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Capitated services

Within the HMO/POS products, there are a number of outpatient designated (capitated) programs.

Generally, Primary Care Physicians (PCP) must refer Members only to their capitated site for these services, as noted under the *Radiology services* and *Laboratory services* headers in this section. Each capitated Provider is contracted to provide a full range of services, including treatment of pediatric Members.

If you are a Provider who is contracted for specialty capitation, you are required to either provide the service on-site or arrange for the service through a subcontractor arrangement. Therefore, it is important that you arrange for provision of the services with a subcontractor and maintain that arrangement in order to serve your patients. If you do not already have subcontractors in place, you must take steps to establish an arrangement.

When using a subcontractor, a Referral should still be completed using the capitated Provider's information.

Radiology services

HMO/POS Members

- Outpatient nonemergent radiology services are provided through a network of contracted Providers.
- Select PCPs in New Jersey are required to select one site as his or her capitated outpatient radiology Provider. All capitated services for each PCP's Members should be referred to this site.
- Preapproval is not required for services performed at a noncapitated site. Only a Referral to a Participating Provider is required. Should the Member choose to receive services you have authorized other than from the capitated site, a Referral is required.
- OB/GYNs must use the NaviNet® web portal or the Provider Automated System to refer patients to the PCP's capitated radiology Provider for general and diagnostic ultrasounds for pregnancy.
- General ultrasounds for a normal pregnancy should be referred to the capitated site designated by the Member's PCP. A list of PCPs and their capitated radiology sites is provided to each OB/GYN office and is also available through NaviNet eligibility transactions. If the Member wishes to use a Provider other than the PCP's capitated radiology site, then a Referral should be made to a Participating Provider site other than the PCP's capitated site.
- Ultrasounds and tests for high-risk patients may be referred to a Participating Perinatal Provider, antenatal testing unit, or any participating hospital.
- Members may obtain screening and/or diagnostic mammography, provided by any accredited in-network Provider, without obtaining a Referral.
- HMO specialists should refer Members back to their PCP for a Referral for any needed radiology services. The exceptions are fracture care and X-rays performed to rule out a fracture by a specialist Physician. These services should be billed as fracture care.
- Routine chest X-rays are excluded from the outpatient Capitation Radiology Program when performed by the admitting facility within 7 – 10 days prior to the admission or to outpatient surgery.
- AmeriHealth HMO Plus and POS Plus Members do not require a Referral to receive radiology services from any participating radiology facility.

Preapproval for diagnostic imaging services

We are contracted with AIM Specialty Health® (AIM) to perform Preapproval for outpatient nonemergent diagnostic imaging services for our managed care Members.

Ordering physicians — PCPs or specialists — are required to obtain Preapproval either through AIM's ***Provider****Portal*℠ or by calling 1-800-859-5288 for the following outpatient nonemergent diagnostic services:

- CT/CTA scans
- echocardiography
- MRI
- MRA
- nuclear cardiology studies
- PET scans
- PET/CT fusion scans

Reviews for the above services will be performed by AIM, as the AmeriHealth designee, according to Medical Necessity criteria. Providers can access AIM's ***Provider****Portal* through NaviNet by selecting *Authorizations* from the Plan Transactions menu and then choosing *AIM* or by visiting *www.americanimaging.net/goweb*. The AIM ***Provider****Portal* is available 7 days a week and offers providers the following:

- an easy-to-use interface for efficient Preapproval requests;
- printable Preapproval summary information sheets for completed requests;
- online tracking of previous Preapproval requests and status of open requests.

Note: If the services previously listed are being ordered as mapping and planning for surgery or are ordered as part of a guided procedure (such as a needle biopsy), the ordering Provider should call the Preapproval telephone number listed on the Member's ID card. Ordering Providers should not call AIM under these circumstances.

For HMO/POS Members, Preapproval replaces the need for a PCP Referral. Therefore, the PCP Referral for these services is not needed. The Preapproval is valid for 60 days from the date the services were requested. For radiology services not included in the previous listing, a Referral is required or claims will be denied for lack of Preapproval.

Short-term rehabilitation therapy services

HMO/POS Members

For conditions subject to significant improvement within the benefits period, HMO Members are *generally* eligible for a maximum of 60 consecutive calendar days of outpatient short-term rehabilitation therapy. Therapy beyond the benefits period is not covered. Chronic conditions that are not likely to significantly improve within the benefits period are not eligible for coverage.

AmeriHealth HMO Plus and POS Plus Members are eligible for a maximum of 30 visits (combined) for physical and occupational therapy, per calendar year. New Jersey Small Employer Health (SEH) Members are eligible for 30 visits per year for physical and occupational therapy (combined) and 30 visits per year for speech and cognitive therapy (combined).

AmeriHealth 65® NJ HMO Members are covered for physical therapy benefits beyond 60 consecutive days when performed with the expectation of improving, restoring, and/or compensating for loss of the

Member's level of function, which has been lost or reduced by injury or illness. Therapy performed repetitively to maintain the same level of function is not covered. Physical therapy Providers must consult the AmeriHealth 65 NJ HMO Member's PCP before discharging the Member from treatment.

For physical medicine and rehabilitation services, a prescription/order must be received from a Physician prior to a Member receiving therapy services.

AmeriHealth requires a prescription from a Physician for our Member's coverage, even though there are Providers (referred to as Direct Access by the American Physical Therapy Association [APTA]*) who have been issued certificates by their State regulatory agency that permit them to treat a patient for 30 calendar days without a prescription/order from a Physician. In addition to other criteria, only physical therapy services ordered by a Physician are eligible for reimbursement. AmeriHealth may also request documentation for therapy services rendered and conduct audits that investigate proper documentation.

Note: Benefits may vary by employer group. Individual benefits must be verified.

**Be advised that the APTA's Direct Access has no relation to the AmeriHealth Direct Access℠ OB/GYN benefit for HMO and POS Members.*

Members (except Medicare Advantage HMO Members) may be referred to any participating physical/occupational therapy site. Should the Member choose to receive services you have authorized other than at your capitated site, a Referral must be issued.

PCPs with office locations in the northern and central counties (Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren) are not required to refer Members with AmeriHealth HMO/POS products to a capitated physical therapy site. These Members may be referred to any physical or occupational therapy Provider that is participating in the AmeriHealth HMO/POS network.

AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements and may use any Participating Provider without Preapproval.

General information

For a complete listing of services included in the capitated PT/OT program, refer to Medical Policy #00.03.06: Physical Medicine and Rehabilitation Services Eligible for Reimbursement Above Capitation to Physical and Occupational Therapy (PT/OT) Providers for Members Enrolled in Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products at *www.amerihealth.com/medpolicy*.

Services excluded from capitation

The following services are **excluded** from the capitation requirement:

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

The provision of splints, braces, prostheses, and other orthotic devices is not included in the monthly capitation. Such devices are provided by HMO-Participating durable medical equipment (DME)/ prosthetic Providers. Certain DME and prosthetic devices require Preapproval by our Clinical Services department.

Services not eligible for coverage

The following services are **not eligible** for coverage:

- functional capacity evaluations and other specialty evaluations not associated with short-term rehabilitation;
- work hardening/reconditioning, including work reconditioning;
- ongoing treatment of chronic medical conditions where there is no expectation of significant improvement within the benefit period (Member benefits may vary).

Referral and Preapproval requirements

A Referral (through NaviNet) from the Member's PCP is required whenever a Member is referred for treatment or evaluation.

- Under most circumstances, one Referral per Member per condition is sufficient.
- All HMO Referrals are valid for 90 days from the date they are issued.
- No Preapproval is required for Referrals made to the capitated Provider. Clinical Services must Preapprove services provided by any Provider other than the PCP's capitated Provider based only on Medical Necessity and not on convenience factors.
- Speech therapy services do not require Preapproval.

Evaluation and treatment

When an HMO Member is first referred to a capitated Provider for evaluation, an initial comprehensive physical therapy evaluation will be given. A specific course of treatment will be coordinated among the PCP, specialist, and therapist. The therapist will then institute the course of treatment determined to be most appropriate.

Treatment required

When a physical therapist evaluates a patient, a course of treatment is recommended at that visit. The following are examples of possible outcomes of this initial evaluation:

- The therapist may evaluate and recommend implementation of a therapy program at the therapy center. In this case, the therapy benefit begins with the *first* visit after the evaluation.
- The therapist may evaluate the Member and determine that the condition does not require therapy at a physical therapy center. In this case, a self-administered home therapy program or other exercises may be prescribed. The therapist may then recommend one or more follow-up visits to properly assess the Member's progress.

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 must electronically submit a new Referral for any therapy that occurs more than 90 days after the date of the original Referral for Members with a benefit of 60 consecutive days.

Autism coverage

The diagnosis and treatment of autism spectrum disorders (ASD) are covered for eligible commercial Members. Before you provide care related to ASD, be sure to verify Member eligibility through NaviNet or the Provider Automated System.

Covered Services include, but are not limited to, Medically Necessary occupational, physical, and speech therapy, as described in a comprehensive treatment plan, and behavioral interventions based on the principles of applied behavioral analysis (ABA), as described in a treatment plan.

Covered Services are subject to Medical Necessity review, the Copayment, Deductible, and Coinsurance provisions of the Member's benefits plan, and any applicable Referral or prescription requirements. Covered Services with a primary diagnosis of ASD are not subject to limits on the number of Provider visits. Treatment for ASD is not covered when provided by or through a school or camp, whether or not as part of an individualized education program.

Refer to Medical Policy #07.03.07: Evaluation and Management of Autism Spectrum Disorders (ASD), which is available at *www.amerihealth.com/medpolicy*, for specific coverage information regarding the diagnosis and treatment of ASD. Note that our Medical Policy is consistent with applicable State mandates.

Laboratory services

General guidelines

If you are a Participating Physician, you may bill only for Covered Services that you or your staff perform. Participating Physician offices are not permitted to submit claims for services that they have ordered but that have not been rendered. Billing of laboratory services performed by a contracted or noncontracted laboratory is not reimbursable.

The following are participating contracted laboratories for outpatient services:

Laboratory name	Laboratory indicator on ID card	Phone number
Abington Memorial Hospital Laboratory	A	215-481-2331
Atlantic Diagnostics	D	267-525-2470
Bio Reference Laboratory (NJ only)	B	201-791-3600
Health Network Laboratories	N	1-877-402-4221
Hospital of the University of Pennsylvania Laboratory*	H	1-800-789-7366
Laboratory Corporation of America	L	1-866-297-3210
Mercy Health Laboratory	M	610-237-4175
Quest Diagnostics®, Inc.	Q	1-800-825-7320
SMA Medical Laboratories	F	215-322-6590
Thomas Jefferson University Laboratory*	T	215-955-6545

**Available to specific practices only.*

You can find laboratory indicators on the front of the Member ID card or through NaviNet.

Specialized pathology testing for HMO, POS, and PPO Members is offered by the capitated laboratories as well as by the following specialized laboratory Providers:

Laboratory name	Specialty	Phone number

Acupath	Dermatopathology/pathology	1-888-228-7624
Ameripath New York, Inc.	Dermatopathology only	1-800-553-6621
CBL Path	Pathology, oncology, genetic testing	1-877-225-7284
DIANON Systems, Inc.	Pathology, oncology, genetic testing	1-800-328-2666
Genomic Health	Oncotype DX® only	1-866-662-6897
Genzyme Genetics	Reproductive/genetic/oncology testing only	1-800-848-4436 (reproductive and genetic testing)
Genzyme Genetics	Reproductive/genetic/oncology testing only	1-800-447-5816 (oncology testing)
Institute for Dermatopathology	Dermatopathology only	610-260-0555
LithoLink	Kidney Stone Prevention	1-800-338-4333
Medical Diagnostics Laboratories (NJ PPO only)	Polmerase Chain Reaction (PCR) based testing	1-877-269-7284
Monogram Biosciences	Trofile™ Co-Receptor tropism assay only	650-635-1100
Myriad Genetics	BRAC Analysis, COLARIS® and COLARIS AP® only	201-791-3600
Penn Cutaneous Pathology	Dermatopathology only	1-866-337-6522
Shiel Medical Laboratory (NJ PPO only)	Clinical laboratory testing	718-552-1000
Millennium Laboratories Inc	Clinical laboratory testing	805-578-8300

Specialists who draw or collect specimens should establish accounts with all laboratories since they are required to send HMO Members' laboratory specimens to their PCP's capitated laboratory.

HMO/POS Members

AmeriHealth HMO/POS Members may choose to receive services you have authorized from a Participating Laboratory Provider other than your capitated laboratory site for routine laboratory services. Should your patient choose to receive services you have authorized somewhere other than your capitated laboratory site, you must issue a Referral.

AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements and may use any Participating Laboratory Provider without Preapproval.

We encourage Providers to set up accounts with their capitated laboratory sites to accommodate testing needs, improve recordkeeping, promote communication between the laboratory and the Physician, and facilitate timely receipt of laboratory supplies. In accordance with your contractual requirements, it is necessary to use a Participating Laboratory Provider.

In the unusual circumstance that you require a specific test for which you believe no participating laboratory can perform, please contact AmeriHealth, as Preapproval is required to issue a Referral to a nonparticipating laboratory. Members who have out-of-network benefits may choose to use a nonparticipating laboratory, but they will have greater out-of-pocket costs associated with that service.

PPO Members

Routine laboratory services for PPO Members must be sent to one of the in-network laboratories. For PPO Members, laboratory class code I and II services may be performed in the Physician's office in accordance with AmeriHealth claim payment policy. For a complete listing of laboratory class code I and II services, refer to *www.amerihealth.com/medpolicy*. If a laboratory test is not listed as level I or level II, it is considered a level III test. Level III outpatient laboratory tests must be referred to a commercial laboratory or one of the network hospitals that has contracted with the AmeriHealth PPO network to perform outpatient laboratory services. You can find laboratory indicators on the front of the Member ID card, through NaviNet, or by calling the Provider Automated System.

Requesting laboratory services

When requesting laboratory services include the most specific diagnosis code possible and fill out the laboratory requisition form completely with the Member's billing information (including the Member's ID number, address, type of coverage, etc.). This helps ensure that the laboratory claim will process properly and reduces Member billing issues.

Keep in mind the following:

- To obtain current capitation information, use the Eligibility and Benefits Inquiry transaction on NaviNet or the Member eligibility option within the Provider Automated System.
- PCPs may obtain a specimen in the office or send an HMO Member to a drawing station.
- All Members sent to a drawing station must be sent with the appropriate laboratory requisition form. The requesting office should complete the appropriate laboratory requisition form (not an HMO Referral). These requisition forms permit multiple Physicians to receive results; the initiator must provide full names and addresses of the Physicians who should receive a duplicate copy.
- **Capitated laboratory change requests.** Capitated laboratory change requests should be submitted in writing to your Network Coordinator, on office letterhead, with the name and signature of the appropriate PCP clearly noted. If a designated laboratory change request is received on or before the 15th day of the current month, it will be effective the first day of the following month. Designated laboratory change requests received on the 16th or later will not be effective until the following month.

  For example: A change request received January 15 was entered and became effective February 1. A change request received January 16 would not be effective until March 1.
- **STAT laboratory services.** For HMO, POS, and PPO Members, STAT laboratory services specifically listed on the STAT laboratory listing may be performed at one of the participating hospital facilities. Routine laboratory services and those not listed on the approved STAT listing must be sent to the PCP's capitated laboratory site for HMO Members. Refer to the current STAT laboratory listing, which is located at *www.amerihealth.com/medpolicy*. If routine laboratory services are provided by a hospital, those services will not be reimbursed and the Member may be billed if he or she has been informed that routine laboratory services provided in a hospital are not Covered Services and if he or she agrees, in writing, to be financially responsible for those services.
- **Home phlebotomy.** Home phlebotomy is available when Members are homebound. Services may be arranged by contacting one of the contracted home phlebotomy Providers in the following table. These Providers perform home phlebotomy services for all Members. Some capitated laboratories also offer home phlebotomy for patients who reside in assisted living or nonskilled nursing homes. This service is covered only as defined by Medicare guidelines. These Providers will perform the

home draw only and deliver the sample to a participating capitated laboratory (HMO) or participating laboratory/hospital (PPO).

Laboratory name	Phone number
Brookside Clinical Laboratories	610-872-6466
Professional Technicians	215-364-4911

Drawing stations

- To locate drawing stations for capitated laboratories, go to *www.amerihealth.com/find_a_provider*, select *Find Participating Doctors, Hospitals, and Ancillary Providers* on the left navigation bar, and choose *Laboratories* from the drop-down menu.
- To refer a Member to a drawing station, use the appropriate laboratory requisition form (not an HMO Referral). For supplies, contact the laboratory at the number provided in the chart earlier in this section.
- Complete the information on the form, including the Member's insurance information, the tests you are ordering, the Member's diagnosis, and the location where the reports are to be sent.
- Send the Member to the nearest drawing station with a completed form. If he or she does not present the form when his or her blood is drawn, the Member will be billed by the drawing station.

Specialists and OB/GYNs

- For laboratory services, specialists (including OB/GYNs) *must* send HMO Member specimens to the laboratory capitated by that Member's PCP. If directing the Member to a drawing station, a requisition form must accompany the Member. Complete the information on the form, including the Member's insurance information, the tests you are ordering, the Member's diagnosis, and the location where the reports are to be sent. Specialists may also refer to the Eligibility and Benefits Inquiry transaction on NaviNet to view the PCP's capitated laboratory site. As noted above, specimens obtained from a Member in the office must be sent to the laboratory capitated by that Member's PCP. Members must be directed to a draw site operated by the laboratory capitated by the Member's PCP.
- Members may elect to go to any participating laboratory site; however, if the laboratory site is not the PCP's capitated site, you will need to issue an electronic Referral. Be sure to note the Preapproval number on the Referral. Note that the Referral is in addition to the laboratory requisition form.
- Laboratory indicators are listed on Member ID cards, as detailed in the chart earlier in this section.

Specialty medical drugs

Specialty medical drugs are injectable and infusion therapy drugs that must be given by a health care Provider, usually in a Physician's office, outpatient facility, infusion suite, or in the Member's home through a home infusion Provider. These drugs are typically eligible for coverage under the Member's medical benefit.

Specialty medical drugs meet certain criteria including, but not limited to, the following:

- the drug is used in the treatment of a rare, complex, or chronic disease;
- a high level of involvement is required by a health care Provider to administer the drug;
- complex storage and/or shipping requirements are necessary to maintain the drug's stability;
- the drug requires comprehensive patient monitoring and education by a health care Provider regarding safety, side effects, and compliance;

- access to the drug may be limited.

For Preapproval request forms and direct ship ordering information for specialty medical drugs, go to *www.amerihealth.com/directship*.

Routine eye care/vision screening

HMO and POS Members: Routine eye exams are covered through HMO and POS medical plans administered by Davis Vision®.

- Members may contact Customer Service to verify eligibility and to locate a Participating Provider for routine services.
- Member Copayments for routine eye care differ depending on the Member's specific benefits. Specialist Copayments are indicated on the Member's ID card.
- For medical conditions, a Referral from the Member's PCP to a participating optometrist or ophthalmologist is required.

PPO Members: Routine eye care is not covered. Non-routine care related to the treatment of a medical condition related to the eye is covered, subject to applicable specialist Copayment.

EPO Members: Routine eye care coverage is available if the group purchases a vision rider.

Hearing aid coverage

Through Grace's Law, the State of New Jersey requires health care insurers to provide coverage of $1,000 per hearing aid for each hearing-impaired ear every 24 months for a covered person ages 15 and younger. The law also allows a Beneficiary to choose a more expensive hearing aid and pay the difference without financial or contractual penalty to the hearing aid Provider. In addition, separate from the $1,000 per hearing aid, insurers must also cover Medically Necessary expenses incurred in the purchase of a hearing aid, including fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds, and headbands for bone-anchored hearing implants. All hearing aids must be prescribed or recommended by a licensed Physician or audiologist.

Note: This mandate does not apply to Medicare Advantage Members, and it excludes certain AmeriHealth New Jersey products.