteria, the case is referred to an AmeriHealth Medical Director for review and determination.

Denial procedures

All cases with questionable Medical Necessity are referred to and reviewed by an AmeriHealth Medical Director for a determination. In approval situations, the Medical Director will not contact the attending physician.

If the Medical Director determines that the information provided by the attending physician is insufficient to support Medical Necessity, the case will be pended until the information is received. The attending physician will be notified immediately, but not to exceed 24 hours, of the specific additional information required.

Written confirmation of the requested information will be sent within two business days to the hospital, Member, and vendor as appropriate. If the request involves urgent care, the hospital, Member, and/or vendor will have two calendar days to submit the required information.

For non-urgent (elective) care, the information must be submitted within 45 calendar days of the request for additional information. If the information is not submitted in the applicable time frame, the request may be denied and the information regarding an appeal process will be included in the denial letter.

All determinations are communicated verbally, and written confirmation is sent to the attending physician, hospital, Primary Care Physician, and Member, as applicable. Clinical review criteria are available and are furnished upon request. All adverse determination (denial) notifications include contractual basis and the clinical rationale for the denial, as well as how to initiate an appeal.

Delays in service

Under per diem reimbursement, when there is a delay in providing Medically Necessary treatment to a Member due to a non-medical reason such as hospital scheduling issues, and such delay lengthens the hospital stay, the days resulting from the delay will be denied for payment.

Decreased levels of care (skilled/subacute vs. acute days)

For Members at facilities paid under per diem arrangements who are no longer at an acute level of care, reimbursement to a hospital at a skilled rate, in accordance with its Agreement, will be appropriate when all of the following circumstances apply:

- The Member no longer requires acute hospital services but still has Inpatient skilled needs.
- Placement in a skilled or subacute facility is problematic and/or delayed for reasons beyond the hospital's or AmeriHealth's control.
- The need for a skilled rate is of limited duration (generally fewer than seven days).
- A skilled rate will not be used for Members who would otherwise require long-term SNF placement. The skilled rate will not be used on a retrospective basis when the hospital has received a denial of days.
- If the facility is not contracted for a skilled rate and the Member is no longer receiving services at an acute level, the days may be denied after review by an AmeriHealth Medical Director. In these denied cases, the hospital provider appeals process will apply.

Member decision days

A Member decision day is defined as: "A day in which the Member is making a decision as to whether he or she will have a certain treatment or procedure, thereby causing a delay in said procedure or treatment."

Under per diem reimbursement, decision days that are not otherwise Medically Necessary will be denied as a delay in service. Requests for exceptions to this procedure will be presented to the AmeriHealth Medical Director by the nurse reviewer. The Medical Director will consider the exceptional circumstances and possibly contact the attending physician to learn more about this situation prior to rendering a determination.

Observation status

Observation status is an Outpatient Service that does not require authorization. It should be considered if a patient does not meet InterQual acute care criteria and one or more of following apply:

- diagnosis, treatment, stabilization, and discharge can be reasonably expected within 24 hours;
- treatment and/or procedures will require more than six hours of observation;
- the clinical condition is changing and a discharge decision is expected within 24 hours;
- it is unsafe for the patient to return home or a caregiver is unavailable (arrangements need to be made for a safe and appropriate discharge setting, such as SAC/SNF, home care);
- symptoms are unresponsive to at least four hours of ER treatment;
- there is a psychiatric crisis intervention or stabilization with observation every 15 minutes.

Observation status does not require a physical "stay" in an observation unit and does not apply to ER observation of less than six hours.

AmeriHealth utilizes the InterQual level of care guidelines to determine Medical Necessity and reserves the right to retrospectively audit claims where there has been billing for observation status to assure that appropriate guidelines have been met.

If a Member has received observation services and is subsequently admitted, the date of the Admission becomes the date that observation began. Observation services that result in an Admission are subject to CMC review for Medical Necessity and Appropriateness.

Any questions about the status or review of a Member who has received services should be discussed with the CMC coordinator or supervisor. For billing issues, please refer to the *Billing & Reimbursement for Hospital Services* section of the manual.

Transfers within and between Inpatient facilities

Members may be transferred within or between Inpatient facilities for a variety of reasons. Some common scenarios include:

- transfer to a specialized facility or unit inside or outside the current facility;
- transfer because the current facility is unable to provide necessary treatment for the Member;
- transfer because the Member's primary or regular physician is at another facility;
- transfer due to Member or family request;
- transfer to an in-network facility from an out-of-network facility.

Transfers within the same facility

All **nonemergency** transfers within an acute care facility to a psychiatric, rehabilitation, or long-term acute care unit within the same facility must be Precertified with CMC or Magellan Behavioral Health, Inc. as appropriate.

All **Emergency** transfers within a facility from a psychiatric or rehabilitation unit to an acute care unit within the same facility do not need to be Precertified, but the facility must notify CMC or Magellan Behavioral Health, Inc.

Transfers between facilities

When a Member requires transfer to another facility for a service unavailable at the admitting facility *and* the Member returns to the admitting facility the same day (e.g., no overnight stay at the second facility) no Precertification or review of the transfer is required.

When services *do* require an overnight stay at the accepting facility, the day of transfer is considered the day of discharge from the transferring facility and the day of Admission to the accepting facility. If the Admission is non-emergent, the second facility must Precertify the new Admission; if the Admission is emergent, the facility must notify CMC or Magellan Behavioral Health, Inc.

Reconsideration and hospital appeals processes

Peer-to-Peer Reconsideration process

In the event that an adverse determination (denial) is issued without direct discussion between an attending/ordering physician and an AmeriHealth Medical Director, the attending/ordering physician, or hospital medical director may request a Peer-to-Peer Reconsideration with an AmeriHealth Medical Director. Peer-to-Peer Reconsideration is an optional, informal process designed to encourage dialogue between the attending/ordering physician and AmeriHealth's Medical Directors and may be requested by an attending/ordering physician for a Pre-Service/Preapproval, Post-Service, or Concurrent Review denial based on Medical Necessity.

- For Concurrent Review denials, the process should be initiated prior to a Member's discharge from the hospital; however, hospitals have up to two business days from the date the Member is discharged to initiate the process. For Pre-Service/Preapproval denials, the process should be initiated within two business days from the date the hospital is notified of the denial.
- The attending/ordering physician, hospital Utilization Management department physicians, or a designated physician representative (e.g., hospital medical director) may contact an AmeriHealth Medical Director by telephone, fax, or by calling the Physician Phone Line at 1-877-585-5731, prompt 1, to initiate the process. The Physician Phone Line is available Monday through Friday from 8:30 a.m. to 5 p.m.
- The requesting physician has the option to submit additional documentation in support of the request. This will typically include pertinent parts of the medical record (usually progress notes and orders) and a written rationale for the approval request. Whenever possible, the written rationale should include justification citing specific InterQual criteria or an explanation that supports exemption from such guidelines.
- The request for Peer-to-Peer Reconsideration will be responded to within one business day of receipt. At this time, the physician will be provided with the opportunity to present additional supporting documentation to support his or her position.

- For Concurrent Review denials, the Peer-to-Peer Reconsideration decision will be completed within ten business days of the Member's discharge date. For Preapproval and Post-Service denials, the decision will be completed within ten days following the request. A decision to overturn all, or a portion of, the initial adverse determination will be communicated in writing to the hospital.

Hospital appeals

If the Peer-to-Peer Reconsideration decision is to uphold all or a portion of the original denial/adverse determination, the hospital may initiate the applicable Appeal for Lack of Medical Necessity process for services that were denied Post-Service or Concurrently as not Medically Necessary.

Payment appeals for hospitals

Where all or part of an Admission or Outpatient Service at a hospital is denied for payment due to failure to obtain Preapproval or not meeting Medical Necessity requirements, the AmeriHealth Member is held harmless and cannot be billed for the denied day(s) or service(s). The hospital may appeal such denial of payment for lack of Medical Necessity through the Appeals for Lack of Medical Necessity process, (Inpatient, Outpatient, and ER) or they may request payment review for lack of Preapproval through the "payment review for lack of Preapproval" process detailed below.

Appeals for lack of Medical Necessity

Inpatient appeals for hospitals

Hospitals must submit the appeal in writing within 180 calendar days of the adverse determination notice (initial adverse determination or facility Peer-to-Peer Reconsideration decision). The written appeal request must contain the complete medical record for the case being appealed. Inpatient appeals for denials due to Medical Necessity should be mailed to the following address:

AmeriHealth New Jersey Appeals Unit
8000 Midlantic Drive
Suite 333 North
Mount Laurel, NJ 08054-1560

Inpatient appeals are reviewed by an external, independent, licensed physician who is of the same or similar specialty that typically manages the care under review and who was not involved in the initial adverse determination.

The decision to uphold or overturn all, or a portion of, the adverse determination is made and communicated in writing to the hospital within 30 calendar days of AmeriHealth's receipt of the written appeal request and the complete medical record. The written determination of the appeal will include the rationale for the determination where all, or a portion of, the adverse determination is upheld. This decision is final and binding.

Outpatient services appeals (except ER)

To appeal a denial of an Outpatient Service claim, hospitals should send their request for payment review, with any applicable supporting documentation, to the following address:

AmeriHealth New Jersey Appeals Unit
8000 Midlantic Drive
Suite 333 North
Mount Laurel, NJ 08054-1560

Hospitals will be notified of the appeal determination in writing within 30 calendar days of AmeriHealth's receipt of the appeal.

ER services appeals

ER claims that do not meet AmeriHealth's criteria for Emergency are automatically processed at the lowest ER payment rate in the fee schedule or as otherwise provided in the Agreement. To appeal an ER determination, please complete an *ER Review Form*, attach the Member's medical record, and submit to:

Claims Medical Review – Emergency Room Review
AmeriHealth
1901 Market Street
Philadelphia, PA 19103-1480

Payment review for lack of Preapproval

To request a payment review for services that were denied for lack of Preapproval, facilities should send their request, with any applicable supporting documentation, to the following address:

Facility Payment Review
P.O. Box 13985
Philadelphia, PA 19101-3985

Payment reviews for lack of Preapproval will be reviewed based on the circumstances of the case.

Appeals process

Utilization management appeals

AmeriHealth maintains a utilization management appeals process for any Member who is dissatisfied with any AmeriHealth utilization management coverage decision. The utilization management appeals process provides the Member the opportunity to discuss the decision with a Plan Medical Director or peer reviewer and appeal the adverse benefit determination. A utilization management coverage decision is defined as any decision to deny, terminate, or limit the provision of covered health care services that is based primarily on Medical Necessity or Appropriateness. Each appeal stage will be completed promptly, based on the Member's health condition, within the applicable time frames described below.

Member representatives

A provider or another individual may appeal on behalf of the Member as the Member's authorized representative ("Member designee") if valid consent forms from the Member are provided to AmeriHealth. The Member may give verbal consent for someone to represent him or her in an appeal while written consent is pursued for the case file. However, in expedited or urgent care appeals, valid Member consent forms are not required if a health care professional with knowledge of the Member's

medical condition (e.g., a treating physician) acts as the Member's authorized representative. Also, AmeriHealth has staff who are available to assist and/or represent Members in the appeals process.

Appeal types

Appeals of utilization management coverage decisions are also sometimes called "Pre-Service Appeals" or "Post-Service Appeals." A Pre-Service Appeal is for benefits that are only covered if Precertified or Preapproved *before* medical care is obtained; all other appeals are Post-service. Utilization management appeals are usually considered Pre-Service Appeals.

Appeal stages

As described below, the Member or Member designee has up to three opportunities to appeal a utilization management coverage decision. There are two internal appeals stages conducted by AmeriHealth — Stage I Appeal and Stage II appeal. After the internal review is completed, the external Stage III Appeal process becomes available to the extent mandated by the State of New Jersey or as determined by other applicable authorities (see the Stage III Appeal section on *page 3.14*).

Decisionmakers

Decisionmakers for utilization management appeals are licensed physicians, psychologists, and other health care professionals in the same or similar specialty as typically manages the care under review. The matched specialist decisionmaker cannot be the person or a subordinate of the person who made the initial adverse benefit determination being appealed.

Information for the appeal review

At each appeal stage, all information gathered for the appeal review will be considered by the decisionmakers. This consists of information obtained from AmeriHealth's investigation, as well as any additional information submitted by the Member or Member designee. Upon request at any time during the appeal process, AmeriHealth will provide, free of charge, the Member or Member designee a copy of the correspondence, documents, medical records, and other information provided to the decisionmakers for internal appeal review. AmeriHealth may redact or delete certain information that it considers confidential and/or proprietary from the copy provided to a Member or Member designee.

Stage I Appeal (internal)

A Member, provider, or other Member designee may initiate a Stage I Appeal with a Plan Medical Director or peer reviewer by calling or writing the AmeriHealth New Jersey Appeals Unit as outlined in the initial AmeriHealth denial letter or by contacting Customer Service at the telephone number listed on the Member's ID card. The appeal must be filed within 180 days of receipt of the initial utilization management determination letter.

A Stage I Appeal consists of an opportunity for a discussion and/or review of a utilization management coverage decision based on review of available information. It will be completed within the time periods that apply to the Stage I Appeal review (as outlined within this section).

Non-expedited Stage I Appeals

Non-expedited (or standard) Stage I Appeals will be completed and a decision letter providing written notice of the decision with an explanation of the appeal rights, as appropriate, will be sent within five business days of AmeriHealth's receipt of the original appeal request.

Expedited Stage I Appeals

The Stage I Appeal will be processed as an expedited or urgent care appeal whenever the Member is confined in an Inpatient facility, as well as upon the request of the Member's physician and/or when AmeriHealth determines that a delay in decisionmaking based on non-expedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function or could subject the Member to severe pain that cannot be adequately managed while awaiting a non-expedited appeal decision. Expedited appeal review will be completed within 72 hours after AmeriHealth's receipt of the appeal, with time usually allotted as follows: 24 hours allotted to the Stage I expedited review and 48 hours allotted to the Stage II expedited review.

The Member, Member designee, and other providers, as appropriate, will be notified of the Stage I expedited appeal decision verbally or by fax within 24 hours after receipt of the expedited appeal. At that time, AmeriHealth will also provide notice of the opportunity to proceed with a Stage II expedited appeal. The letter with written confirmation of the expedited Stage I decision will include an explanation of appeal rights, as appropriate. That decision letter will be sent to the Member, Member designee, and other providers, as appropriate, within 24 hours after receipt of the original expedited appeal request.

Stage II Appeal (internal)

If not satisfied with the outcome of the Stage I Appeal, the Member or Member designee may file a Stage II Appeal by calling or writing to AmeriHealth within 60 days of receipt of the Stage I Appeal decision letter. Directions for filing a written or verbal Stage II Appeal are outlined in the Stage I Appeal decision letter.

Stage II Appeals are presented to a panel of physicians and/or other health care professionals who have not been previously involved in the decisionmaking on the case. The Member or Member designee may appear before the panel, participate via conference call, or other appropriate technology. The Member may also ask AmeriHealth to appoint a staff Member who has no direct involvement with the case to represent him or her before the panel. The Stage II Appeal panel will review available information including all information in the Stage I Appeal case file. If requested by the Member or Member designee, AmeriHealth will arrange for a consultant practitioner — a matched specialist with no prior involvement in the case — to be available to participate in the panel's review of the case.

Non-expedited Stage II Appeals

For non-expedited (or standard) Stage II Appeals, AmeriHealth will send an acknowledgement letter upon receipt of the Stage II Appeal request. The Stage II Appeal will be completed with review by an appeal panel as described above within 15 calendar days of receipt of the appeal. A letter providing written notice of the Stage II Appeal decision and an explanation of appeal rights, as appropriate, will be also be sent within 15 calendar days of receipt of the Stage II Appeal request.

Expedited Stage II Appeals

The Stage II Appeal will be processed as an expedited or urgent care appeal whenever the Member is confined in an Inpatient facility, as well as upon the request of the Member's physician and/or when AmeriHealth determines that a delay in decisionmaking based on non-expedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function or could subject the Member to severe pain that cannot be adequately managed while awaiting a non-expedited appeal decision. Expedited appeal review will be completed within 72 hours after AmeriHealth's receipt of the appeal, with time usually allotted as follows: 24 hours allotted to the Stage I expedited review and 48 hours allotted to the Stage II expedited review.

The Stage II review will be conducted by an appeal panel as described above. The Member, Member designee, and other providers, as appropriate, will be notified of AmeriHealth's decision on the expedited Stage II Appeal verbally or by fax within the final 48 hours of the 72-hour period following receipt of the original expedited appeal request. The letter with written confirmation of the expedited Stage II decision will include an explanation of appeal rights, as appropriate. That decision letter will be sent to the Member, Member designee, and other providers, as appropriate, no later than the end of the 72-hour period after receipt of the original expedited appeal request.

Stage III Appeal (external)

If the Member or Member designee is not satisfied with the outcome of the Stage II Appeal, he or she may initiate an external appeal under the processes applicable to the Member's health plan. For most health plans, external review is conducted by an Independent Utilization Review Organization (IURO) consistent with processes mandated by New Jersey state laws.

For plans subject to New Jersey state-mandated requirements, the Member or Member designee may initiate the Stage III Appeal to an IURO within 60 days of receipt of the Stage II determination. If the IURO accepts the appeal, it will issue a decision within 30 business days of receiving all necessary documentation to complete the review. The IURO may extend its review period for a reasonable period of time due to circumstances beyond its control. In such an event, the IURO must provide written notice to the Member and/or Member designee prior to the end of the original 30 business day review period setting forth the reasons for the delay. A decision reached by an IURO that is adverse to the Plan is binding on the Plan. A Member or Member designee may appeal directly to the IURO if the Plan waives its right to an internal review or fails to meet the time frames for completing Stage I or Stage II of the internal appeals process.

Note: The appeal procedures stated above may change due to changes in the applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting organizations, or to otherwise improve the Member appeals process. For additional information, contact Customer Service at the telephone number listed on the Member's ID card.

Complex Case Management program

The Complex Case Management program provides telephonic case management to assist in the education and health care coordination of specific Members with complex needs. These individuals are considered to be those with complex medical/psychosocial needs and/or those who have a high utilization of health care services and require individual case management services to support coordination of and/or access to complex care and services.

Examples of cases to refer to case management include, but are not limited to, the following:

- traumatic and non-traumatic brain injury
- complex pediatric issues
- oncology
- multiple/complex co-morbid conditions

To refer a case for case management, please call 1-800-313-8628 or 856-778-6374 within New Jersey.

Baby FootSteps® Maternity Program

Baby FootSteps is our perinatal high-risk maternity program. The program is designed to educate all pregnant Members about pregnancy and preparing for new parenthood. Important details about the program are described below.

- A Member is enrolled in the program through the prenotification process initiated in the obstetrician's (OB) office. No Preapproval/Precertification is needed for deliveries.
- Risk assessments are performed to help identify expectant mothers who may be at risk for complications during their pregnancy and to assist in improving the quality of care to pregnant women and newborns. If any risk factors are detected, our obstetrical nurse case managers support our Members and their physician or midwife by telephone to help coordinate their benefits and provide information they need for the healthiest delivery possible.
- Educational information is sent to each pregnant Member after enrollment in Baby FootSteps, regardless of risk. This educational material is organized according to the stage of pregnancy to best meet the needs of the Member.
- OB nurse case managers are available 8 a.m. to 5 p.m., Monday through Friday, by calling 1-800-598-BABY. Nurse case managers are available after business hours for urgent/emergent requests.

Preapproval/Precertification of antepartum home care services

Please call Baby FootSteps for Preapproval/Precertification of all antepartum home care programs and services, such as:

- hyperemesis gravidarum
- gestational diabetes
- pregnancy-induced hypertension
- preterm labor

A Referral will be made to a participating perinatal home health agency. The agency will then obtain orders for all care to be rendered from the attending physician.

For more information about our Baby FootSteps program or to refer a Member, call 1-800-598-BABY.

Postpartum program – Mother's Option®

All Members who have an uncomplicated pregnancy and delivery have the option of choosing a shorter length of stay in the hospital. In order to support a smooth and safe transition home, home care visits are available per the following guidelines:

Uncomplicated vaginal delivery

- If discharged within the first 24 hours following delivery, two home health visits are available if desired by the Member. These visits do not require Precertification but should be arranged by a hospital discharge planner with one of the Mother's Option home care providers. The first visit should occur within 48 hours of discharge. The second visit should occur within five days of discharge.
- If discharged within the first 48 hours following delivery, one home health visit is available if desired by the Member. This visit does not require Preapproval/Precertification but should be arranged by a hospital discharge planner with one of the Mother's Option home care providers. This visit should occur within 48 hours of discharge.

Uncomplicated cesarean delivery

If discharged within the first 96 hours following delivery, one home health visit is available if desired by the Member. This visit does not require Precertification but should be arranged by a hospital discharge planner with one of the Mother's Option home care providers and should occur within 48 hours of discharge.

Standard length of stay

Managed care HMO/PPO

When the hospital stay is longer than 48 hours (vaginal) or 96 hours (cesarean), one home health visit is available if desired by the Member or provider. This visit does not require Precertification, but should be arranged by a hospital discharge planner with one of the Mother's Option home care providers. These visits must occur within five days of discharge.

Additional home health visits that are Medically Necessary beyond the described Mother's Option visits must be Preapproved by calling the Perinatal Case Management department at 1-800-598-BABY.

CMM Members

Members who opt for less than 48 hours discharge for vaginal delivery and less than 96 hours for cesarean section are eligible for one home care visit under their home health benefits. Precertification for this visit can be done by calling the Perinatal Case Management department as noted above.

Baby FootSteps® postpartum services

Postpartum care

- Postpartum home skilled nursing visits beyond those provided through Mother's Option are approved when Medically Necessary. These visits must be Preapproved through Baby FootSteps or the HRC.

Lactation consultation

- Lactation support services include information about valuable community resources, educational websites, and certified lactation consultants.
- Managed care Members who enroll in the Baby FootSteps program are eligible to receive a reimbursement of 100 percent up to $100 for a visit with an International Board of Lactation Consultant Examiners (IBLCE) Certified Lactation Consultant.
- A Member can locate an IBLCE Certified Lactation Consultant by:
  - contacting her OB provider
  - contacting the maternity department at the facility of delivery
  - visiting *www.ilca.org/index.php*

Breast pumps

- Managed care Members who participate in Baby FootSteps may obtain a manual/mini-electric breast pump at pharmacies or baby supply stores and then submit their receipt to AmeriHealth Healthy Lifestyles℠ for reimbursement consideration up to $50 within 90 days after delivery.
- Hospital-grade electric breast pump rentals must be Preapproved for Medical Necessity through the Baby FootSteps department or the HRC. These pumps are covered when supplied by an in-network provider and under the following circumstances:
  - detained premature newborn;
  - infants with problems that interfere with breast feeding (e.g., cleft palate/lip).

Precertification for home phototherapy

When ordering home phototherapy to treat jaundiced newborns, please obtain Precertification through Baby FootSteps. Skilled nursing visits must also be Precertified through Baby FootSteps.

Other CMC procedures and requirements

Termination of benefits

Termination of benefits (TOB) may occur when a Member chooses to remain in the hospital following a determination that acute care is no longer Medically Necessary in that setting. Upon TOB, the Member is financially responsible for care received following the administration of the TOB notice.

The following criteria define the circumstances under which AmeriHealth considers TOB to be appropriate. The patient must meet discharge criteria in all circumstances.

- The attending physician orders a discharge or documents that the Member is no longer at acute hospital level of care, but the Member or responsible party refuses available alternative settings.
- The Member or responsible party has refused to cooperate with discharge planning.
- The Member or responsible party has shown continued noncompliance with the hospital plan of care.

Members may not be held financially responsible for denials unless the above criteria are met. Disagreements with determinations made by AmeriHealth are to be resolved through the Hospital Inpatient Appeals Process.

Urgent Admissions

Urgent Admissions during business hours, Monday through Friday from 8 a.m. to 5 p.m., must be Preapproved/Precertified at the time of Admission. If an urgent Admission occurs outside of business hours, clinical information is obtained from the hospital within one business day of notification of the Admission.

Urgent Admissions are generally those that are not life- or organ-threatening if not treated immediately but are Medically Necessary to prevent ensuing complications and cannot wait for normal scheduling.

Upon review, a Medical Necessity decision is rendered. Cases that do not meet acute Inpatient criteria are referred to a Medical Director for review and determination.

Connections^{SM} Health Management Programs

Our Connections^{SM} Health Management Program offers disease management support to Members with the following conditions:

- asthma
- chronic obstructive pulmonary disease (COPD)
- coronary heart disease (CHD)
- diabetes
- gastroesophageal reflux disease (GERD)
- heart failure
- hypertension
- migraine
- peptic ulcer disease (PUD)

Decision support is also provided by Health Coaches to Members facing treatment decisions for certain conditions (e.g., joint replacement, back pain, women's health issues, etc.). Health Coaches help Members work effectively with their physicians to make "shared decisions" that are right for them.

Support is also offered to Members with one or more of 16 complex, chronic conditions including multiple sclerosis, rheumatoid arthritis, and Chrohn's disease through the Connections^{SM} AccordantCare^{TM} Program.

For more details on our Connections programs, please visit *www.amerihealth.com/providers/resources/connections.html*.

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Quality Management

QM Program activities

The Quality Management (QM) department is responsible for the following:

- providing tools and information that network providers can use to assist in developing and maintaining a standard of care;
- managing a positive relationship with network providers;
- monitoring and evaluating care;
- suggesting improvements to our medical policies;
- conducting credentialing oversight;
- overseeing our various processes for hearing grievances and appeals;
- collecting Member suggestions for quality initiatives;
- monitoring aspects of care based on the demographics of the Members served (e.g., age, sex, health status);
- investigating and tracking potential quality of care concerns through the recredentialing, grievance and appeal, and peer review processes.

Member safety activities

The QM department drives plan-wide activities that promote and support providers and Members in increasing Member safety initiatives and reducing medical/medication errors. These activities include:

- communicating information on Member safety;
- preventing medical/medication errors through Member and provider mailings and newsletters;
- supporting regulatory agency standards;
- implementing initiatives that pertain to quality of care, Member safety, and medical/medication errors.

Monitoring continuity and coordination of care

Our goal is for Members to receive seamless, continuous, and appropriate care and coverage. For this reason, we assess continuity and coordination of care based on three important aspects:

1. coordination among medical providers treating the same Member;
2. special attention to coordination between medical and behavioral health care, as appropriate;
3. potential problems caused when a provider leaves a network and has Members in active treatment.

Quality improvement

Information about our Quality Improvement Program is available to our providers and Members upon request. This information includes a description of our Quality Improvement Program and a report on our progress in meeting our goals. For more information, providers may contact Customer Service at 1-800-275-2583, prompt 2 for Provider Services. Members can contact Customer Service at the telephone number listed on their ID card.

Hospital responsibilities

Hospitals contracted with AmeriHealth are required to comply with AmeriHealth's QM Program. Hospitals have the *responsibility* to:

- ensure that all necessary authorizations are obtained prior to rendering services;
- be available and accessible 24 hours a day, 7 days a week;
- notify the Primary Care Physician (PCP)/family practitioner of follow-up care for services performed in the Emergency department;
- notify the PCP/family practitioner of follow-up care for services performed after a hospital stay;
- maintain Member confidentiality and comply with HIPAA* regulations;
- respect Member rights and responsibilities;
- comply with QM Program initiatives and any related policies and procedures;
- comply with QM requirements including, but not limited to, the following:
  - cooperate with the onsite medical review process and provide medical records when requested for clinical and/or service outcome measures;
  - respond to investigations of Member complaints regarding quality of care and services;
  - cooperate with the development of corrective action plans when measurements identify opportunities for improvement or as a result of a quality of care inquiry.

** HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability and continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations explicitly stated within the Act.*

Confidentiality of information

Protected health information is protected against unauthorized or inadvertent disclosure. Medical records are safeguarded against loss or destruction and are maintained according to state requirements.

For complete information on AmeriHealth's QM Program, including Member rights and responsibilities, please visit *www.amerihealth.com/providers/quality_management.*

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Fraud, Waste, and Abuse

Corporate and Financial Investigations Department

The Corporate and Financial Investigations Department (CFID) is responsible for the prevention, detection, and investigation of all potential areas of fraud, waste, and abuse against AmeriHealth. The CFID is also responsible for conducting audits of providers and pharmaceutical-related services. It identifies, selects, and audits providers for inaccurately paid claims; seeks financial recoveries of overpaid claims; and submits these claims for correct adjudication.

The CFID is comprised of the following:

- CFID Support
- Financial Investigations
- Professional Provider Audit
- Facility Provider Audit
- Ancillary Provider Audit
- Pharmacy Audit

Financial Investigations

The Financial Investigations team investigates all allegations of fraud, waste, and abuse by providers, Members, vendors, associates, and others. The team uses a wide array of investigative tools to:

- identify and investigate fraudulent activities;
- make referrals to Federal, State, and local law enforcement for criminal and/or civil prosecution;
- make referrals to regulatory authorities for violations of professional licensure;
- recover losses related to fraud, waste, and abuse;
- employ prevention techniques to decrease and eliminate future losses;
- make recommendations to terminate providers for cause from participation in AmeriHealth networks.

Audits

Facility Provider Audit

The Agreement between your facility and AmeriHealth includes language that allows AmeriHealth the right to audit medical and financial records related to Covered Services provided to our Members and the records related to the billing and payment for services rendered. Ancillary and facility provider audits are conducted by AmeriHealth staff or by an independent audit firm engaged by AmeriHealth.

Process

In order to conduct a facility provider audit, AmeriHealth takes the following steps:

1. Reviews prepayment and post-payment claims;
2. Reviews billing and/or medical records, if necessary, for audit process;
3. Notifies provider in advance of an onsite audit;
4. Notifies provider of specific purpose and scope (subject to change) of audit;
5. Gives the provider a draft report of the audit findings;
6. Communicates, in writing, the final audit results to the provider;
7. Conducts provider credit balance audits, such as access to current credit balance reports and aged accounts receivable trial balances, for any account where AmeriHealth made payment as primary, secondary, or tertiary Payor;
8. Requires provider to repay any overpaid claims;
9. Gives providers a 2-level review process of audit findings; this must be requested in writing.

Ancillary Provider Audit

The purpose of ancillary provider audits is to determine the appropriateness of ancillary claims submitted by durable medical equipment (DME) providers and home infusion providers (HIP) for services rendered to AmeriHealth Members.

Audits compare information from an ancillary provider's claim with the ancillary provider's medical documentation. Ancillary billing audits determine whether all medical items or services appear on the bill and/or whether the ancillary provider's documentation substantiates the charge. Through routine and ad hoc audits, ancillary audits identify patterns of potential fraud, waste, and abuse with support of the Financial Investigations team.

AmeriHealth contracts with external audit firms to conduct field audits of providers to compare service provisions and billing with your contract Agreement. Audit procedures are followed across all lines of company business. Routine and ad hoc desk and field audits are performed by ancillary audit staff on claims submitted by DME providers and HIPs to identify billing inaccuracies, unbundling of charges, inappropriate HCPCS and CPT® coding, and processing errors leading to overpayments. In addition, a comparison of service provisions and claims in accordance with ancillary provider contract Agreements is performed. Providers are afforded a 2-level review process of audit findings. Ancillary auditors and analysts will serve as first-level reviewers familiar with billing practices, coding, medical terminology, and medical record charting. The scope of an ancillary provider audit includes any ancillary provider, regardless of contracting status, that renders and bills for services to AmeriHealth Members. Prepayment or post-payment audits may be performed and will vary based on provider and type of service billed for the Member.

Production of records and examination under oath

When requested by AmeriHealth or designated representatives of Federal, State, or local law enforcement and/or regulatory agencies, providers shall produce copies of all medical/financial records requested. Providers will permit access to the original medical/financial records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

Report fraud, waste, and abuse

If you suspect health care fraud, waste, or abuse against AmeriHealth, we urge you to report it. All reports are confidential. You are not required to provide your name, address, or other identifying information. You have three options for submitting your report:

1. Submit the Online Fraud, Waste & Abuse Tip Referral Form electronically at *www.amerihealth.com/anti-fraud*.
2. Call the confidential anti-fraud and corporate compliance toll-free hotline at 1-866-282-2707; TTY/TDD: 1-888-789-0429.
3. Write a description of your complaint, enclose copies of supporting documentation, and mail it to:

   AmeriHealth
   Corporate and Financial Investigations Department
   1901 Market Street, 15th Floor
   Philadelphia, PA 19103

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Behavioral Health

General Information

Magellan Behavioral Health, Inc. is an independent managed care behavioral health care company contracted by AmeriHealth to manage the mental health and substance abuse (behavioral health) benefits for the majority of our Members with HMO/POS, PPO, and Comprehensive Major Medical (CMM) coverage. Magellan Behavioral Health, Inc. develops, contracts with, and services its own network of behavioral health providers and facilities.

In order for a Member with Magellan Behavioral Health, Inc. as their behavioral health provider to receive the highest level of benefits, behavioral health services must be coordinated by Magellan Behavioral Health, Inc. Benefits vary based on the benefits plan type and employer group. Not all employer groups use Magellan Behavioral Health, Inc. for their behavioral health benefits.

Note: Magellan Behavioral Health, Inc. is available 24 hours a day, 7 days a week.

Emergency Admissions – Behavioral Health (HMO/POS/PPO/CMM)

Preapproval/Precertification for Emergency behavioral health Admissions is not required. When a Member is admitted as an Inpatient through the emergency room, the hospital is required to notify Magellan Behavioral Health, Inc.'s Preapproval/Precertification Review department within 48 hours or on the next business day, whichever is later.

Member eligibility

Providers are encouraged to verify Member benefits and eligibility via NaviNet®, the Interactive Voice Response (IVR) system, or by calling Magellan Behavioral Health, Inc. at 1-800-809-9954. The contact information is also located on the Member's ID card.

Claims submission

HMO/POS

HMO/Referred (In-Network) POS

In order for HMO/Referred (In-Network) POS Members to receive the highest level of benefits, members must use a Magellan in-network mental health and substance abuse provider. Providers are encouraged to verify HMO and POS Member benefits and eligibility via NaviNet or the IVR system.

All HMO/Referred (In-Network) POS Inpatient, non-Emergency Admissions, intensive Outpatient, partial hospitalization treatment, and substance abuse services must be Preapproved. To Preapprove an Admission, intensive Outpatient program, partial hospitalization program, or substance abuse Outpatient Service, please contact Magellan Behavioral Health, Inc. at 1-800-809-9954.

Please submit AmeriHealth HMO/Referred (In-Network) POS claims to:

Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958

Self-Referred (Out-of-Network) POS

All Self-Referred (Out-of-Network) POS Inpatient, non-Emergency Admissions must be Preapproved. To Preapprove an Admission, please contact Magellan Behavioral Health, Inc. at 1-800-809-9954.

Please submit all AmeriHealth Self-Referred (Out-of-Network) POS claims to:

AmeriHealth Processing Center
P.O. Box 41574
Philadelphia, PA 19101-1574

POS Plus with the National Access Rider

Please submit all AmeriHealth New Jersey POS (Referred and Self-Referred) with the National Access Rider mental health and substance abuse claims to:

Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958

PPO

The majority of Members with PPO coverage must utilize Magellan Behavioral Health, Inc.'s PPO provider network to receive the highest level of in-network mental health and substance abuse benefits. Benefits vary based on benefits plan type and employer group.

All Inpatient and in-network PPO partial/Outpatient mental health and substance abuse services must be Preapproved by calling Magellan Behavioral Health, Inc. at 1-800-809-9954. Since some PPO and HSA-qualified High Deductible Health Plan options still require that all in-network and out-of-network behavioral health services must have Preapproval, please verify Preapproval requirements before providing behavioral health services.

Please submit AmeriHealth New Jersey *without* the National Access Rider Standard and Flex PPO mental health and substance abuse claims to:

AmeriHealth Processing Center
P.O. Box 41574
Philadelphia, PA 19101-1574

Please submit AmeriHealth New Jersey *with* the National Access Rider (In-Network and Out-of-Network) mental health and substance abuse claims to:

Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958

CMM

Magellan Behavioral Health, Inc. manages the mental health and substance abuse benefits for CMM Members. Inpatient and partial hospitalization services for mental health and substance abuse services must be Preapproved. To Preapprove an Admission or partial hospitalization service, please call Magellan Behavioral Health, Inc. at 1-800-809-9954.

Please submit CMM mental health and substance abuse claims to:

AmeriHealth New Jersey CMM
P.O. Box 41574
Philadelphia, PA 19101-1574

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Billing & Reimbursement for Hospital Services

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Billing & Reimbursement for Hospital Services

Billing & Reimbursement for Hospital Services

Overview

The purpose of this section is to describe the specific billing requirements for services rendered in the hospital setting and to supplement the *General Information* section.

Inpatient Services

Hospitals will be reimbursed for Inpatient Services according to the terms of their Agreement.

- **Reimbursement rates.** The rate of payment is determined by the effective date of a Member's Inpatient Admission and applies for the length of the Admission (i.e., any rate change under the contract during the Member's stay will not apply).
- **Services prior to admission.** Preadmission testing (PAT) is considered a component of an Inpatient stay. Charges for PAT are to be included on the Inpatient claim.
- **Discharge day.** There is no reimbursement for the day of discharge.

Maternity Admissions

- **Normal delivery claims.** When billing newborn baby charges with revenue codes 0170, 0171, 0172, or 0179, the maternity charges for mother and baby must be combined on the same UB-04 form. Neonatal Intensive Care Unit (NICU) charges should also be added to the mother's Inpatient bill using revenue code 0173 or 0174.
- **"Detained" baby claims.** When the baby remains hospitalized after the mother is discharged (detained baby), a new Admission with its own Preapproval/Precertification is required. The detained baby's Admission date is the same date as the mother's discharge date. A separate claim for the detained baby's Admission is required.

Outpatient Services

You will be reimbursed for Outpatient Services according to your facility's Agreement. Please use the chart that follows along with the Correlation Table when determining which revenue, CPT and HCPCS® codes to use for billing.

Correlation Tables are emailed quarterly and may be viewed at *www.amerihealth.com/providers/communications/bulletins* by selecting the appropriate ancillary or facility bulletin.

Service	Revenue code	CPT and HCPCS required?
Audiology	0470, 0471, 0472, 0479	Yes
Cardiology	0480, 0482, 0483, 0489, 0730-0732, 0739, 0921 **EKG procedure codes:** 93000, 93005, 93010	Yes
Chemotherapy	0331, 0332, 0335	Yes
Diabetic education	0942	Yes
Dialysis*	0820, 0821, 0829, 0830, 0835, 0839, 0840, 0841, 0845, 0849, 0850, 0851, 0855, 0859	Yes

Emergency services	0450, 0451, 0452, 0456, 0459 **Critical care:** 99291	Yes
Gastroenterology	0750 or 0759	Yes
Laboratory services	0300-0307, 0309-0312, 0314, 0319, 0923, 0925	Yes
Sleep study (neurology)	0740 or 0749	Yes
Nutrition therapy services (for Members with a diagnosis of either diabetes or end-stage renal disease)	0949 97802 – medical nutrition therapy; initial assessment 97803 – reassessment and intervention, individual 97804 – group (two or more)	Yes
Observation services	0762	No
Outpatient surgery	**Category M:** 0360, 0361, 0362, 0367, 0369, 0490 **Category 1-8:** 0360, 0361, 0362, 0367, 0369, 0490 **Category 9:** 0481 or 0499	Yes
Outpatient implantable devices	Please refer to contract	When applicable
Pharmacy	0250-0259, 0631-0636 Use 0257 only when a specific pharmacy code does not exist. 0257 does not require a CPT and HCPCS code.	Yes
Pulmonary/Respiratory	0410, 0412, 0413, 0419, 0460, 0469	Yes
Radiation therapy	0280, 0289, 0330, 0333, 0339	Yes
Radiology services	0320-0324, 0329, 0340-0342, 0349-0352, 0359, 0400-0404, 0409, 0610-0612, 0618, 0619 **Therapeutic/chemotherapy services:** 0330-0333, 0335, 0339	Yes
Short-term rehabilitation services	**Physical/occupational services:** 0420-0424, 0429, 0430-0434, 0439, 0951, 0952 **Speech therapy services:** 0440-0444, 0449	Yes

**Services performed on the same day as dialysis should be reported on the same bill.*

Diabetic education

Outpatient diabetic education is a covered benefit for eligible Members who have been diagnosed as having diabetes mellitus and have been referred by their Primary Care Physician (PCP) or attending physician to an AmeriHealth participating Outpatient diabetic education program. In order for a participating hospital's Outpatient diabetic education program to be eligible as an approved diabetic education program in the AmeriHealth network, the program must be certified by the American Diabetes Association (ADA) and specifically referenced in your Agreement.

In addition to hospital-based programs, AmeriHealth contracts with freestanding Outpatient diabetic education facilities whose programs have been certified by the ADA. Services provided by a

nonparticipating Outpatient diabetic education provider are not covered under our Member's benefits program.

When billing for diabetic education, use the revenue code 0942. You must also include the CPT and HCPCS code, the number of units, and a diabetic diagnosis on the UB-04 form. For correct billing and reimbursement purposes, one unit is equal to one session. A unit/session is defined as one of the following:

- an initial baseline assessment;
- an individual session, which is to be a minimum of one hour in duration;
- a group session, which is to be a minimum of two hours in duration.

Emergency services

Emergency services are reimbursed in accordance with AmeriHealth's medical policies. Please refer to our policies on *www.amerihealth.com/medpolicy*.

- Whenever one of the revenue codes in the 45X series is present, the UB-04 admitting diagnosis and the patient's reason for the visit are required fields for Outpatient claims. Please report one ICD-9 diagnosis code describing the patient's stated reason for seeking care. Emergency room (ER) claims that do not have the required information completed may not be accepted for processing. When multiple ER level of service procedure codes are billed with 99291 (critical care), the claim will be paid at the lower level of service or non-critical care rate. Report coding discrepancies via NaviNet® to request an adjustment.
- ER services are reimbursed according to the hospital's contracted Outpatient fee schedule, unless otherwise specified in your Agreement.
- If the ER visit results in an Inpatient Admission, the date that the physician wrote the order becomes the date of Admission. The ER charges should be included on the Inpatient claim. No separate ER claim is to be filed.
- If an ER visit includes surgery performed in a fully equipped and staffed operating room, the facility will receive fee schedule reimbursement for the ER and for the surgery. The surgery should be billed using the appropriate surgery revenue, CPT, and HCPCS codes.

Note: Critical care in the ER is to be billed with procedure code 99291. Code 99292 is not separately payable under our fee schedule reimbursement. A complete list of required codes can be found in the table on *page 7.1*.

Services billed together	Services reimbursed*
ER and observation services	Both ER and observation services are reimbursed
ER and surgery services	Both ER and surgery services are reimbursed
Surgery and observation services	Surgery services are reimbursed; observation services are not separately reimbursed
ER, surgery, and observation services	ER and surgery services are reimbursed; observation services are not separately reimbursed

**Fee schedule reimbursement for these services includes all ancillary services provided during the visit.*

Emergency services review

If a facility has a triage fee and a claim does not meet the automatic payment criteria, the facility and the physician automatically receive an Emergency department "triage" fee. If the facility wishes to dispute the application of the triage fee, the hospital is instructed to submit a copy of the medical record for review using the *ER Review Form*. A sample form is included in this section.

The review includes the following stages:

- Upon receipt, the medical record is reviewed by a nurse in our Claims Medical Review department who examines the circumstances of the ER visit and makes a determination regarding the appropriate payment of an ER fee.
- A care coordinator, who is a registered nurse, may approve cases where a prudent layperson, acting reasonably, could have believed that an Emergency medical condition existed, as defined in statute and Member coverage materials. Cases that cannot be approved by the care coordinator are referred to a Medical Director for further review and coverage determination.
- If a Medical Director determines that the circumstances of the ER visit did not constitute a medical Emergency, the ER reimbursement may be denied, although the hospital and the physician may receive reimbursement for the evaluation of the patient. The Member may not be billed for any ER services beyond the copayment specified in his or her benefits. The only exception would be if a Member uses the ER solely for elective reasons, such as a checkup or a routine physical exam.
- Follow-up care in an Emergency setting is not eligible for reimbursement consideration.

AmeriHealth

EMERGENCY ROOM REVIEW FORM

Please complete the following information and attach this form with each Emergency Room Medical Record. Thank You!

******Product (Please Circle One)******

AmeriHealth Commercial HMO
AmeriHealth 65
AmeriHealth 65 Choice
AmeriHealth Point-of-Service
AmeriHealth PPO

PROVIDER NAME_____

NPI and/or 10-DIGIT LEGACY PROVIDER ID NUMBER_____

PATIENT ID NUMBER_____

DATE OF SERVICE _____

AMERIHEALTH CLAIM NUMBER_____

PATIENT'S FIRST NAME_____

PATIENT'S LAST NAME _____

_____ ( ) _____
Form Completed By *(Please Print)* Telephone Number

******Return Completed Form with Medical Records to:******

Claims Medical Review - Emergency Room Review
AmeriHealth
1901 Market Street
Philadelphia, PA 19103-148

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey • QCC Insurance Company d/b/a AmeriHealth Insurance Company

Laboratory services

PPO and Comprehensive Major Medical (CMM) coverage. Members with PPO or CMM coverage may obtain routine and STAT laboratory services from any AmeriHealth participating hospital with a written physician order. For PPO, the Member must be directed to a participating laboratory to obtain in-network benefits.

HMO/POS coverage. Members with HMO or POS coverage must be directed to and have services done by the PCP's designated laboratory site.

Routine laboratory services

Participating hospitals should not perform any routine laboratory services for HMO Members unless they are the designated laboratory site. If routine services are provided by a hospital that is not the designated site for that Member, those services will not be reimbursed and the Member may not be billed.

Draw station services

Draw station services apply to routine services. A hospital may have an agreement with a participating laboratory to draw a specimen and forward it to the laboratory for processing. Laboratory agreements include drawing fees; billing arrangements must be handled directly between the hospital and the laboratory. To provide draw station services to HMO Members, participating hospitals must contract directly with one of the designated laboratories.

STAT laboratory services

AmeriHealth has developed a list of laboratory services that can be ordered by a participating PCP or specialist when Medically Appropriate. STAT laboratory services can be provided by any AmeriHealth participating hospital with a written physician order. A Referral is not required for any STAT laboratory tests listed in the medical policy, which can be found at *www.amerihealth.com/medpolicy*.

Reimbursement

Payment will be made directly to the facility according to the Outpatient Laboratory Fee Schedule (only if there is no separate designated laboratory agreement). The laboratory fee schedule reimbursement is a global (technical and professional component) payment for services rendered to HMO and PPO Members.

Observation services

Observation services are defined as short-term services (less than 24 hours) that are reasonable and appropriate to monitor and evaluate a Member's condition, establish diagnosis, or determine the necessity for Inpatient hospitalization.

Observation services are an alternative to Inpatient Services. The payment for observation stays shall not exceed the lesser of 24 hours or your contracted per diem rate. If the observation stay results in an Inpatient Admission, the Inpatient Admission is considered to have started at the time of the Admission for observation services. The Inpatient claim should include all charges incurred during the stay. No separate observation claim is to be filed.

Example: A Member is admitted for observation on November 4, admitted to an Inpatient bed on November 5, and discharged on November 7. An Inpatient claim should be submitted with dates of service from November 4 to November 7; no observation claim would be filed.

How to bill for observation services

Observation room services must be billed with revenue code 0762 plus the appropriate number of units (1 unit per hour) that the Member spent in observation. No procedure code is required.

Reimbursement

Observation services are reimbursed in accordance with your Agreement. Reimbursement for these services include all ancillary services provided during the visit.

Please refer to the chart on *page 7.3* for more information on both ER and observation services.

Outpatient surgery

Covered surgical services will be reimbursed in accordance with the terms of your Agreement. Reimbursement of Outpatient surgery includes PATs and all facility services provided during the Outpatient surgical procedure and should be billed on the same claim.

With the exception of specified implantable devices, the categories and fees indicated on the fee schedule represent an all-inclusive payment. This applies to laboratory and radiology as well as all PATs.

Each procedure code on the fee schedule is assigned to a category number, and the category number will determine the level of reimbursement. Procedures that are not listed on the Outpatient Hospital Surgery Fee Schedule are individually reviewed for payment consideration when performed in a hospital Outpatient setting.

How to bill for Outpatient surgery services

Bill Outpatient surgeries with the appropriate revenue code plus the appropriate procedure code (CPT and HCPCS), as listed on the Outpatient Hospital Surgery Fee Schedule. To review correct coding correlation requirements, refer to the current Correlation Table at *www.amerihealth.com/providers/communications/bulletins*. The Outpatient Surgery Fee Schedule and the Correlation Table are updated periodically to reflect the addition or deletion of codes.

Sequencing

Claims with multiple surgical procedures are processed in the same order that they appear on the claim. Please be sure to bill the procedure with the highest allowable (primary) procedure first. AmeriHealth does not reorder the claim lines; however, some clearinghouses use software that changes the order, thus affecting the processing by AmeriHealth.

Payment for multiple surgical procedures

When multiple surgical procedures are performed during the same date of service, the highest allowable (primary) procedure is paid at 100 percent of the fee schedule rate, and the remaining procedures are paid at 50 percent of the fee schedule rate.

Revenue codes

Hospitals performing Outpatient same day surgeries (SDS) should use the following revenue codes for surgery claims: 0360 and 0361. The same revenue code should be used for each procedure. When providers bill with different revenue codes, there is no additional reimbursement.

Example 1:	Rev code	CPT and HCPCS	Status	Percent
	0360	23410	Highest allowable (primary)	100%
	0360	36530	Second highest allowable	50%
	0360	11402	Second highest allowable	50%
Example 2:	**Rev code**	**CPT and HCPCS**	**Status**	**Percent**
	0360	67105	Highest allowable (primary)	100%
	0360	67105	No reimbursement	–

Charges for procedures

All billed procedures must have corresponding charges. AmeriHealth cannot accept procedures with a $0.00 charge. If your system rolls up all charges to the first procedure, be sure to drop down a nominal amount (e.g., $1.00) to the other procedures.

Example:	Rev code	CPT and HCPCS	Charges	Status	Percent
	0361	36530	$1810.00	Highest allowable (primary)	100%
	0361	11402	$1.00	Second highest allowable	50%

Incidental procedures

When multiple procedures are billed, no additional payment is made to hospitals for procedures that are considered integral to the highest allowable (primary) procedure. The Member may not be balance-billed for incidental procedures (IP).

Payment for an IP is made when that procedure is the only procedure performed or when it is the highest allowable (primary) procedure for the episode of care. IPs are marked as "IP" on the Outpatient Hospital Surgery Fee Schedule.

When multiple procedures are performed and all are incidental, only the IP that is the highest allowable (primary) procedure is reimbursed.

Example:	Rev code	CPT and HCPCS	Incidental	Status	Percent
	0360	29877	IP	Highest allowable (primary)	100%
	0360	29880	IP	Second highest allowable	–
	0360	11402	–	Second highest allowable	50%
	0360	58120	IP	Second highest allowable	–

Surgery with observation

When Outpatient surgical claims are paid according to the fee schedule, there is no additional reimbursement for observation services. Please refer to the chart on page *7.3* for more information.

Procedures not found on the Outpatient Surgery Fee Schedule

All claims submitted for procedures that are not on the Outpatient Hospital Surgery Fee Schedule are suspended for manual prepayment review.

Variations before and after surgery

Advance approval by AmeriHealth is based on the code for the procedure planned, but the code assigned after the procedure may be different. Assuming the codes are reasonably related, this is not a barrier for payment; however, updated Preapproval/Precertification may be required.

Coding discrepancies

When a claim is suspended because the procedure billed is not on the fee schedule, AmeriHealth's Provider Payment department may also review the CPT and HCPCS coding to ensure that the procedure was not miscoded. The review may involve medical record review. The claim will remain pended until documentation is received. It is in the hospital's best interest to expedite these requests. Coding discrepancies will be discussed with the Medical Records department before any action is taken.

Cancelled surgeries

Currently, three types of Outpatient cancelled surgery scenarios are eligible for reimbursement. In order for these claims to be processed correctly, certain coding and billing criteria must be met. Claims submitted that do not meet these criteria must be returned to the facility for correction, resulting in a delay of the reimbursement cycle. Please note the criteria for each of the scenarios below when coding and billing your claims.

Scenario 1: Patient has PAT, but surgery is cancelled. For example, the patient has PAT for intended cataract surgery but subsequently develops a cold and the surgery is cancelled.

Coding and billing requirements:

- Report principal diagnosis code, which is the reason for the surgery.
- Report the secondary diagnosis with the appropriate V code indicating cancelled surgery (V.64.1, V64.2, or V64.3).
- Submit claim for the PAT date of service indicating procedures performed. The hospital will be reimbursed for the PATs according to its Agreement.

Scenario 2: Planned surgery is begun but stopped before the entire procedure is completed. For example, the patient has planned a laparoscopic adhesiolysis. Surgery proceeds as far as the insertion of the laparoscope when the patient develops an arrythmia and the surgery is stopped.

Coding and billing requirements:

- Report principal diagnosis code, which is the reason for the surgery.
- There is no need to use a V code indicating cancelled surgery.
- Code the procedure to the extent it was completed. In this example, the diagnostic laparoscopy code would be used to describe the insertion of the scope.
- Submit the claim through the standard channels — no medical record review is required.

The hospital will be reimbursed to the extent that the procedure was performed (e.g., diagnostic laparoscopy) according to its Agreement.

Scenario 3: Patient had been admitted to SDS/short procedure unit, but surgery was cancelled before it began. Some services related to the intended procedure have been rendered. For example, the patient is in the operating room, and anesthesia has been induced. But the patient's blood pressure drops, and the procedure is cancelled.

Coding and billing requirements:

- Report the principal diagnosis code, which is the reason for the surgery
- Report the secondary diagnosis with the appropriate V code (V64.1-V64.2) to indicate that surgery was cancelled.
- Report the CPT and HCPCS code for the intended procedure with the correct revenue code for Outpatient surgery.
- Submit the claim with medical records for the encounter with the reasons for the cancellation attached.
- Submit claims to your Hospital/Ancillary Services Coordinator.

The hospital/facility may be reimbursed for surgical procedures cancelled for reasons beyond the hospital's control. The hospital will be reimbursed at the minor surgery rate for fee schedule claims or according to their Agreement for all other claims. If the cancellation is administrative (e.g., equipment failure, staffing problems), the procedure will not be reimbursed.

In addition to the criteria specified above, please also note the following guidelines:

- Do not submit claims using facility level of service (clinic) codes (99201-99205, 99211-99215) to describe services.
- Do not use treatment room, observation room, or recovery room revenue codes (0761, 0762, 0710) for place of service.
- Do not submit claims that simply list medications or IV fluids without the corresponding surgical code.
- Claims submitted without the required information will not be considered for payment.

Outpatient implantable devices

Reimbursement of implantable devices is dependent on the hospital's contracted Outpatient surgery reimbursement methodology.

How to bill implantable devices

Submit the claim electronically through standard channels. Bill the implant using the applicable revenue codes.

Charges must also be assigned to implants. According to the terms of your Agreement, these devices may be reimbursed separately at the provider's cost as documented on the manufacturer's invoice (shipping and sales tax excluded).

The applicable implant revenue code and charges must be billed on initial claim submission. Otherwise, they will not be added when the request for implant reimbursement is submitted.

After the base claim is paid, submit the following documentation:

- operative report
- implant record
- implant manufacturer's invoice (not purchase order)

Note: The purchase order is not acceptable in lieu of the manufacturer's invoice. It may be submitted in addition to the manufacturer's invoice to clarify a date discrepancy.

Generally, we will not accept an invoice with a date greater than the date of surgery as applicable documentation. However, it may be your hospital's billing practice to request a device with a purchase

order, receive the device and utilize it during surgery, and then be billed by the manufacturer after the actual surgery date. If this is the case, include both the invoice and purchase order for documentation and specify that this is your hospital's practice.

A manufacturer's invoice received with handwritten amounts will not be considered acceptable documentation. If an implantable device is ordered in bulk, this invoice is considered acceptable documentation as long as the cost per unit and units per order (e.g., pack, case, box) are identified.

To facilitate processing, include a cover sheet that contains a summary of the required information, including:

- Member's name
- Member's AmeriHealth ID
- Member's claim number
- implant type
- invoice amount

Implant record

The implant record is required to verify the model and lot/serial number of the implant device. This information is found on the implant labels that are attached to the implant record. Please check with your facility's operating room staff to determine their procedure for implant labels. The facility may place these labels on the operative report, purchase order, or one of the following:

- cardiac catheterization report
- implantable device registration form
- intra-operative nursing record
- medical device or issue tracking form
- operative notes (seeds)
- progress notes

You may submit one of these forms in lieu of the implant record as long as they include the implant label indicating the implant's model and lot/serial number and a brief description of the device.

With the exception of radioactive seeds and some screws, all other types of implantable devices are forwarded by the manufacturer with implant labels.

Implant requests received without all the required documentation will not be considered for reimbursement. All received documentation will be returned to the facility. Please submit the necessary documentation to the attention of your Hospital/Ancillary Services Coordinator (depending on your location) to:

AmeriHealth New Jersey
8000 Midlantic Drive
Suite 333 N
Mount Laurel, NJ 08054

AmeriHealth New Jersey
485-C Highway 1 South
Suite 300
Iselin, NJ 08830

Please note that originally submitted requests for implant payments will be processed in accordance with the timely filing provisions of your Agreement.

Reimbursement exceptions

Following are a few examples of circumstances when implant devices are not eligible for reimbursement:

- The type of device is not specified on approved listing.
- There is insufficient documentation.
- The Member is not found or is ineligible on date of service.
- The base surgery claim has been denied, has not yet been paid, or is limited to the lesser of total allowable charges.
- AmeriHealth is not the primary payor.

Radiology services

The following Outpatient radiology services for HMO and PPO Members require Preapproval/ Precertification through American Imaging Management, Inc.:

- computed tomography (CT and CTA) scanning
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- nuclear cardiology studies
- positron emission tomography (PET) scanning (PET scans are already subject to Precertification)
- PET/CT fusion (PET/CT fusion are already subject to Precertification)

HMO/POS coverage. Radiology services for HMO Members are generally provided by the designated radiology provider under the Capitated Radiology Program*. A complete listing of the radiology services included in this program can be found at *www.amerihealth.com/medpolicy*. Search for the claim payment policy "Diagnostic Radiology Services Included in Capitation." Outpatient radiology services that are excluded from capitation are paid at the contracted fee schedule.

For HMO Members, hospitals that are not the Member's designated radiology site may perform and be reimbursed for ultrasounds and testing for identified high-risk patients enrolled in Baby FootSteps®. Pediatric Members (newborn through 4 years old) may be Referred to any radiology facility in the HMO network. While this age group is excluded from the capitation program, a Referral for a Participating Radiology Provider is required.

Services provided by any provider other than the PCP's designated radiology provider will be denied unless the Member's PCP or the treating specialist obtains the necessary authorization to have the services performed at a site other than the designated radiology provider.

**Applies to Southern New Jersey counties only.*

PPO coverage. A Member must receive all non-Emergency diagnostic radiology and imaging studies from a network radiology provider in order to receive in-network benefits. Members with PPO coverage may obtain radiology services from any participating facility in the AmeriHealth PPO network.

CMM coverage. Members with CMM coverage may receive radiology services from any AmeriHealth participating facility. All services for CMM Members are reimbursed at the facility's negotiated Outpatient rate unless otherwise specified in your facility Agreement.

How to bill for radiology services

- Bill radiology services with one of the following revenue codes: 0320-0324, 0329, 0340-0342, 0349-0352, 0359, 0400-0404, 0409, 0610-0612, 0614-0616, 0618, or 0619. Radiology billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes.
- Bill therapeutic/chemotherapy radiology with one of the following revenue codes: 0330-0333, 0335, or 0339.

Requirements for mammography and breast ultrasounds

- A Referral is not required for HMO/POS Members to obtain screening and/or diagnostic mammography and breast ultrasounds provided by an accredited in-network radiology provider.
- Screening and diagnostic mammograms performed at a network radiology site will be covered in full and will not be subject to any copayment, deductible, or coinsurance.
- There are no age restrictions on the provision and payment of mammograms.
- Radiology facilities may require a physician's written prescription.
- Bill diagnostic mammographies with revenue code 0401, and bill screening mammography services with revenue code 0403.

Interventional radiology

Interventional radiology (IR) involves procedures with both a surgical and radiological component.

HMO/POS. For HMO and POS Members, a Referral is required only for the services listed in *Appendix D*. All other IR services require Preapproval/Precertification.

If several IR procedures are being performed, some that are payable with a Referral only and some that require Precertification, you will need to obtain Precertification for the applicable procedure. Claims should be submitted with a radiology revenue code and correlated radiology procedure code in addition to a surgical revenue code and correlated surgical procedure code. The surgical procedure code is reimbursed and includes the radiology services.

Short-term rehabilitation therapy services

HMO/POS. Physical therapy and occupational therapy services for HMO Members are generally provided by the designated provider under the Capitated Physical Therapy Program*. A complete listing of the services included in this program can be found on *www.amerihealth.com/medpolicy*. Search for the claim payment policy "Physical Therapy and Occupational Therapy Services Included in Capitation." Any therapy services that are excluded from capitation are paid at the contracted fee schedule.

Services excluded from capitation

The following services are not included in the capitation program:

- diagnosis-specific hand therapy
- speech therapy
- lymphedema therapy
- vestibular rehabilitation
- orthoptic/pleoptic therapy when provided by a licensed ophthalmologist or optometrist

**Applies to Southern New Jersey only.*

Referral requirements

A Referral (via the IVR system or NaviNet) from the Member's PCP is required whenever a Member is Referred to the designated provider for treatment or evaluation.

Under most circumstances, one Referral per patient per condition is sufficient. The Referral should specify "Rehabilitation (PT/OT) Evaluate and Treat." This will allow the designated physical therapy provider to evaluate the patient and recommend a treatment program, as well as coordinate the course of treatment among the PCP, specialist, and therapist. The therapist, with the approval of the PCP and specialist, will then institute the course of treatment determined to be most appropriate.

Interrupted therapy

Occasionally, due to a change in the treated condition or a concurrent illness, rehabilitation therapy may be interrupted. For example, a Member receives short-term rehabilitation therapy for an acute condition, during which time he or she has surgery for this condition. The surgery is considered an interruption of therapy, and the Member is eligible to use any of the remaining benefit days postoperatively. The PCP will need to electronically submit a new Referral for any therapy that occurs more than 90 days after the date of the original Referral.

The provision of splints, braces, prostheses, and other orthotic devices is not included in the capitation program. Such devices are provided by participating HMO DME/prosthetic providers and must be Precertified by AmeriHealth's Care Management and Coordination department if more than $500.

Individual benefits must be verified, as some group plans do not require Preapproval/Precertification for items over $100. For more information, please refer to our policies at *www.amerihealth.com/medpolicy*.

How to bill for physical/occupational/speech therapy services

Bill physical therapy/occupational therapy (PT/OT) services with one of the following revenue codes: 0420-0424, 0429, 0430-0434, 0439, 0951, 0952. PT/OT billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes. To review AmeriHealth correlation bulletins for acceptable revenue codes, refer to the current Correlation Table Bulletin at *www.amerihealth.com/providers/communications/bulletins*.

Bill speech therapy services with one of the following revenue codes: 0440-0444, 0449. Speech therapy billing requires that a CPT and HCPCS code is billed with the appropriate revenue codes.

Sleep study

In order for a participating hospital's sleep study program to be eligible as an approved sleep study program for AmeriHealth's network, it must be accredited by the Joint Commission or the American Association of Sleep Medicine, as specifically referred to in your Agreement. For hospital billing, sleep study is part of the neurology fee schedule and should be billed using the neurological revenue codes.

Additional billing information

All claims, regardless of the submission method, should clearly indicate whether the claim is the result of an accident, such as a motor vehicle accident, or related to employment. The claim should be submitted to the appropriate primary insurance carrier, and it should include all services rendered during the patient Admission or date of service.

Timely Filing

The standard policy for timely filing includes the following:

- For Inpatient Services, providers should submit claims to AmeriHealth within 12 months following the date of discharge for an Inpatient Admission.
- For all other Covered Services, providers should submit claims within 12 months following the date of service (e.g., outpatient services, office visits, date of medical transport, or date of delivery for DME).

In the event that AmeriHealth's payment responsibility is not determined until after the date of discharge or Covered Services, providers must submit the claim within 12 months of the determination.

Please note that claims will not be accepted for payment if submitted more than 12 months from:

- the date the Covered Services are rendered;
- where AmeriHealth is the secondary payor, the date the primary payor has made payment or denied the claim.

In accordance with the terms of your contract, Members may not be billed for claims that were not accepted because they were not timely filed.

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Billing & Reimbursement for Ancillary Services

Overview

The purpose of this section is to describe the specific billing requirements for services rendered by ancillary facility and ancillary professional providers and to supplement the *General Information* section.

Ambulance services

Preapproval/Precertification requirements

- Preapproval/Precertification is required for all non-emergent ambulance transport, except for transport from one acute-care setting to another (billed with HH modifier). Please complete field locator 23 on the CMS-1500 form.
- Transfers from a medical facility to a mental health facility by ambulance must be Preapproved by Magellan Behavioral Health, Inc.

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires that contracting ambulance providers submit their claims on a CMS-1500 form. Please take special notice of the following billing requirements that may be unique to AmeriHealth claims:

- The National Provider Identifier (NPI) assigned to your organization must appear on every claim.
- Only those services specified in your Agreement will be reimbursed.

Electronic billing (837P)

National Association of Insurance Commissioners (NAIC) codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID list at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through Electronic Data Interchange (EDI), you will receive a Functional Acknowledgement (FA)/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing, as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305.

For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

Ambulatory surgical center services

Preapproval/Precertification requirements

Precertification/Preapproval is based on the HCPCS and CPT® codes for the planned procedure. If there is a change to the planned procedure, the HCPCS and CPT codes on the claim may be different from the code originally reported. Assuming the codes are reasonably related, this is not a barrier for payment. Significant discrepancies may be questioned prior to payment.

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires contracted ambulatory surgical center (ASC) claims to be submitted using the UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification numbers, when applicable, should appear in field locator 63.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- A "no-pay" bill must also be sent to the fiscal intermediary for any AmeriHealth 65® Member.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID list at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Sequencing

Claims with multiple surgical procedures are processed in the order they appear on the claim. Please be sure to bill the procedure with the highest allowable (primary) procedure first. AmeriHealth does not reorder the claim lines; however, some clearinghouses use software that changes the order, thus affecting the processing by AmeriHealth.

Payment for multiple surgical procedures

When multiple surgical procedures are performed on the same date of service, the highest allowable (primary) procedure is paid at 100 percent of the fee schedule rate, and the remaining procedures are paid at 50 percent of the fee schedule rate.

Revenue codes

ASCs should use the following revenue code for surgery claims: 0490. The same revenue code should be used for each procedure. When providers bill with different revenue codes, there is no additional reimbursement.

Example 1:	**Rev code**	**CPT/HCPCS**	**Status**	**Percent**
	0490	23410	Highest allowable (primary)	100%
	0490	36530	Second highest allowable	50%
	0490	11402	Second highest allowable	50%
Example 2:	**Rev code**	**CPT/HCPCS**	**Status**	**Percent**
	0490	67105	Highest allowable (primary)	100%
	0490	67105	No reimbursement	–

Charges for procedures

All billed procedures must have corresponding charges. AmeriHealth cannot accept procedures with a $0.00 charge. If your system rolls up all charges to the first procedure, be sure to drop down a nominal amount (e.g., $1.00) to the other procedures.

Example:	**Rev Code**	**CPT/HCPCS**	**Charges**	**Status**	**Percent**
	0490	36530	$1810.00	Highest allowable (primary)	100%
	0490	11402	$1.00	Second highest allowable	50%

Incidental procedures

When multiple procedures are billed, no additional payment is made for procedures that are considered incidental to the highest allowable (primary) procedure. The Member may not be balance-billed for incidental procedures (IP).

Payment for an IP is made when that procedure is the only one performed or when it is the highest allowable (primary) procedure for the episode of care. When multiple procedures are performed and all are incidental, only the IP that is the highest allowable (primary) procedure is reimbursed.

IPs are marked with an “IP” on the ASC Surgery Fee Schedule.

Example:	Rev Code	CPT/HCPCS	Incidental	Status	Percent
	0490	29877	IP	Highest Allowable (primary)	100%
	0490	29880	IP	Second highest allowable	–
	0490	11402	–	Second highest allowable	50%
	0490	58120	IP	Second highest allowable	–

Note: Updates are made periodically to the ASC Surgery Fee Schedule.

Birthing centers

Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires all birthing center claims to be submitted using the UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- The correct bill type, 84X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Dialysis centers

Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires all dialysis center claims to be submitted using a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 72X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- All bills must be submitted on a monthly basis.
- Referrals for HMO Members are not required.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing, as well as those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Billing & Reimbursement for Ancillary Services

In order to ensure correct claim payment, please use the following revenue codes when billing for services rendered in accordance with your Agreement:

Revenue code (UB-04 field locator 42)	Description (UB-04 field locator 43)
0821	Hemodialysis
0825	Hemodialysis with training
0829	Home dialysis training and treatment
0831	Peritoneal dialysis
0835	Peritoneal dialysis with training
0841	CAPD dialysis
0845	CAPD dialysis with training
0851	CCPD dialysis
0855	CCPD dialysis with training

Billing procedures

The following requirements for submitting claims to AmeriHealth for renal dialysis services are based on Medicare's billing instructions (National Uniform Billing Committee/Health Care Financing Administration [HCFA]). In order for your claims to be accepted and processed by AmeriHealth, the billing requirements defined below must be used.

Note: Follow the coding guidelines in the current UB-04 and ICD-9-CM/CPT manuals when reporting all services.

HCPCS/CPT codes: HCPCS/CPT codes are required when reporting services in the following series of revenue codes:

30X	**31X**	**32X**	**73X**	**92X**
82X	**3X**	**84X**	**85X**	**636**

Notice of Medicare coverage

Upon enrollment of any AmeriHealth Member, participating dialysis centers must submit to AmeriHealth a copy of the Medicare HCFA-2728 form that is sent to the Renal Networks. These forms are needed to facilitate our Member reconciliation efforts with those of the Centers for Medicare & Medicaid Services (CMS) and to ensure appropriate coordination of benefits. Please submit forms for AmeriHealth Members covered under all products referred to in this manual to:

AmeriHealth
1901 Market Street
29th floor
Philadelphia, PA 19103-1480

Please refer to the *General Information* section of this manual for claims information.

Durable medical equipment

Preapproval/Precertification requirements

- Purchased durable medical equipment (DME): Preapproval/Precertification is required for purchased DME costing $500 or more per line item (except diabetic supplies, unit dose medications for nebulizers, and ostomy supplies).
- Rental DME: Preapproval/Precertification is required for all DME rentals (with the exception of oxygen), regardless of price.
- Preapproval/Precertification is required for the repair and/or replacement of DME and prosthetic devices.

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Note: Member benefits should always be verified as some groups have Preapproval/Precertification requirements for services over $100.

Billing information

AmeriHealth requires that contracting DME providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim.
- The "from" and "to" dates of care must be provided.
- A Certificate of Medical Necessity is not required for billing but must be kept on file with the patient's chart to be made available upon request.
- The claim form must show a written description for any miscellaneous billed service that has not been defined or priced.

Note: The above information is subject to state mandates.

Electronic billing (837P)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

Freestanding sleep study centers

Preapproval/Precertification requirements

Preapproval/Precertification is required for HMO Members. A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires sleep study center claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

In order for a sleep study center to be eligible as an approved sleep study center for AmeriHealth's network, the center must be accredited by the Joint Commission or the American Association of Sleep Medicine.

Please take special note of the following guidelines:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The correct bill type, 89X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to your facility.
- Only those services specified in your Agreement will be reimbursed.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent monthly. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Fee schedule billing and reimbursement

Fee schedules are the method of reimbursement for procedures performed in the sleep study center. Freestanding sleep study centers are reimbursed on a standard fee schedule. Physician services are separately billable.

Home health

Preapproval/Precertification requirements

All home health services require timely Preapproval/Precertification. A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires all home health claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The revenue codes listed in this section should be used to bill home health services.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Covered Services	
Revenue code	**Description**
0421	Physical therapy, visit charge
0431	Occupational therapy, visit charge
0441	Speech therapy, visit charge
0551	Skilled nursing, visit charge
0561	Medical social worker, visit charge
0571	Home health aide (hourly rate)
0590	Nutrition consultation, visit charge – benefit only for Managed Care benefit programs; not for CMM

Mother's Option®

Billing information

AmeriHealth requires all Mother's Option claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification is not required for the Mother's Option well-mom/baby home care visit, provided that the visit(s) complies with the Mother's Option guidelines.
- The claim should be billed with the mother as the patient, never the baby. If additional visits for the baby are needed, Preapproval/Precertification should be obtained and the service should be billed under your home health provider number.
- Timely Preapproval/Precertification is required for all phototherapy services. A separate authorization should be obtained for the skilled nursing visit and for the rental of the Wallaby® blanket.
- Phototherapy claims must always be billed with the baby as the patient.
- The revenue codes listed in this section should be used to bill Mother's Option services.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required fields are filled in.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).
- For more information, please see the *Care Management and Coordination* section of this manual.

Note: Self-funded groups are not required to follow any state mandates, including the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA of 96). Be sure to verify that a baby has been added to a policy prior to billing phototherapy or standard home care services.

Mother's Option®	
Revenue code	**Description**
0551	Well-mom/baby, visit charge
0291	Phototherapy (Wallaby rental), daily charge

Covered diagnoses	
Diagnosis code	**When reporting service**
V24.2, 650	Well-mom/baby visit
774.6	Phototherapy (Wallaby rental)

Perinatal/Baby FootSteps®

Billing information

AmeriHealth requires all Perinatal/Baby FootSteps claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately, whether you bill via EDI or on paper. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- All perinatal services require timely Preapproval/Precertification.
- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The revenue codes listed in this section should be used to bill perinatal services.
- The correct bill type, 33X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

Covered Services	
Revenue code	**Description**
0551	Skilled nursing, visit charge
0561	Medical social worker, visit charge
0571	Home health aide, hourly charge
0589	Fetal non-stress test, visit charge
0590	Nutrition consultation, visit charge

Home infusion therapy

Billing information

AmeriHealth requires that contracting infusion therapy providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- All home infusion services require Preapproval/Precertification. For more information please visit *www.amerihealth.com/medpolicy*.
- Claims must be submitted biweekly or monthly.
- The NPI assigned to your organization must appear on every claim.
- The start and end dates of care must be provided.
- Only those services specified in your Agreement will be reimbursed.
- When more than one antibiotic therapy is administered, it must be reported with the correct approval number assigned for each therapy.
- When reporting hydration therapy, only one rate shall be reimbursable on a per-day basis, regardless of volume used.
- The line maintenance services are reported only when a Member is not receiving active therapy.
- National Drug Code (NDC) numbers are used for determining the average wholesale price (AWP) of the drug component. The AWP is determined using First DataBank pricing. When billing for a drug used in conjunction with infusion therapy, you must use the NDC number of the dispensed drug and the number of units dispensed. Each NDC number must appear on a separate line of the claim form.

Note: A new edit to validate the NDC submitted on paper and electronic claims for claims submitted with an unlisted and nonspecific drug code became effective January 1, 2009.

All drug claims will require the submission of an accompanying 11-digit NDC. This includes claims for hemophilia factor products that are currently submitted with specific J codes.

The NDC must be submitted using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string, or the claim will be returned for correction prior to processing.

Electronic billing (837P)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI support group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

Private-duty nursing

Billing information

AmeriHealth requires that contracting private-duty nursing providers submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- Preapproval/Precertification is required for all private-duty nursing services.
- The NPI assigned to your organization must appear on every claim.
- The procedure codes listed in this section must be used in order to ensure proper claims payment.
- Since Precertification is required for the reported service, please complete field locator 23 on the CMS-1500 form.

Covered services	
Code	**Description**
S9123	Registered nurse, per hour
S9124	Licensed practical nurse, per hour

Electronic billing

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

Hospice

Preapproval/Precertification requirements

All Inpatient hospice services require timely Preapproval/Precertification. There is no Preapproval/ Precertification requirement for home hospice services (revenue code 0651). A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires all hospice claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The revenue codes listed in this section should be used to bill hospice services.
- The correct bill type, 81X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all Member information is correct (e.g., date of birth, relation-to-insured code).

Covered services	
Revenue code	**Description**
0651	Home hospice care, visit charge
0652	Continuous care home hospice (per hour)
0655	Respite care hospice (per day)
0656	Inpatient hospice care (per day)

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Independent laboratory

Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires contracting laboratory providers to submit their claims on a CMS-1500 form. A description of how to complete a CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim.
- Only those service codes specified in your Agreement will be reimbursed.

Electronic billing (837P)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing

If you must submit a claim on paper, you will need to bill on a CMS-1500 form.

Lithotripsy centers

Preapproval/Precertification requirements

A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires all lithotripsy claims be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following billing requirements that may be unique to AmeriHealth claims:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "from" and "through" dates.
- The correct revenue code assigned by AmeriHealth (0790) must be reported in order to ensure proper claim payment.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your provider type, the claim will be rejected and returned to you.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. Once claims are submitted through EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form.

Skilled nursing facility

Preapproval/Precertification requirements

Preapproval/Precertification numbers, when applicable, should appear in box 63. A list of current Preapproval/Precertification requirements by product is available in *Appendix A*; however, these requirements vary by benefits plan and are subject to change.

Billing information

AmeriHealth requires skilled nursing facility (SNF) claims to be submitted on a UB-04 form. Any claim that is not submitted in the UB-04 format will be returned to the facility. All required UB-04 field locators must be completed accurately. A description of how to complete a UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*.

Please take special note of the following guidelines:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified/included on the claim.
- A charge amount must appear in the total charge field for each line item. Lines with zero dollar charges will not be accepted. The amount billed must be greater than zero.
- Miscellaneous CPT/HCPCS codes (codes ending in "99") are not acceptable.

Electronic billing (837I)

NAIC codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate *payer ID list* at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html* for a complete list of the NAIC-assigned codes.

When billing electronically, claims may be submitted through a vendor that you are contracted with or directly to AmeriHealth via your own computer system. Claims are submitted in batches and may be sent monthly. Once claims are submitted via EDI, you will receive an FA/U277 from your contracting vendor or directly from AmeriHealth. The FA/U277 will identify those claims that were accepted for processing and those that could not be forwarded for processing and the corresponding reason.

If your facility is not operational on EDI for all products, please contact the EDI Support Group at 215-241-2305. For electronic submission instructions, please refer to the appropriate Companion Guide at *www.amerihealth.com/edi*.

Paper billing (UB-04)

If you must submit a claim on paper, you will need to bill on a UB-04 form. In order to assure correct claims payment, use the following revenue codes when billing for services rendered:

Revenue code	Description
0121	Days after Medicare
0130, 0150	Basic SNF – Freestanding or hospital-based
0120, 0191	Subacute medical
0129, 0199	Subacute medical – high-cost IV drug*
0118, 0128, 0190, 0192	Subacute rehab
0206, 0193	Ventilator dependent-chronic care
0200, 0194	Ventilator dependent-active weaning

**High-cost IV drug is when the cost of the drug is greater than $100 AWP.*

Managed care products

The facility's per diem rate is all-inclusive for Members at a skilled or subacute level of care. Facilities are responsible for paying any subcontracted provider who furnishes ancillary services to Inpatient Members. This includes, but is not limited to, the following:

- routine diagnostic lab tests and processing
- venipuncture
- DME (except for those items set forth under the exceptions noted below)
- enteral feedings
- medical/surgical supplies
- parenteral hydration therapy
- pharmaceuticals, including IV therapies
- physical, occupational, and/or speech therapy, including supplies to support these services
- routine radiology services performed onsite at the SNF

The services itemized below should be Preapproved/Precertified by an AmeriHealth Participating Provider who will bill and be reimbursed directly for the service.

The following items are excluded under the per diem rates.

- DME:
  - customized orthotics/prosthetics
  - low air loss specialty beds/mattresses and Clinitron®/air fluidized beds consistent with CMS Group II and III requirements
  - bariatric beds
  - wound vac devices and supplies
- Other services:
  - physician services
  - MRIs, CAT scans, Doppler studies
  - emergent transportation
  - dialysis services
- blood and blood products

Referrals for HMO Members in long-term care/custodial-care nursing homes

A Referral is required for ancillary services or for consultation with a specialist for Members residing in long-term care (LTC) or nursing homes. In such cases, Preapproval/Precertification Review is not required. We have established LTC panels for our PCPs who provide care in LTC participating facilities. The LTC panels do not have designated ancillary services (e.g., laboratory, physical therapy, radiology, or podiatry). The completion of a Referral is required for any ancillary service for an LTC panel Member. In addition, a Referral is required for any specialist physician consultation and/or follow-up for an LTC panel Member.

LTC panel PCPs must issue Referrals for any professional service or consultation for an LTC panel custodial nursing home Member. Examples of services that require Referrals include specialist, podiatry, physical therapy, and radiology. Participating Providers should submit Referrals in advance of the service being provided using NaviNet® or the IVR system.

Consultants and ancillary providers are encouraged to provide Referral information with the claim to assist in processing. Preapproval/Precertification Review is required only for Inpatient Admission for hospital care, SNF care, short procedure unit cases, or Outpatient surgi-center procedures.

During an approved skilled nursing care Admission, it is not necessary for the attending physician to issue a Referral. All providers giving care to the Member should use our Inpatient skilled nursing care authorization number for claims during dates of service within the skilled nursing Inpatient stay.

Note: Certain products have specialized Referral and Preapproval/Precertification requirements and/or benefits exemptions.

Part B therapy services for Medicare Advantage Members

SNFs that provide Outpatient therapy services — physical, occupational, or speech therapy — will be reimbursed separately only for Members who reside at the facility at a custodial level of care.

Note: The reimbursement depends on the terms of your Agreement.

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Appendix A

A list of Precertification requirements by product can be found at *www.amerihealth.com/providers/preapproval*.

Appendix B

The following outpatient short procedure unit services do *not* require Precertification for HMO Members:

Description
Abdominal mass needle biopsy
Anorectal manometry
Biliary endoscopies/stents
Biliary stone extraction percutaneous
Breath hydrogen test
Colonoscopic procedures
Electrogastrography
Endoscopy of small bowel
Esophagus dilation procedures
Esophagus motility/acid study
Gastric lavage
Gastric testing
Insertion of Miller-Abbott tube
Intestinal bleeding tube
Intestine biopsy by tube/capsule
Liver biopsy
Liver tubes/stents/injections
Pancreas biopsy percutaneous needle
Peritoneocentesis, abdominal paracentesis or peritoneal lavage, diagnostic or therapeutic; initial and subsequent
Rigid proctosigmoidoscopy procedures
Small intestine gastrostomy tube placement/manipulation
Stomach biopsy by tube/capsule
Upper endoscopies

Appendix C

Aldurazyme®	Eloxatin®*	Orencia®
Aredia®	Erbitux®	Remicade®
Avastin®	Fabrazyme®	RespiGam®**
Boniva®	Genasense®**	Rituxan®*
Ceredase®	Herceptin®	Tysabri®
Cerezyme®	IVIG	
Elaprase™	Myozyme®	

**Effective January 1, 2009, these drugs require Precertification in all settings.*
***Effective January 1, 2009, these drugs no longer require Precertification.*

Note: Infusion drugs that are newly approved by the U.S. Food and Drug Administration during the effective term of the contract are considered new and emerging technology and will be subject to Preapproval requirements, pending notification by the Plan.

Appendix D

For HMO and POS Members, a Referral is required only for the interventional radiology (IR) services listed below. All other IR services require Precertification.

IR services that require a Referral for HMO/POS Members
Amniocentesis
Aspiration/injection of renal cyst or pelvis by needle/percutaneous
Biopsy of spinal cord, perc needle
Biopsy, bone, trocar/needle, deep
Biopsy, bone, trocar/needle, superficial
Biopsy, breast, incisional
Biopsy, breast, needle core
Biopsy, liver, needle, percutaneous
Biopsy, muscle, percutaneous needle
Biopsy, pancreas, perc needle

Biopsy, pleura, perc needle
Biopsy, pleura, perc. needle
Biopsy, prostate, needle/punch
Biopsy, thyroid, perc core needle
Biospy, abdominal/retroperitoneal mass, perc needle
Biospy, liver, needle, perc w/ other op
Biospy, lung/mediastinum, perc needle
Chorionic villus sampling
Contrast injection for assessment of abscess or cyst via previo
Fine needle aspiration, w/ or w/o smears, deep tissue
Fine needle aspiration, w/ or w/o smears, superficial tissue
Hysterosalpingogram
Injection and placement of chain for contrast and or chain uret
Injection for cystography or voiding urethrocustography
Injection of air or contrast into peritoneal cavity
Injection of contrast medium for dacryocystography
Injection of sinus tract, diagnostic
Injection procedure for ankle arthrotomy
Injection procedure for contrast venography
Injection procedure for copora cavernosography
Injection procedure for elbow arthrography
Injection procedure for evaluation of previously placed peritone
Injection procedure for hip arthrography w/ anesthesia
Injection procedure for hip arthrography w/o anesthesia
Injection procedure for knee arthrography
Injection procedure for lymphangiography
Injection procedure for mammary ductogram or galactogram

Injection procedure for pelography through ostomy tube
Injection procedure for percutaneous transhepatic cholagiography
Injection procedure for shoulder arthrogaphy
Injection procedure for sialography
Injection procedure for splenoportogrphy
Injection procedure for temporomandibular joint arthrography
Injection procedure for ureterography via ostomy or catheter
Injection procedure for visualization of ileal conduit and/or uret
Injection procedure for wrist arthrography
Instillation of contrast material for laryngography or bronchography
Introduction of catheter, superior or inferior vena cava
Percutaneous aspiration, spinal cord cyst or syrinx
Puncture aspiration of cyst or breast
Puncture aspiration of cyst or breast, each additional cyst
Puncture of shunt tubing or reservoir for aspiration or injection
Renal biopsy, perc, trocar/needle
Selective catheter placement, venous system, 1st order branch, more
Selective catheter placement, venous system, 2nd order, more

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Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the Member's ID card for the telephone number to contact for behavioral health services, if applicable.

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