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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 Preapproval/Precertification of elective health care services, medical review, facilitation of discharge plans, and case management. *All capitalized terms in this section shall have the meaning set forth in either your Provider Agreement or the Member's benefits plan, as applicable.*

Utilization review process and criteria

Utilization review overview

Utilization review is the process of determining whether a given service is eligible for coverage or payment under the terms of a Member's benefits plan and/or a network Provider's contract.

In order for a service to be covered or payable, it must be listed as included in the benefits plan, it must not be specifically excluded from coverage, and it must be Medically Necessary. The vast majority of AmeriHealth benefits plans exclude coverage for services considered experimental/investigational and those considered to be primarily cosmetic in nature.

To assist us in making coverage determinations for certain requested health care services, we apply established AmeriHealth medical policies and medical guidelines based on clinical evidence to determine the Medical Necessity for the requested services. We also evaluate the appropriateness of the setting (e.g., office, inpatient, outpatient) for Covered Services requested by a Member's health care provider that may be provided in alternate settings or sites. When a Covered Service can be administered in various settings, providers should request preapproval, as required by the applicable benefits program, to provide the Covered Services in the most appropriate and cost-effective setting for the Member's current medical needs and condition, including any required monitoring. The AmeriHealth review for preapproval will be based on the clinical documentation from the requesting health care provider supporting the requested setting.

It is not practical to verify Medical Necessity for 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, inpatient surgical procedures directly related to cancer diagnoses are approved without a requirement for detailed review.

Utilization reviews generally include several processes depending on the timing of the review and the service for which a determination is requested.

- **Preapproval/Precertification.** When a review is required *before* a service is performed, it is a Preapproval/Precertification review.
- **Concurrent review.** Reviews occurring *during* a hospital stay or when services are already being provided are concurrent reviews.
- **Retrospective/Post-service review.** Those reviews occurring *after* services have been performed are either retrospective or post-service reviews. AmeriHealth follows applicable State and federal

standards for the time frames in which such reviews are to be performed and for when coverage or payment determinations are issued and communicated.

Generally, where a requested service requires utilization review to determine Medical Necessity, nurses perform the initial case review and evaluation for coverage approval. Only an AmeriHealth Medical Director may deny coverage for a service based on Medical Necessity.

The nurses review applicable policies and procedures in the benefits plan, taking into consideration the Member's condition and applying sound professional judgment. Evidence-based clinical protocols are applied to specific procedures. When the clinical criteria are not met, the service request is referred to an AmeriHealth Medical Director for further review and coverage or payment determination. Independent medical consultants, who are board certified in the relevant medical specialty as required by the particular case under review, may also be engaged to conduct a clinical review. If coverage for a service is denied based on lack of Medical Necessity, written notification is sent to the requesting Provider and Member notifying them of the denial and their due process appeal rights in accordance with applicable law.

The AmeriHealth utilization review program encourages peer-to-peer discussion regarding coverage decisions based on Medical Necessity by giving Physicians direct access to AmeriHealth Medical Directors to discuss coverage determinations. 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. It is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the benefits available under the Member's coverage, our definition of Medical Necessity, and applicable medical policies.

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 under-utilization.

For Pennsylvania Members

Pennsylvania law requires that initial prospective, concurrent, and retrospective utilization review decisions of managed care plans be communicated verbally and confirmed in writing to the Member and the requesting health care provider within specific time frames. We ask that our Participating Providers inform Members of our initial utilization review decisions upon their receipt of the communication from AmeriHealth.

Providers should document that they gave this verbal notification. AmeriHealth provides written notification of determinations to both Providers and Members within the required time frames.

Note: For retrospective determinations, in situations where the Member is held harmless from financial responsibility for the service, Providers are not required to notify the Member in this way.

For Delaware Members

AmeriHealth requests that all initial prospective, concurrent, and retrospective utilization review decisions be communicated verbally and confirmed in writing to the Member by the requesting health care Provider. We ask that our Participating Providers inform Members of our initial utilization review decisions upon their receipt of the communication from AmeriHealth.

Providers should document that they provided this verbal notification. AmeriHealth provides written notification of determinations to Providers and Members within the required time frames.

Note: For retrospective determinations, in situations where the Member is held harmless from financial responsibility for the service, Providers are not required to notify the Member in this way.

Selective medical review

In addition to the foregoing requirement, AmeriHealth reserves the right, under our Utilization and Quality Management Programs, to perform a medical review prior to, during, or following the performance of certain Covered Services (selective medical review) that are otherwise not subject to reviews as previously described. In addition, we reserve the right to waive medical review for certain Covered Services for certain Providers, if we determine that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services.

Coverage penalties are not applied to Members where required selective medical review is not obtained by the Provider.

Delegation of utilization review activities and criteria

In certain instances, AmeriHealth has delegated utilization review activities to entities with expertise in medical management of a certain Membership population (such as neonates/premature infants) or type of benefits (such as mental health/substance abuse and diagnostic imaging). 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 adopted by AmeriHealth for use by the delegated entity.

Utilization review and criteria for mental health/substance abuse services

Utilization review activities for mental health/substance abuse services have been delegated by AmeriHealth to a contracted behavioral health management company, Magellan Behavioral Health, Inc. This company administers the mental health and substance abuse benefits for the majority of our Members.

Clinical criteria, guidelines, and other resources

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

- **InterQual®.** McKesson's 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:
  - certain elective coronary procedures
  - inpatient hospitalizations
  - inpatient rehabilitation
  - long-term, acute care facility
  - observation
  - skilled nursing facility (SNF)
  - some elective-surgery settings for inpatient and outpatient procedures

  In addition, we apply InterQual acute-care guidelines for Emergency admissions. Admissions that do not meet acute intensity of services and severity of illness are reviewed by an AmeriHealth Medical Director, and coverage or payment is denied if guidelines are not met. Observation services do not require Preapproval/Precertification but are subject, at the discretion of AmeriHealth, to InterQual criteria for Medical Necessity, which requires that the treatment and/or procedures include at least six hours of observation.

Note that medical records may be required to complete a review to determine coverage or payment in many situations including, but not limited to, a Medical Necessity review, pre-existing investigation, or cosmetic review.

When submitting a written request for utilization review, be sure to attach the request letter to the medical records and submit records as instructed. Medical records that arrive attached to a request letter require less research and are rapidly forwarded to the appropriate team for review.

We may conduct focused evaluation of the Medical Necessity for the use of an inpatient setting for certain elective surgical procedures. Examples include, but are not limited to: laparoscopic cholecystectomies, tonsillectomies, adenoidectomies, hernia repairs, and battery and generator changes. Providers must submit clinical documentation for instances where it is believed that the outpatient setting would not be appropriate and inpatient admission is necessary. In addition, Emergency admissions where these procedures are performed must also meet guidelines from InterQual regarding acute admission.

Note: Emergency admissions that do not appear to meet InterQual criteria are reviewed by an AmeriHealth Medical Director, and coverage or payment may be denied if guidelines are not met.

- **Centers for Medicare & Medicaid Services (CMS) guidelines.** CMS adopts and publishes a set of guidelines for coverage of services by Medicare (for Medicare Advantage HMO Members).
- **AmeriHealth medical policies.** AmeriHealth internally develops a set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services that are considered Medically Necessary. AmeriHealth medical policies may be applied for Covered Services including, but not limited to, the following:
  - durable medical equipment (DME)
  - infusion therapy
  - nonemergency ambulance transports
  - review of potential cosmetic procedures
  - review of potential experimental or investigational services
  - speech therapy

Important definitions

"Medically Necessary" or "Medical Necessity"

"Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease of its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care Provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factor.

Experimental/investigational

Experimental/investigational services: A drug, biological product, device, medical treatment, or procedure that meets any of the following criteria:

- is the subject of ongoing phase I or phase II clinical trials;
- is the research, experimental study, or investigational arm of ongoing phase III clinical trials, or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with a standard means of treatment or diagnosis;
- is not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;
- is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence*, as effective and appropriate for the particular diagnosis or treatment of a covered person's particular condition;
- is generally recognized by either the Reliable Evidence* or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of a covered person's particular condition is recommended.

A drug will not be considered experimental/investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process (e.g., an investigational new drug exemption — as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia recognize the usage as appropriate medical treatment:

- American Hospital Formulary Service (AHFS) Drug Information
- U.S. Pharmacopeia (USP) – National Formulary

Any drug that the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered experimental/investigational.

A biological product, device, medical and/or behavioral health treatment, or procedure is not considered experimental/investigational if it meets all of the Reliable Evidence* criteria listed below:

- Reliable Evidence exists that the biological product, device, medical and/or behavioral health treatment, or procedure has a definite positive effect on health outcomes.
- Reliable Evidence exists that over time the biological product, device, medical and/or behavioral health treatment, or procedure leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the biological product, device, medical and/or behavioral health treatment, or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts, regarding the biological product, device, medical and/or behavioral health treatment, or procedure, is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

**Reliable Evidence is defined as any of the following: Reports and articles in the authoritative medical and scientific literature; the written protocol used by the treating facility or the protocol of another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure.*

Preapproval/Precertification review

For services requiring Preapproval/Precertification, Providers are encouraged to contact AmeriHealth **at least five business days prior** to the scheduled date of the procedure to ensure documentation of timely Preapproval/Precertification. Preapproval/Precertification can be requested through the NaviNet® web portal or by calling the Provider Automated System at 1-800-275-2583. Representatives are available Monday through Friday, 8 a.m. to 5 p.m. Providers with NaviNet access are expected to use NaviNet to initiate requests for Preapproval/Precertification. Providers may also obtain the status of an authorization through NaviNet or by calling the Provider Automated System.

After business hours, a nurse is on call to assist with 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.

The CMC department will evaluate your request and will notify your office once a decision has been reached for those cases that require clinical review. You will be provided with a Preapproval/Precertification reference number based on the determination of your request. Failure to obtain Preapproval/Precertification may result in provider penalties or denials of payment regardless of medical necessity.

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

- name, address, and phone number of the Subscriber
- relationship to the Subscriber
- 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 Provider should contact AmeriHealth following admission using NaviNet or by calling 1-800-275-2583 to initiate approval of the admission.

Certain products have specialized Referral and Preapproval/Precertification requirements. Visit *www.amerihealth.com/preapproval* to view the following:

- A list of current services and drugs, including without limitation infusion drugs, that require Preapproval/Precertification. *Note: These requirements vary by benefits plan and are subject to change.*
- A list of services exempt from Preapproval/Precertification.

For *all drugs* covered under the medical benefit that require precertification, providers will be required to report member demographics, such as height and weight.

Certain drugs require adherence to Dosing and Frequency Guidelines will be reviewed during Precertification: The Dosing and Frequency Guidelines will be included in the medical policies for such drugs, which are available at *www.amerihealth.com/medpolicy*.

The Dosing and Frequency Guidelines help AmeriHealth verify that our members' drug regimens are in accordance with national prescribing standards. These guidelines are based on current U.S. Food and Drug Administration approval, drug compendia (e.g., American Hospital Formulary Service Drug Information®, Micromedex®), industry-standard dosing templates, drug manufacturers' guidelines, published peer-reviewed literature, and pharmacy and medical consultant review. Requests for coverage outside these guidelines require documentation (i.e., published peer-reviewed literature) to support the request.

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

Use NaviNet or call the Provider Automated System to verify individual Member benefits.

Providers registered with NaviNet *may* submit authorization requests for services rendered by an infusion therapy provider, a prosthetics provider, or a DME provider. Providers registered with NaviNet *must* submit authorization requests for services rendered by a home health provider, including skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide, and dietitian.

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.

Visit *www.amerihealth.com/medpolicy* to view our Nonemergency Ambulance Transport Services policy.

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. Member registration into the program and prenotification for delivery will be completed at the same time.

Out-of-network requests

HMO: In the rare event a given service is not available from Providers in the AmeriHealth network, and a Primary Care Physician (PCP) wishes to refer an HMO Member to an out-of-network Provider, the Referral must be Preapproved/Precertified; otherwise, the service may not be covered. All HMO out-of-network requests are referred to a Medical Director. The Member must meet the following guidelines:

- The Member must have first sought and received care from a Participating Provider in the same specialty as the non-preferred Provider as recognized by the American Board of Medical Specialties or American Osteopathic Association.
- The Member must have been advised that there are no Participating Providers who offer the requested Covered Services. AmeriHealth reserves the right to make the final determination.

POS: PCP-referred requests are the same as for HMO Members. However, POS Members have the option to seek care from any Provider without a Referral, when one is required, subject to our Deductible and Coinsurance, without a Preapproval/Precertification review requirement.

PPO: PPO Preapproval/Precertification review requests for services performed by out-of-network Providers are the responsibility of the Member. Member requests for coverage of an out-of-network service will be reviewed for Medical Necessity and, if approved, will pay at the out-of-network benefits level.

Preapproval/Precertification for diagnostic imaging services

AmeriHealth has contracted with AIM Specialty Health℠ (AIM) to perform Preapproval/Precertification for outpatient nonemergent diagnostic imaging services for managed care Members.

Ordering Physicians are required to obtain Precertification for the following outpatient nonemergency diagnostic imaging services:

- CT/CTA scans
- MRI
- MRA
- nuclear cardiology services
- PET scans
- PET/CT fusion

Members are responsible for Precertification when these services are performed by an out-of-network Provider, where out-of-network services are covered under their plan.

Note: If the above-mentioned tests are being ordered as mapping and planning for surgery or are ordered as part of a guided procedure (such as a needle biopsy), then the ordering Provider should call the Preapproval/Precertification phone number listed on the back of the Member's ID card, not AIM.

For more detailed information on AIM and imaging services, refer to the *Specialty Programs and Laboratory Services* section of this manual.

Penalties for lack of Preapproval/Precertification

It is the network Provider's responsibility to obtain Preapproval/Precertification for the services listed at *www.amerihealth.com/preapproval*. If Preapproval/Precertification is not obtained where required under the Member's benefits, neither the Member nor AmeriHealth will be responsible for payment. Members are held harmless and may not be billed for the service that was not Preapproved/Precertified where required.

Standing Referrals and specialist used as a PCP (PA and DE only)

HMO Members with life-threatening, degenerative, or disabling diseases/conditions are permitted to receive a standing Referral to a specialist with clinical expertise in treating the disease or condition. This will be granted upon approval of the treatment plan by CMC, the Member's PCP, and the specialist.

Members with life-threatening, degenerative, or disabling diseases/conditions are also permitted to have a specialist designated as their PCP to provide and coordinate their primary and specialty care. This will occur only after the specialist has agreed to meet our requirements to function as a PCP and after CMC has approved the treatment plan.

Customer Service can provide direction on how to initiate a request for these circumstances. A standardized form must be completed by the Member, the PCP, and the specialist, as appropriate, and must include the diagnosis and clinical plan. The form is sent to CMC and reviewed by an AmeriHealth Medical Director. If the request is denied, the Member, PCP, and specialist will be notified verbally and in writing of the denial and the clinical rationale for the denial. The Member will be directed on how to initiate an appeal.

All Members who request standing Referrals shall be evaluated for ongoing case management support and continued follow-up of their disease or condition.

Concurrent review

Concurrent review is the review of continued stay in the hospital after an admission is determined to be Medically Necessary. Our concurrent review program consists of both onsite and telephone reviews, based on the Agreement with the individual hospital.

Keep the following in mind:

- Concurrent review is performed when the reimbursement is per-diem.
- When 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.
- In certain situations, based on diagnosis, procedure, or when an Agreement with the hospital does not support the review, concurrent review may not be performed.

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 initial review;
- Preapproval/Precertification was not performed as required or was unavoidably delayed.

Requests for retrospective review can be initiated by calling 1-800-275-2583. Services requiring Preapproval/Precertification that were not Preapproved/Precertified may be denied on an administrative basis.

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 sub-acute rehab or SNF) will be reviewed for Medical Necessity. Providers must supply 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, his or her family, the attending Physician, and the hospital discharge planner.

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 that do not appear to satisfy the relevant Medical Necessity criteria are referred to and reviewed by an AmeriHealth Medical Director for a determination. If the service is determined to be covered, AmeriHealth staff will inform the Provider who submitted the request.

If the Medical Director determines that the information provided by the attending Physician is insufficient to determine Medical Necessity, the case will be pended until the required information is received. The attending Physician will be notified as soon as possible, not more than 24 hours later, of the specific additional information required.

Written confirmation of the request for additional information will be sent within two business days to the Provider, Member, and vendor, as appropriate. If the request involves urgent care, the Provider, 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 for commercial plans, and 28 days for Medicare Advantage HMO plans. 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, PCP, and Member, as applicable. The clinical review criteria applied in rendering an adverse coverage or payment determination are available free of charge and will be furnished upon request. All adverse determination (denial) notifications include the contractual basis and the clinical rationale for the denial, as well as instructions for how to initiate an appeal.

For detailed information about the appeals process, refer to the appropriate *Appeals* section of this manual.

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 the 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 sub-acute/SNF or 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 uses 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.

Reconsideration and review processes

Peer-to-Peer Reconsideration process

In the event that an adverse determination (denial) was issued without direct discussion between an attending/ordering Physician and an AmeriHealth Medical Director, the requesting Provider (including 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 requesting Provider and the AmeriHealth Medical Directors and may be requested by a Physician for a Preapproval/Precertification, concurrent, or post-service 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 Preapproval/Precertification denials, the process should be initiated after the Provider has received notification of the denial but before the service is actually rendered.
- To initiate the process, the attending Physician, ordering Physician, or hospital utilization management department Physicians or their designated Physician representative (e.g., hospital medical director, physician advisors) may contact an AmeriHealth Medical Director by email or fax or by calling the Physician Referral Line at 215-241-4079 within Philadelphia, or at 1-888-814-2244 if calling from outside Philadelphia. The Medical Director Support Unit staff is available to take calls Monday through Friday from 9 a.m. to 5 p.m. Voice messages left after hours will be retrieved during regular hours of operation.
- 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 to explain why the requested service or settings are medically necessary, based on medical judgment and InterQual criteria.
- A Medical Director will initiate a call to the Provider within two business days from the time the request for a peer-to-peer reconsideration has been received. If the provider cannot be reached after two attempts, the Medical Director documents the two failed attempts and renders a final determination. "Whenever possible, the Medical Director Support Unit staff facilitates "warm call transfers" between providers and Medical Directors and schedules telephone appointments between Medical Directors and Providers.
- Peer-to-Peer Reconsideration decision for hospital concurrent reviews can be requested by a Provider or his/her representatives (see above) up to ten business days after the Member's discharge date.
- Preapproval/Precertification must be completed before the service is actually rendered. If the service has already been rendered, the Provider must initiate a post-service Provider appeal. However, no

peer –to-peer reconsideration discussion is available for Preapproval/Precertification denials after a service has been rendered. After two failed attempts at connecting with the Provider, including through telephone appointments, the Medical Director will render a final determination, even if the peer-to-peer discussion has not occurred.

- In all cases (concurrent reviews and Preapproval/Precertification) a medical director will render a final determination not later than ten business days from the date when the request for peer-to-peer discussion was first received by the Medical Director Support Unit.
- A decision to overturn all or a portion of the initial adverse determination will be communicated in writing to the Provider.

Continuity-of-care

For Delaware Members

Continuity-of-care requirements for Delaware are as follows:

- Member notice is required six weeks prior to termination or withdrawal of doctor, except in "for cause" situations.
- Continued coverage at the contracted price is required for up to 120 days in cases where Medically Necessary, except when the termination was due to unsafe health practices.
- For pregnant Members, Medical Necessity is deemed to have been demonstrated and coverage shall continue until completion of postpartum care.

For Pennsylvania Members

- If we initiate termination of a Provider contract without cause, the Member may continue an ongoing course of treatment with that Provider for a transitional period, which will be the lesser of the current period of active treatment, or up to 90 calendar days for Members undergoing active treatment for a chronic or acute medical condition.
- In the case of a Member in her second or third trimester of pregnancy, this period extends through postpartum care related to the delivery. The continuity-of-care period may be extended by AmeriHealth when clinically appropriate. Coverage of Covered Services provided during the continuity-of-care period is contingent upon the Provider's agreement to comply with the terms and conditions applicable to our Participating Providers, prior to providing services for this time period.

If we initiate termination of a Provider contract *with cause*, we will not be responsible for coverage of health care services provided by the terminated Provider to the Member following the date of termination.

A newly enrolled AmeriHealth Member may continue on an ongoing course of treatment with a nonparticipating Provider for a transitional period, which will be the lesser of the current period of active treatment or up to 90 calendar days for Members undergoing active treatment for a chronic or acute medical condition. In the case of a new Member in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. This period may be extended by us, when clinically appropriate. Coverage of Covered Services provided during the continuity-of-care period is contingent upon the Provider's agreement to comply with the terms and conditions applicable to our Participating Providers, prior to providing services for this time period.

To initiate continuity of care, Members must contact Customer Service and complete a *Continuation of Care Form*. This form is submitted to CMC. *The nonparticipating Providers must agree that all Covered*

Services provided during this transition period shall be provided under the same terms and conditions applicable for AmeriHealth Participating Providers.

Case management program

Case management is a collaborative process that provides a Member with health management support through coordinated programs for Members who are experiencing complex health issues or challenges in meeting their health care goals.

Through telephone outreach, case managers provide education about a Member's disease, condition, or medications and offer resources and information to help the Member better understand how to manage his or her health. Case managers help Members navigate the health care and social service system to optimize his or her ability to use those resources effectively. Case managers also refer the Member to other AmeriHealth programs and can refer Members to available community resources for additional assistance and support.

When a Member is referred to case management, our case managers contact your office to offer support, with the goal of helping the Member reach the medical treatment goals you have established. The case manager will ask questions about the treatment plan and offer information on what services are available through the Member's benefits plan. He or she will incorporate any information you provide into the case management plan of care and support your treatment plan by maintaining contact with the Member in between office visits.

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

- chronic condition or disease with multiple co-morbid conditions
- medication issues, including non-adherence
- nutritional deficits
- frequent admissions for same or similar conditions
- non-healing wounds
- end-stage renal disease
- cancer patients in active treatment
- complex pediatric medical conditions
- frequent falls/safety issues
- Member requiring multiple services in the home

To refer a Member to case management, go to *www.amerihealth.com/providerforms*, and select the link for the *Physician Referral Form*. You will be taken to the case management referral page and will be able to refer the Member by completing the online form. You may also refer a Member by calling us at 1-800-313-8628.

A case manager will call your office to discuss the referral with you. A referral to case management provides both you and your patient with additional support when it is needed most. When your patient has met all of the case management goals that you helped establish, case management will end. The case manager will notify you when this has been achieved.