PROVIDER MANUAL

for Participating Professional Providers

AmeriHealth NEW JERSEY

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Provider Manual

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The *Provider Manual for Participating Professional Providers (Provider Manual)* is part of your Professional Provider Agreement, as applicable, with AmeriHealth (referred to as "AmeriHealth" or "Plan" throughout this manual). This manual supplements the terms of your contract and is updated regularly to provide you with pertinent policies, procedures, and administrative functions relevant to the daily administration of your practice.

The *Provider Manual* is one of several communication vehicles that enables us to offer timely, germane information to you, our Participating Physicians. We also publish updates through our monthly *Partners in Health Update*℠ newsletter, the NaviNet® web portal, and our website, *www.amerihealth.com/providers*. These communications are designed to provide you with the information you need, when you need it.

This *Provider Manual* has been organized and designed to be an easy-to-use reference tool for daily use in your practice. Our color-coded and indexed system helps you to easily locate the information you need.

Who is the "Plan"?

As used herein, the term "Plan" refers to the AmeriHealth affiliate companies, including but not limited to, AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey. Refer to the *Administrative Procedures* section of this Manual for a complete list of products.

Navigating through the *Provider Manual*

This *Provider Manual* has been published in the Adobe® Acrobat Portable Document Format (PDF). The PDF offers time-saving, Web-like functionality that makes locating information quick and easy. For optimal performance, we suggest that you visit the Adobe® website at *www.adobe.com/downloads* and download the latest edition of Adobe® Reader at no cost.

A brief overview of some of the time-saving enhancements is listed below.

Keyword search function

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

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

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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 information.

Reference links

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

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

Note: Each section of the online edition of the *Provider Manual* has been split into separate PDF files in order to reduce download times. When you click a green reference link, a separate PDF will open.

Hyperlinked websites

All websites mentioned in the *Provider Manual* are hyperlinked. If the *Provider Manual* refers to a website — either an AmeriHealth or third-party website — you can click the *italicized* web address, and the website will open in your 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.

Definitions

All capitalized terms in this manual shall have the meaning set forth in either your Provider Agreement or the Member's benefits plan, as applicable.

A Payor is an entity that, pursuant to a Benefit Program Agreement with AmeriHealth, funds, administers, offers, or arranges to provide Covered Services and which has agreed to act as Payor in accordance with the AmeriHealth Agreement with its Participating Providers AmeriHealth itself is a Payor in certain circumstances. With respect to a self-insured plan covering the employees of one or more employers, the Payor is the employer.

AmeriHealth is not a guarantor of payment for other Payors. In the event a Benefit Program Agreement with a self-insured plan Payor is terminated, for any reason, including, but not limited to, the failure of such Payor to fund its self-insured plan in accordance with the terms of the Benefit Program Agreement, AmeriHealth shall update its electronic Member eligibility database as soon as reasonably possible, to reflect the non-Member status of such self-insured plan's employees. In accordance with your agreement with AmeriHealth, Hospital may directly bill individuals who are not or were not Members on the date of service. Notwithstanding anything to the contrary in your agreement with AmeriHealth, Hospital may also directly bill Members of such self-insured plans for services, which are denied by AmeriHealth, or for any amounts owed, when a self-insured Payor fails to fund its self funded plan in accordance with the terms of the Benefit Agreement.

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Contact information

Important telephone numbers

AIM Specialty Health® (AIM) Call for CT/CTA, MRI/MRA, PET scans, Nuclear Cardiology, and 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	1-800-313-8628, prompt 3
Care Management and Coordination HMO/PPO (Medicare Advantage and Commercial) Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-313-8628
Connections℠ Health Management Program Disease Management and Decision Support Hours: 24 hours a day, 7 days a week	1-888-YOUR-AH1
Credentialing Credentialing violation hotline Credentialing and re-credentialing inquiries	215-988-1413 *www.amerihealth.com/credentials* 1-866-227-2186
Customer Service **AmeriHealth HMO** Hours: Mon. – Fri., 8 a.m. – 6 p.m. **AmeriHealth PPO** Hours: Mon. – Fri., 8 a.m. – 6 p.m. **AmeriHealth New Jersey EPO** Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-888-968-7241
AmeriHealth 65® NJ HMO Hours: 8 a.m. – 8 p.m., 7 days a week (on weekends and holidays from February 15 through September 30, your call may be sent to voicemail)	1-800-645-3965
AmeriHealth Value Network	1-888-YOUR-AH1
TTY/TDD Language assistance services are offered through the AT&T Language Line for Members who have difficulty communicating because of an inability to speak or understand English.	215-241-2944 or 1-888-857-4816
FutureScripts® (Pharmacy Benefits) Hours: Mon. – Fri., 8 a.m. – 6 p.m. **FutureScripts® Secure (Medicare Part D)** Hours: Mon. – Fri., 8 a.m. – 6 p.m. **Blood Glucose Meter Hotline**	1-888-678-7012 Toll-free fax: 1-888-671-5285 1-888-678-7015 1-888-678-7012

Highmark EDI Operations Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-992-0246
Mental Health/Substance Abuse Magellan Behavioral Health, Inc. Customer Service and Precertification Hours: 24 hours a day, 7 days a week	1-800-809-9954
NaviNet® NaviNet customer care (technical issues) eBusiness Hotline (portal registration and questions)	1-888-482-8057 609-662-2565
Preapproval/Precertification Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-888-YOUR-AH1
Provider Automated System Authorization services are available Monday through Saturday, 5 a.m. to 11 p.m., and Sunday, 9 a.m. to 11 p.m.	1-888-YOUR-AH1 *www.amerihealth.com/providerautomatedsystem*
Provider Supply Line	1-800-858-4728 *www.amerihealth.com/providersupplyline*

Claims mailing addresses

For a complete list of claims submission addresses, refer to the professional payer ID grid at *www.amerihealth.com/edi*. There, claims submission information is broken out by alpha prefix/product name. The following are other claims-related addresses:

AmeriHealth New Jersey Value Network P.O. Box 41574 Philadelphia, PA 19101-1574	**AmeriHealth Service Center (Professional Claim Inquiry)** P.O. Box 7930 Philadelphia, PA 19101-7930

Appeals mailing addresses

Inpatient Appeals – NJ Member Appeals Department 259 Prospect Plains Rd. – Building M Cranbury, NJ 08512	**Claims Medical Review /Emergency Room Review** AmeriHealth New Jersey Appeals 259 Prospect Plains Rd. – Building M Cranbury, NJ 08512
Medicare Advantage HMO Member Appeals Medicare Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1820	**Provider Claims Appeals – NJ HMO/PPO** Claims Payment Appeals Unit P.O. Box 7218 Philadelphia, PA 19101
Member Medical Necessity Appeals – NJ AmeriHealth New Jersey Appeals 259 Prospect Plains Rd. – Building M Cranbury, NJ 08512	**Member Administrative Appeals – NJ HMO/PPO** Member Appeals Department 259 Prospect Plains Rd. – Building M Cranbury, NJ 08512

General mailing addresses

Magellan Behavioral Health, Inc. P.O. Box 1958 Maryland Heights, MO 63043	**Provider Data Administration (PDA)** P.O. Box 41431 Philadelphia, PA 19101-1431

Network Coordinators

Network Coordinators play a critical role in educating our network Providers and their office staff on policies, procedures, and specific billing processes. Network Coordinators also serve as a liaison for the Provider's office and may promote or suggest workflow solutions.

In an effort to build and sustain a strong working relationship with Participating Providers, Network Coordinators:

- contact Primary Care Physician (PCP) offices and select specialists on a regular basis to help resolve issues, review medical and claims payment policies, discuss new policy implementation, review utilization reports, recommend sources for more efficient utilization, and explain new products and programs;
- investigate and assist in providing resolution to Provider inquiries;
- identify policy and procedural issues that your office experiences and recommend potential resolutions;
- conduct initial orientation with your staff about our managed care network;
- explain procedures for requesting claims adjustments or initiating appeals.

Note: Network Coordinators cannot revise claims submissions.

We encourage you to contact your Network Coordinator for help in making day-to-day office operations run as smoothly as possible and to help you work efficiently and effectively with us.

Network Coordinators serve multiple Provider offices in the network. All calls and issues regarding your office are important to us. Your Network Coordinator will address your call in as timely a manner as possible.

Please note that some practices are part of health systems that have designated specific AmeriHealth personnel as their contact.

Network Coordinator Locator Tool

The Network Coordinator Locator Tool identifies your Network Coordinator, his or her direct telephone number, fax number, manager, and the Medical Director who supports your practice or facility. Inquiries can also be submitted directly to your Network Coordinator through this tool.

To use the Network Coordinator Locator Tool, go to *www.amerihealth.com/providers* and select *Contact Information* from the left navigation menu. When you open the tool, you will be prompted to enter either your AmeriHealth corporate ID number or your tax ID number. Your Network Coordinator's contact information will be displayed. If you receive an error message, or if your Network Coordinator's information is unavailable, contact Customer Service for assistance.

Provider Services

Provider Services also serves as a valuable resource to you, in addition to your Network Coordinator. The role of Provider Services is to:

- service Provider telephone inquiries in an accurate and timely manner;
- educate Providers and facilitate effective communications between Providers and AmeriHealth by providing timely, accurate responses to telephone inquiries;
- educate Providers with self-service utilization;
- assist Providers in the identification and resolution of claim inquiries.

To reach Provider Services, call Customer Service at 1-888-YOUR-AH1 and follow the voice prompts.

Provider Communications

To access the most current and updated information regarding AmeriHealth and our policies, procedures, and processes, refer to our monthly newsletter, *Partners in Health Update*[SM], our website at *www.amerihealth.com/providers*, the Provider News Center, NaviNet Plan Central, and this *Provider Manual*. These resources are designed to work in unison to provide your office with timely informational updates.

To receive email updates that provide you with the latest information, including *Partners in Health Update* and news alerts, simply complete our email address submission form at *www.amerihealth.com/providers/email*. Allow up to two weeks for us to process your request, and remember to add AmeriHealth (*providercommunications@amerihealth.com*) to your email address book. We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to *www.amerihealth.com/privacy*.

amerihealth.com/providers

Find important information and resources, such as forms, bulletins, and billing guidelines, specific to our Provider network. Simply choose from the menu that appears on the left. Information in this menu is broken out as follows:

- Communications
- Policies and Guidelines
- Claims and Billing
- Interactive Tools and Resources
- Pharmacy Information
- Resources for Patient Management
- Contact Information

Provider News Center

The Provider News Center is our Provider-dedicated website, located at *www.amerihealth.com/pnc*, which features up-to-date news and information of interest to Providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office:

- **Latest News.** All Provider news published within the previous month is listed on the home page.
- **Spotlight.** Promotional banners located along the top of the website highlight important news.

- **Dedicated News.** The home page features dedicated sections for important topics (e.g., ICD-10) with significant impact to our Participating Providers.
- **Sortability & Searchability.** All news is grouped into convenient categories (such as Billing & Reimbursement, NaviNet®, and Products) and broken out by Provider type (Professional, Facility, or Ancillary) so you can quickly find news that's relevant to you and your office staff. You can also conduct keyword searches to pinpoint specific content.

Additionally, the Provider News Center includes a Quick Links section that gives easy access to our traditional AmeriHealth resources, such as AmeriHealth forms, the AmeriHealth Medical Policy portal, NaviNet, and our annually published Provider publication indices.

NaviNet Plan Central

In addition to fast, secure, and HIPAA-compliant access to Provider and Member information and real-time transactions, NaviNet-enabled Providers have access to a valuable source of information on our NaviNet Plan Central page. This page contains important tools and resources, including:

- the latest Provider news and announcements;
- the most current version of our publications and Provider manuals;
- information about upcoming ICD-10 changes;
- helpful documents, including user guides, frequently asked questions, enrollment forms for our Medicare Advantage plans, and health and wellness tools;
- contact information.

The Provider Supply Line

To replenish office supplies such as Provider Manuals, allergy stickers, and directories, call the toll-free Provider Supply Line at 1-800-858-4728 or use the online request form available at *www.amerihealth.com/providersupplyline*. Have the following information ready so your order can be processed in an error-free, timely manner:

- NPI
- office name
- office address
- office telephone number

Orders are normally shipped within 24 hours and should arrive at your office within 3 – 5 business days.

Note: Calls to the Provider Supply Line should be for supply requests only. All other Provider inquiries should be directed to Customer Service or your Network Coordinator. Supply orders will not be accepted through Customer Service.

Privacy and confidentiality

Provider obligations

Contracted Providers are required to maintain confidentiality of Member protected health information (PHI) and records, in accordance with applicable laws.

Access to PHI

The Health Insurance Portability and Accountability Act (HIPAA) and its implemented privacy regulations permit a HIPAA-Covered Entity, such as AmeriHealth, to request and obtain our Members'

individually identifiable health information from third parties. An example of "third party" would be a HIPAA-Covered Entity such as a health care Provider. When such PHI is requested for purposes of treatment, payment, and/or health care operations, the Member's authorization is not required. HIPAA specifically permits health care Providers to disclose PHI to health plans for treatment, payment, or health care operations and includes disclosure of Members' medical records. AmeriHealth uses this information to promote Members' ready access to treatment and the efficient payment of Members' claims for health care services.

Other AmeriHealth activities that can be categorized as "treatment, payment, or health care operations" under HIPAA include, but are not limited to, the following:

- Treatment includes the provision, coordination, and management of the treatment. It also includes consultation and the Referral of a Member between and among health care Providers.
- Payment includes review of various activities of health care Providers for payment or reimbursement; to fulfill the health benefit plans' coverage responsibilities and provide appropriate benefits; and to obtain or provide reimbursement for health care services delivered to its Members. Activities that fall into this category include, but are not limited to, determination of Member eligibility, reviewing health care services for Medical Necessity, and utilization review.
- Health care operations includes certain quality improvement activities, such as case management and care coordination, quality of care reviews in response to Member or State/federal queries, and prompt response to Member complaints/grievances; site visits as part of Provider credentialing and recredentialing; medical record reviews to conduct clinical and service studies to measure compliance; administrative and financial operations, such as conducting Healthcare Effectiveness Data and Information Set (HEDIS®) reviews and Customer Service activities; and legal activities, such as audit programs, including fraud and abuse detection, and to assess Providers' conformance with compliance programs.

Privacy policies

Protecting the privacy of our Members' information is very important to us. That is why we have taken numerous steps to see that our Members' PHI, whether in oral, written, or electronic form, is kept confidential.

We have implemented policies and procedures regarding the collection, use, and disclosure of PHI by and within our organization and with our business associates. We continually review our policies and monitor our business processes to ensure that Member information is protected, while continuing to make the information available as needed for the provision of health care services. For example, our procedures include processes designed to verify the identity of someone calling to request PHI, procedures to limit who on our staff has access to PHI, and policies that require us to share only the minimum necessary amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks, or by using encryption technology when the information is sent by email.

We do not use or disclose PHI without the Member's written authorization unless we are required or permitted to do so by law. If use or disclosure of a Member's PHI is sought for purposes that are not specifically required or permitted by law, the Member's written authorization is required. To be deemed valid, Member authorizations must include certain elements required by State and/or federal law. Members may print a copy of our *Authorization to Release Information* form from *www.amerihealth.com/privacy* or request a copy by calling Customer Service.

For more detailed information about our Members' privacy rights and how we may use and disclose PHI, review our *Notice of Privacy Practices* on our website at *www.amerihealth.com/privacy*.

Email

New software that secures outbound email containing PHI encrypts the email so that it is unintelligible to unauthorized parties. Instead of receiving an email with Member PHI directly to your inbox, you will receive an email stating that there is a secure message waiting for you on a secure server. A link will take you, via a secured browser, to that server, where you will receive instructions for opening the email.

We have implemented this secured email system to meet the requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). While this process requires some extra steps, we are making every effort to ensure that there is no significant disruption to your communications with us.

AHNJ On the Go mobile app

We encourage both Members and Providers to download our free smartphone app, AHNJ On the Go. Offered on both iPhone and Android mobile platforms, AHNJ On the Go is a convenient, fast, and secure way to access plan information and manage health information wherever you go.

Some of AHNJ On the Go features include:

- **Plan Information:** Subscribers and dependents can quickly access basic benefits information, such as Copayment amounts, and contact information for their PCP and ancillary medical providers.
- **Finders:** Robust search engines help users locate in-network hospitals, Physicians, Patient-Centered Medical Homes, urgent care centers, and pharmacies.
- **Doctor's Visit Assistant:** Members can view their open Referrals; display, email, or fax an ID card to their Provider; and record notes from conversations with their Physician.
- **My Health Assistant:** Users can set health goals and build an activity plan to get and stay healthy. Trackers help users monitor their progress and manage their activity plan on the go.
- **Medicine Cabinet:** Members can view and keep track of all their medications and identify them with pictures.
- **Medication Reminders:** Users are able to set daily or weekly reminders to take their medications.
- **Food and Drug Interactions:** Members can check their current medications for potentially dangerous combinations with foods or other medications to avoid complications.
- **Shop for Insurance:** Consumers can learn about various AmeriHealth New Jersey benefit plans.

The AHNJ On the Go mobile app is available as a free download for iPhones and all Android devices at Apple's App Store and the Google Play Store.

Providing PHI for Member appeals of enrollees in self-insured group health plans

Employers and health and welfare funds are called "Plan Sponsors" when they sponsor self-insured group health plans that have a large number of enrollees. When they make elections about claim fiduciary status, they also determine the entity ultimately responsible for final decisions on benefits and other issues in Member appeals for these plans. Sometimes their elections require special arrangements for processing Member appeals for their self-insured group health plans. Because self-insured group health plans are HIPAA-covered entities, we have summarized the following points that network Providers need to know about requests for PHI for Member appeals of enrollees in self-insured group health plans.

- Network Providers may receive requests for PHI for the Member appeals of enrollees in self-insured group health plans offered through AmeriHealth from (1) AmeriHealth, (2) employers or health and welfare funds that sponsor the self-insured group health plan, and/or (3) other entities.

- A response to these PHI requests satisfies HIPAA privacy requirements when the PHI is released to an authorized entity as part of the self-insured group plan's treatment, payment, and/or health care operations (TPO).
- Requests by AmeriHealth for PHI of enrollees involved in these Member appeals will always qualify for release as TPO because AmeriHealth is a HIPAA-authorized entity for these self-insured group health plans. Plan Sponsors authorize the initial filing of all Member appeals for self-insured group plans that they offer through AmeriHealth to be submitted to AmeriHealth. Beyond that, the Plan Sponsor's claims fiduciary election determines whether AmeriHealth acts in these Member appeals in (a) its full, standard role as processor and decision-maker for all internal levels of review or (b) a more limited role that facilitates review by other designated entities.
- Employers, health and welfare funds, and other designated entities may only obtain PHI for enrollees involved in Member appeals of self-insured group health plans if they have proper authorization. The Plan Sponsor may authorize them to obtain PHI for these Member appeals by designating them to handle processing and/or decision-making at certain levels of the self-insured group plan's Member appeals process. When this occurs, PHI may be released to them as TPO consistent with the Plan Sponsor's authorization.

Network Providers should rely on their own internal resources and established protocols for handling PHI requests. Provider Services and other AmeriHealth departments will only be able to give you limited information about the role of AmeriHealth in processing Member appeals for self-insured group health plans that are offered through AmeriHealth.

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Rendering services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., Copayments, Coinsurance, and Deductibles) each time a Member is seen.

Member eligibility

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

How to check eligibility

- Always check the Member's ID card before providing service. If a Member is unable to produce his or her ID card and/or is not listed on the Primary Care Physician's (PCP) capitation/eligibility roster, ask the Member for a copy of his or her Enrollment/Change Form or temporary insurance information printed from *www.amerihealthexpress.com*, our secure Member website. This form is issued to Members as temporary identification until the actual ID card is received and may be accepted as proof of coverage. The temporary ID card is valid for a maximum of ten calendar days from the print date.
- Participating Providers are required to use either the NaviNet® web portal or the Provider Automated System for all Member eligibility inquiries.
- A guide and webinar are available for guidance on where to obtain Member eligibility through NaviNet. You can find these materials at *www.amerihealth.com/pnc/changes* in the NaviNet Transaction Changes section.

Note: For HMO and POS Members, PCPs should refer to their monthly capitation/eligibility roster. Members are listed in alphabetical order, with family Members listed together. In the event that there is a question about the Member's eligibility or panel assignment, check NaviNet. If we are unable to verify eligibility, we will not be responsible for payment of any Emergency or nonemergency services.

Treating Members of Affiliates

You may find that some of your patients are covered by one of our Affiliates. If you or one of your affiliated practices is located in one of the counties listed below, you should treat the patient and use the information in this manual as if the patient were covered by the same plan in your own State. Although you will see the logo of an Affiliate on the Member ID card, you should recognize the name of the product under which the Member receives coverage.

New Jersey: Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem, and Warren counties

Copayments

Members are responsible for making all applicable Copayments. The Copayment amounts vary according to the Member's type of coverage and benefits plan. In addition, please note the following:

- Copayments may not be waived and should be collected at the time services are rendered. If a Member is unable to pay the Copayment at the time services are rendered and has been provided with prior notice of this requirement, Providers may bill the Member for the Copayment.
- A Provider must notify a Member if the office provides services where the Member may be billed by more than one Provider. For example, the office must inform the Member when he or she will be

charged a Copayment for a Physician service and a Copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two Copayments may be required.

- PCPs may not charge a Member for a Copayment unless the Member is seen by a Provider. No Copayment is to be charged or collected by the PCP if a Member is only picking up a copy of a Referral or prescription from the office.
- If the Member's specified Copayment is greater than the allowable amount for the service, only the allowable amount should be collected from the Member. However, if the allowable amount for the service is greater than the Copayment, the specified Copayment should be collected in full from the Member. In the event that a Copayment is collected and the practice subsequently determines that the allowable amount is less than the Copayment, the difference between the Copayment and the allowable amount must be refunded to the Member within a reasonable period of time (i.e., 45 days) at no charge/cost to the Member.
- For HMO and POS Members, the PCP Copayment is noted on the monthly capitation roster.
- On NaviNet, Copayments are listed on the Eligibility Details screen when using the Eligibility and Benefits Inquiry transaction.
- Radiology, physical therapy, and occupational therapy services may also be subject to Copayment amounts that may differ from the specialist Copayment amount identified on the Member's ID card.
- **Preventive care services.** As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), there is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Claim Payment Policy #00.06.02: Preventive Care Services, which includes the list of applicable preventive codes, is available on NaviNet or at *www.amerihealth.com/medpolicy*.

  Note: The $0 Copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a Copayment. However, if the Member is experiencing a significant problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for cost-sharing.
- **Out-of-pocket maximums.** As required by Health Care Reform, Members should not be charged any cost-sharing (i.e., Copayments, Coinsurance, and Deductibles) once their annual limit for essential health benefits has been met. These limits are based on the Member's benefit plan but may not exceed $6,350.00 for an individual, and $12,700.00 for a family. To verify if Members have reached their out-of-pocket maximum for essential health benefits, Providers should use the Eligibility and Benefits Inquiry transaction on NaviNet.
- **Medicare-eligible Members.** AmeriHealth coordinates benefits for commercial Pennsylvania Members who are Medicare eligible, have not enrolled in Medicare Parts A or B, and for whom Medicare would be the primary payer. If a Member is eligible to enroll in Medicare Parts A or B but has not done so, AmeriHealth will pay as the secondary payer for services covered under an AmeriHealth HMO/PPO commercial group Benefits Program, even if the Member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Parts A or B benefits. This affects any Pennsylvania Member who is Medicare-eligible and for whom Medicare would be the primary payer.

  It is important that you routinely ask your Medicare-eligible Members to show their Medicare ID cards. If you have identified a Pennsylvania Member who is eligible to enroll in Medicare Parts A or

B, but has not done so, you may collect the amount under "Member Responsibility" on the SOR, which includes any cost-sharing plus the amount Medicare would have paid as the primary payer.

- **Members of non-profit religious organizations**. Under Health Care Reform, AmeriHealth is required to pay the cost of certain contraceptive services for eligible Members within these organizations. These Members will receive a separate ID card that indicates "Contraceptive Coverage." Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic equivalent under the pharmacy benefit at retail and mail order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an AmeriHealth prescription drug plan.

AmeriHealth routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the Member's benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

Referrals

One of the most important functions a PCP performs is coordinating the care a Member receives from a specialist. By coordinating Referrals, PCPs help to make the process of patient care appropriate and continuous.

Participating specialists and facilities must receive PCP Referrals through NaviNet. Referrals can be accessed from 5 a.m. until 10 p.m., Monday through Saturday. Referrals can be accessed from 9 a.m. until 9 p.m. on Sunday. Submitting Referrals in a timely manner helps to prevent claim denials for "no Referral."

Because Referrals submitted through NaviNet are electronic, you are not required to mail hard copies of these Referrals to AmeriHealth.

Issuing encounters/Referrals

If you are not certain whether a specialist is a participant in our network, use the Find a Doctor tool that is available at *www.amerihealth.com*. A link to the Provider Directory can also be found on NaviNet by selecting *Reference Tools* from the Plan Transactions menu.

HMO and POS plans

Physicians must issue a Referral for managed care patients covered under our HMO or POS plans when referring them for specialty care, including nonemergency specialty and hospital care. HMO Members are required to have a Referral from their PCP to access specialty care. Referrals are valid for 90 days and do not guarantee active eligibility on the date of service.

Referrals are valid for active HMO and POS Members. Members who are not eligible on the date of service are responsible for payment. The PCP must submit an encounter/Referral for all nonemergency, specialty, and hospital services. Nonemergency Services (other than Direct Access services) that have not been referred by the PCP are not covered.

Note the following:

- It is important to be as specific as possible when issuing a Referral. All visits must occur within the 90-day period following the date the Referral is issued.
- For AmeriHealth HMO and POS Members, all short-term rehabilitation and outpatient laboratory Referrals must be referred to the PCP's capitated site. Refer to the *Specialty Programs* section of this manual for additional information.

- For AmeriHealth New Jersey Members in southern New Jersey*, all radiology Referrals should be made to the PCP's capitated site.
- AmeriHealth New Jersey Members may choose to select a site other than the PCP's capitated site for these specialty services. Should the Member choose to receive services you have authorized from a Participating Provider or facility other than the PCP's capitated site, you will need to issue a Referral and may refer to any Participating Provider; Preapproval is not required.
- AmeriHealth New Jersey Members do not need a Referral for behavioral health services.
- AmeriHealth HMO and AmeriHealth 65® NJ HMO Members must be referred only to Participating Providers. If a Participating Provider cannot provide care, and a Referral to a nonparticipating Provider is contemplated, such a Referral will require Preapproval.
- Members enrolled in "Plus" and EPO products are exempt from all Referral requirements.
- PCPs in the AmeriHealth New Jersey Value Network should only issue referrals to specialists who are participating in the AmeriHealth New Jersey Value Network. A list of participating providers can be found online by using the Provider Finder tool at *www.amerihealthnj.com*.

**Counties that represent southern New Jersey are: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.*

Referrals are *not* required for the following services:

- vision screenings
- routine, preventive, or symptomatic OB/GYN care
- screening or diagnostic mammography
- behavioral health
- out-of-network care (for POS Members only)
- radiology services preapproved by AIM Specialty Health® (AIM)
- dialysis

POS Members may need Preapproval for some specialty services. When requesting Preapproval through NaviNet for these Members, you will be asked, "Has the Member been referred by the PCP for treatment?" It is very important to answer "Yes" if your office has a Referral on file for the Member to ensure that the highest level of benefits is covered for the Member. Be sure to check the Member's chart for a Referral, or verify that an electronic Referral is "on file" through NaviNet by selecting *Encounters and Referrals* from the Plan Transactions menu, and then *Referrals*.

If you incorrectly answer "No" and the Member has a Referral on file, the system will automatically default to the self-referred benefits level, and the Member will be subject to higher out-of-pocket expenses. In addition, if the system defaults to the self-referred benefits level, you may receive the following message due to the differences in Preapproval requirements: "This Member's benefits program does not require preauthorization for the procedure(s) requested based upon the information provided." Claims will be denied for lack of Preapproval.

Note: For services requiring precertification through AIM (CT/CT scans, MRI/MRA, sleep study services, echocardiography services, nuclear cardiology services, and PET scans), a separate Referral is not required. Additionally, Referrals are never required for mammography.

AmeriHealth 51+ HMO Plus Coinsurance

AmeriHealth New Jersey launched AmeriHealth HMO Plus Coinsurance for 51+ groups – a no-Referral product that uses Deductibles and Coinsurance. Under this plan, Members must select a PCP but can

access care within the AmeriHealth New Jersey network without a Referral. There are three plan options offering a variety of Deductible, Copayment, and Coinsurance options and out-of-pocket maximums.

AmeriHealth HMO Plus and POS Plus

- AmeriHealth HMO Plus and POS Plus require Members to select a PCP for their primary and Preventive Care. However, AmeriHealth HMO and POS Plus Members may use any Participating PCP, regardless if they are included on a PCP's roster. AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements. Members may access care from any Participating Provider without a Referral from their PCP and receive the highest level of coverage.
- AmeriHealth POS Plus Members may seek care from a nonparticipating Provider but will be responsible for higher out-of-pocket costs and penalties.

PPO plans

PPO Members may use a nonparticipating Provider, but may be responsible for a higher cost-sharing. If you are not certain whether a specialist is a participant in our network, use the Find a Doctor tool, which is available on our website at *www.amerihealth.com*. A link to this tool can also be found on NaviNet by selecting *Reference Tools* and then *Provider Directory* from the Plan Transactions menu. If you do not have access to the Internet, please call Customer Service.

OB/GYN Referrals

Under our Direct Access OB/GYN℠ Program, HMO and POS Members may see any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife

Services not requiring Referrals from PCPs or OB/GYN Providers include, but are not limited to, the following:

- all antenatal screening and testing
- fetal or maternal imaging
- hysterosalpingogram/sonohysterogram

You must continue to use the *OB/GYN Referral Request Form* for the following services:

- pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans (these tests must be performed at the Member's capitated radiology site);
- initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).

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

Mammography Referrals

All commercial HMO and POS Members may obtain screening and diagnostic mammography, provided by an accredited in-network radiology Provider, without obtaining a Referral or prescription.

Medicare Advantage HMO Members have access to screening and diagnostic mammography without the need for a Referral or written prescription.

Note the following:

- Certain radiology facilities may still require a Physician's written prescription. This may need to be communicated to your HMO and POS Members asking about mammography. Please continue to provide a prescription for the mammography study if required by the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to provide mammography services to our Members.

Hospital Referrals

When referring a Member for a surgical procedure or hospital admission, the PCP needs to issue only one Referral to the specialist or attending/admitting Physician. This Referral will cover all facility-based (i.e., hospital, ASC) services provided by the specialist or attending/admitting Physician for the treatment of the Member's condition. The Referral is valid for 90 days from the date it was issued. The admitting Physician should obtain the required Preapproval. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval.

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

Referrals for Members in long term/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 is not required. We have established LTC panels for our PCPs who provide care in LTC-participating facilities. The LTC panels do not have capitated sites for ancillary services (i.e., laboratory, physical therapy, or radiology). 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.

Note the following:

- 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 a Referral include specialist, podiatry, physical therapy, and radiology.
- All Referrals should be made to AmeriHealth HMO Participating Providers. Referrals should be submitted in advance of the service being provided using NaviNet or the Provider Automated System.
- PCPs should submit Referrals to AmeriHealth in a timely manner to allow for appropriate claims processing. No claim will be authorized for payment without a Referral on file.
- Consultants and ancillary Providers are encouraged to provide Referral information with the claim to assist in processing. Preapproval review is required only for inpatient admission for hospital care, skilled nursing facilities (SNF), short procedure unit cases, or ASC 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 requirements and/or benefits exemptions.

Member consent for financial responsibility

The *Member Consent for Financial Responsibility* form, which is available on our website, is used when a Member does not have a required Referral for nonemergency services or elects to have services performed that are not covered under his or her benefits plan. By signing this form, the Member agrees to pay for noncovered services specified on the form. The form must be completed and signed before services are provided.

The form is available on our website at *www.amerihealth.com/providerforms*, or Providers may use their own. This form does not supersede the terms of your Professional Provider Agreement, and you may not bill Members for services for which you are contractually prohibited.

Medicare Advantage HMO Members

Providers must furnish AmeriHealth 65 NJ HMO Members with written notice that noncovered/excluded services are not covered and that the Member will be responsible for payment before services are provided. If the Provider does not give written notice of noncovered/excluded services to the Member, then he or she is required to hold the Member harmless.

Product offerings

Providers are required to use NaviNet or the Provider Automated System to obtain Member eligibility information. Providers may call Customer Service for specific product information.

The following grid outlines the products offered through AmeriHealth New Jersey to assist you in quickly identifying our Members. For a complete list of alpha prefixes that correspond to these products, refer to our payer ID grids at *www.amerihealth.com/edi*.

Health Maintenance Organization HMO and Small Employer Health (SEH) HMO
51+ HMO Plus Coinsurance
Point-of-Service (POS), SEH POS, and POS Plus
Preferred Provider Organization (PPO)
SEH PPO
SEH Comprehensive Major Medical (CMM) Plans
Medicare Advantage HMO: AmeriHealth 65® NJ HMO and AmeriHealth 65® Preferred HMO
Medicare Advantage POS
CMM
Value Network
Exclusive Provider Organization (EPO)
Cooper Advantage and Tier 1 Advantage (EPO tiered products)

Preapproval guidelines

Preapproval is required to evaluate the Medical Necessity of proposed services for coverage under applicable Benefits Programs. When referring Members to a hospital, the PCP only needs to refer to the admitting/performing Physician, who is then responsible for obtaining Preapproval.

Responsibilities

Responsibilities of the admitting/performing Physician for hospital admissions

- Make hospital admission arrangements.
- Acquire the following required information:
  - Member name and date of birth
  - Member ID number
  - admission date
  - place of admission
  - diagnosis
  - planned procedure
  - medical information to support the Preapproval request
- For HMO and POS Members, notify the Member's PCP of the diagnosis, planned procedure, and hospital arrangements and request one Referral.
- Contact the hospital with the Preapproval code.

Responsibility of the PCP

Submit one Referral for the admitting/performing Physician through NaviNet.

Responsibility of the HMO and POS Member

- Request a Referral from the PCP.
- POS Members are responsible for obtaining Preapproval, when required, when seeking services without a Referral.

Responsibility of the PPO Member for out-of-network care

Obtain Preapproval for all services requiring Preapproval.

Responsibility of the hospital, SNF, freestanding ASC, or rehabilitation facility

- To initiate Preapproval, Providers should use NaviNet or call the Provider Automated System. Providers can check the status of an authorization using NaviNet by selecting *Authorization Status Inquiry* from the Authorizations option in the Plan Transaction menu.
- NaviNet-enabled Providers may submit electronic Preapproval requests to AmeriHealth for services to be rendered at an acute care facility or ASC. Discharge planning questions are presented during the submission process and are optional.

Refer to the *Clinical Services* section of this manual for more information on Preapproval requirements. Preapproval requirements are also available on our website at *www.amerihealth.com/preapproval*.

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

The NaviNet® web portal

NaviNet, a HIPAA-compliant Web-based connectivity solution offered by NaviNet, Inc., is a fast and efficient way to interact with us to streamline various administrative tasks associated with your AmeriHealth patients' health care. By providing a gateway to back-end systems at AmeriHealth, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy. The portal also supports HIPAA-compliant transactions.

All Participating Providers, facilities, Magellan-contracted Providers, and billing agencies that support Provider organizations are required to have NaviNet access and must complete the tasks listed below using NaviNet. Detailed guides and webinars are available for many transactions in the NaviNet Transaction Changes section of our System and Process Changes site at *www.amerihealth.com/pnc/changes*.

- **Eligibility and claims status**. All participating Providers and facilities are required to use NaviNet (or call the Provider Automated System) to verify Member eligibility and check claims status information. The claim detail provided includes specific information, such as check date and number, service codes, paid amount, and Member responsibility.
- **Authorizations.*** All participating Providers and facilities must use NaviNet in order to initiate authorizations, including ones for medical/surgical procedures, chemotherapy/infusion therapy, durable medical equipment (DME), Emergency hospital admission notification, home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, and outpatient speech therapy.

  Requests for medical/surgical procedures can be made up to six months in advance on NaviNet, and in most cases, requests for Medically Necessary care are authorized immediately. NaviNet submissions that result in a pended status can take up to two business days to be completed. These may include requests for additional clinical information as well as requests that may result in a duplication of services. If the authorization remains pended beyond two business days, or if the authorization request is urgent, call 1-888-YOUR-AH1 for assistance.
- **Claim adjustment.** Providers who call Customer Service to question a claim payment or to request a claim adjustment will be directed to submit the request via NaviNet using the Claim Investigation transaction. Please refer to the *Billing* section for further instruction.

**This information does not apply to Providers contracted with Magellan Behavioral Health, Inc. (Magellan). Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 for authorizations.*

If you are a current NaviNet user and need technical assistance, contact NaviNet at 1-888-482-8057 or our eBusiness Provider Hotline at 609-662-2565. If you are not NaviNet-enabled, go to *www.navinet.net* and select *Sign Up* from the top right.

Interactive training demos are also available to all users on NaviNet. Simply select *Customer Support* from the top navigation menu, and then select *Customer Care*.

Capitation rosters

PCPs and specialty capitated Providers can view, print, and download electronic copies of their capitation rosters through NaviNet. For detailed instructions on how to do so, refer to the *PCP and Specialist CAP Rosters Guide*, which is available in the NaviNet Transaction Changes section of our System and Process Changes site at *www.amerihealth.com/pnc/changes*.

iEXCHANGE®

AmeriHealth Administrators, which offers third-party administration services to self-funded health plans throughout the United States, provides you with an additional online service called iEXCHANGE, a MEDecision product. iEXCHANGE supports the direct submission and processing of health care transactions, including inpatient and outpatient authorizations, treatment updates, concurrent reviews, and extensions. Certain services require precertification to ensure that your patients receive the benefits available to them through their health benefits plan. With just a click of the mouse, you can log into iEXCHANGE, complete the precertification process, and review treatment updates.

Available transactions:

- inpatient requests and extensions
- other requests and extensions (outpatient and ASC)
- treatment searches
- treatment updates
- Member searches

After registering, you can also access iEXCHANGE through NaviNet for AmeriHealth Administrators plan Members. For more information or to get iEXCHANGE for your office, visit *www.amerihealth-tpa.com/providers* or contact the iEXCHANGE help desk at AmeriHealth Administrators by calling 1-888-444-4617.

Provider Automated System

Providers can use the Provider Automated System, our speech-enabled, automated phone service, to retrieve Member eligibility information for HMO, POS, PPO, and EPO Members and receive authorization status updates. You can also cancel an existing authorization. The Provider Automated System is accessible 24/7 at 1-888-YOUR-AH1.

A guide that contains step-by-step instructions on how to use all of the menu prompts available through Customer Service, including transactions in the Provider Automated System, is available at *www.amerihealth.com/providerautomatedsystem*.

Note: For behavioral health services, Providers should still call the number on the Member's ID card under Mental Health/Substance Abuse.

Change of network status

Updating your Provider information*

When submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. You are contractually required to notify us in a timely manner when changing key practice information, such as:

- address
- phone number
- fax number
- partner status
- tax ID number
- name of practice

- change from board-eligible to board-certified
- hospital privileges

Please complete the *Provider Change Form* to notify us of such changes. Detailed instructions are included in the next section, *Completing the Provider Change Form*. You may also submit this information to us electronically through NaviNet or by calling your Network Coordinator or Customer Service.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 for updates to their practice information.*

Note the following:

- At least 30 days prior written notice is needed to process Provider information changes and/or Member changes.
- At least 60-days prior written notice is needed for closure of a PCP practice to additional patients.
- At least 90-days prior written notice is needed for resignation/termination from our network.
- If you have accepted any payments during the year, we must report that income on the annual 1099 Form. All Providers are reminded that practice demographics should be kept current to receive accurate 1099 Forms.
- Payments will be processed more efficiently if Provider information is current.
- The recredentialing process is another way we keep your Provider information current. Return your recredentialing application packet promptly or update your CAQH application at least quarterly.

Completing the Provider Change Form*

Professional Providers can quickly and easily submit changes to their basic practice information using the Provider Change Form transaction on NaviNet. Simply select *Provider Change Form* from the Plan Transactions menu.

If you are not registered for NaviNet, you can download a copy of the *Provider Change Form* at *www.amerihealth.com/providerforms*. Please be sure to print clearly, provide complete information, and attach additional documentation as necessary. Fax your completed *Provider Change Form* to Network Data Administration at 215-988-6080 or mail to:

AmeriHealth
P.O. Box 41431
Philadelphia, PA 19101-1431

When faxing the form, make sure you receive a confirmation of your fax.

Thirty days advance notice is required for processing. AmeriHealth will not be responsible for changes not processed due to lack of proper notice from Provider.

The types of changes you can request vary depending on your Provider type as well as on the lines of business for which you are contracted. Physicians can:

- change address, office hours, total hours, and phone or fax numbers;
- change selection of capitated Providers (for HMO PCPs only);
- add newly credentialed Providers or Participating Providers to a participating group (applicable to group practices only);
- add hospital affiliation.

Note: The *Provider Change Form* cannot be used if you are closing your practice or terminating from the network. Refer to the *Resignation/termination from the AmeriHealth network* section regarding policies and procedures when resigning or terminating from the network.

Authorizing signature and W-9 Forms

A signature from the Physician is required for any change that may result in a change on your W-9 Form. This includes changes to a Provider's name, tax ID number, billing vendor, "pay to" address, or ownership. You must also submit to us a copy of your W-9 Form for these changes to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

An office manager's signature will suffice for any other changes.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 for updates to their practice information*

Closing a PCP practice to additional patients

A Participating PCP must notify his or her Network Coordinator at least 60 days in advance of any intent to close the practice to additional patients. There are three status levels for offices:

- **Open:** Practice is accepting new patients.
- **Current:** Practice is accepting existing patients currently in the practice but covered by other insurance.
- **Frozen/Closed:** Practice is not accepting additions to the HMO or POS panel. Providers in this category do not appear in the Provider Directory.

Offices with practices designated as "current" will be listed in the Provider Directory as such. Should *existing* patients of one of our Plans switch to another of our Plans through their employer group, they will be able to select a closed office.

Note: Close-of-practice notification should be in writing and addressed to your Network Coordinator.

Age limitations on a PCP practice

If your practice subscribes to minimum and/or maximum age limits for Members, notify your Network Coordinator of this policy in writing. Members have expressed dissatisfaction over choosing a practice and subsequently discovering that the practice limits patients based on age.

PCPs should check their capitation/eligibility rosters to identify Members who fall outside their practice's age limitations. Contact Customer Service to arrange to have Members who fall outside of your practice's age limitations notified to choose a new PCP.

Patient transition from a pediatrician to an adult PCP

Pediatricians should systematically alert adolescents who are approaching the maximum age for patients treated in their practice to allow patients to make a smooth transition to a new PCP who has experience in treating adults.

If Members require further assistance on how to switch from a pediatrician to a new PCP, ask them to call Customer Service at the telephone number on their ID card.

Changing PCPs

A Member can change his or her PCP through our secure Member website, *www.amerihealthexpress.com*, or by calling Customer Service. The change will be effective on the first day of the following month.

Note: Providers cannot make a change to a Member's PCP on the Member's behalf.

Discharging a Member from the panel

A PCP must notify the Member and AmeriHealth in writing if discharging a Member from his or her panel. The PCP can notify his or her Network Coordinator, contact Customer Service or address correspondence to:

AmeriHealth New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

The Provider must also continue treating the Member for 30 calendar days; during this time, we will assist the Member in selecting a different PCP.

Resignation/termination from the AmeriHealth network*

Providers who choose to resign from the network should first contact their Network Coordinator to discuss the reason for the resignation. In addition to the telephone call, the Provider must give the network at least 90 days advance written notice in order to terminate network participation.

Written notice can be sent to:

AmeriHealth New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

In accordance with your contractual obligation to comply with our policies and procedures and professional licensing standards, a specialist or specialty group must notify affected Members if a specialist leaves the group or otherwise becomes unavailable to AmeriHealth Members or if the group terminates its agreement with us.

To help ensure continuity and coordination of care, we notify Members affected by the resignation/ termination of a PCP or PCP practice site at least 30 days prior to the effective date of termination and assist them in selecting a different Provider or practice site. This notification of PCP resignation/ termination by AmeriHealth does not relieve the PCP from his or her professional obligation to also notify his or her patients of the resignation/termination. Call Customer Service with any questions.

Continuity of care

If a Provider's contract is discontinued without cause, a Member may continue an ongoing course of treatment with the terminated Provider, at the contracted rate, for up to four months in cases where Medically Necessary. Exceptions are noted under "Continuity of Care" in the *Clinical Services* section of this manual.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 regarding their resignation from the network.*

Compliance training for Medicare programs

As a provider of health care services for AmeriHealth Medicare Advantage HMO, you and your staff are expected to comply with CMS requirements by completing Medicare compliance training on an annual basis. You must complete the training provided by AmeriHealth, or a similar Medicare compliance training that meets CMS requirements, within 90 days of hire and then annually thereafter. We have posted Medicare compliance training materials for your convenience at *www.amerihealth.com/providers/interactive_tools/compliance.html*.

We suggest that you and your staff maintain records of completion.

Hospital comparison tool

Through an agreement with WebMD®, the Hospital Advisor tool provides hospital quality and safety information. Both Providers and Members can research and compare hospitals based on procedure/diagnosis and location and can review details on process and outcomes results. The search results can also be customized according to which measures (e.g., volume, mortality, complications, and length-of-stay) are most important to the user.

Members can access the tool through our secure Member website, *www.amerihealthexpress.com*. Providers can access the Hospital Advisor through NaviNet by selecting *Reference Tools* from the Plan Transactions menu and then selecting *Provider Directory*.

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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. In addition, the CFID 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 and Ancillary Provider Audits
- Facility Provider Audits
- Pharmacy Audits

CFID Support

CFID Support uses data-mining software to proactively identify aberrant claims, billing patterns, and trends across all AmeriHealth lines of business. CFID Support gathers and evaluates information from a variety of sources to support CFID:

- STARS and STAR Sentinel — sophisticated software data-mining tools that analyze all categories of claims received, Provider demographics, and Member benefits — are primary sources of audit and investigation identification and selection.
- Members and Providers can confidentially report concerns through the toll-free hotline, 1-866-282-2707, and our website, *www.amerihealth.com/antifraud*.
- Leads are received from internal business areas, as well as external law enforcement agencies, regulatory authorities, and industry specialists.

Financial Investigations

Financial Investigations evaluates all allegations of fraud, waste, and abuse involving Providers, Members, vendors, associates, and others. They use a wide array of investigative tools to:

- identify and investigate fraudulent and abusive 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 and abuse;
- employ prevention techniques to decrease and eliminate future losses;
- make recommendations to terminate Providers for cause from in the AmeriHealth network.

Professional and Ancillary Provider Audits

The Provider Audits area reviews claims, medical records, and billing records of professional and ancillary Providers to determine the presence of unsupported charges and incorrect payments. It also ensures that all Provider categories and specialties are subject to audits and that claim adjustments are made to accurately reflect the services performed.

Communication is maintained between auditors and Provider representatives throughout the audit process. This process typically includes the following:

- advance notification to the Provider of an intent to audit;
- notification to the Provider about the anticipated purpose and scope of the audit (subject to change);
- possible onsite and/or desk audits;
- contact with the Provider to obtain copies of billing and/or medical records(original records may be inspected onsite);
- an initial findings report which is submitted to the Provider;
- a two-level internal review process for any Provider who has concerns about the audit findings*;
- final audit findings, communicated to the Provider in writing.

Note the following:

- Providers must request any review process in writing and furnish documents not previously submitted.
- Both pre- and post-pay claims are subject to audit selection.
- Peer claim submission comparisons may be utilized.
- Repayment for overpaid claims will be required.

**This two-level review process is limited to reviews of the AmeriHealth initial audit findings and is separate from the Provider claim appeal or Member appeal process.*

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 within 30 days. 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.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, in addition to other remedies, AmeriHealth reserves the right to require Selective Medical Review before claims are processed for payment to verify that claim submissions are eligible for coverage under the applicable benefits plan.

Documentation requirements for durable medical equipment services

The AmeriHealth durable medical equipment (DME) documentation requirements are consistent with the Centers for Medicare & Medicaid Services documentation requirements, which underscore the importance of securing and retaining documentation. If required documentation is not available on file to support a claim at the time of an audit or record request, AmeriHealth may seek repayment from the DME supplier for claims not properly documented.

Documentation requirements for DME include the following:

- Before submitting a claim to AmeriHealth, the DME supplier must have on file a timely, appropriate, and complete order for each billed prescription order item that is signed and dated by the Member's servicing Provider.
- Proof of delivery is required in the medical record and must include a contemporaneously prepared delivery confirmation or Member's receipt of supplies and equipment. If delivered by a commercial carrier, the medical record documentation must include a copy of delivery confirmation. If delivered by the DME supplier/Provider, the medical record documentation must include a copy of delivery

confirmation that is signed by the Member or caregiver. All documentation must be prepared at the same time as delivery and be available to AmeriHealth upon request.

- The DME supplier must monitor the quantity of accessories and consumable supplies that a Member is actually using and contact the Member regarding replenishment of supplies no sooner than approximately seven days prior to the delivery/shipping date. Dated documentation of this Member contact is required in his or her medical record. Delivery of the supplies should be done no sooner than approximately five days before the member would exhaust his or her on-hand supply.

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 & Abuse Tip Referral Form* electronically at *www.amerihealth.com/antifraud*.
2. **Call** the confidential anti-fraud and corporate compliance toll-free hotline at 1-866-282-2707.
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
   Philadelphia, PA 19103

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Claim Payment Policy Department

The goal of the Claim Payment Policy Department (CPPD) is to facilitate Member access to health care that is clinically appropriate, effective, and of high quality as determined by a critical analysis of scientific literature, current community practice, and the involvement of practitioners in policy development.

CPPD's role within AmeriHealth

CPPD works with various areas in the company to determine, verify, and publish coverage decisions for services through policy development, maintenance, and revision. Coordination of policy implementation and ensuring accurate claims processing are also part of this process. Specific functions of CPPD include the following:

- determine coverage positions for medical products or services through technology evaluation, new policy development, and revisions to existing policies;
- develop claim payment policy to communicate:
  - the AmeriHealth coverage and reimbursement position on a specific topic or service;
  - the requirements for coverage and reimbursement;
  - the instructions for reporting specific services.
- monitor and evaluate medical and claim payment policies for clinical/administrative accuracy in accordance with National Committee for Quality Assurance (NCQA) guidelines, or more frequently when changes in technology have occurred;
- support medical code activities as well as establish and maintain the development and documentation of coverage positions for Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) medical codes;
- facilitate clinical review of Quality Management initiatives/programs through the medical policy committee;
- meet regulatory requirements related to technology assessment and medical policy to achieve accreditation (by NCQA, among others);
- comply with governmental policies (e.g., Medicare), legislative mandates, etc.;
- communicate medical and claim payment policy determinations to Participating Providers through newsletters, direct mail, and our website;
- research and communicate responses to inquiries regarding policies, Medical Necessity issues, new and emerging technologies, reimbursement issues, and coding;
- make medical and claim payment policies available on our website;
- coordinate the consistent application of medical and claim payment policies;
- provide routine review and revision activity to update policy information as new data is received;
- educate AmeriHealth associates regarding policy and supporting documents;
- serve as content owner of procedure code-to-procedure code edits and edit rationale disclosure;
- offer support of procedure code-to-procedure code software for accuracy of claims processing;
- develop ongoing review to ensure utilization in the most appropriate and cost-effective setting for the delivery of injectables.

Access to policies

Providers can view our medical and claim payment policies online at *www.amerihealth.com/medpolicy*. The policies are available to assist Providers in administering and understanding the provisions of benefits.

Notifications are posted online prior to the effective date of the policies. Notifications are listed by the intended effective dates, so you can become familiar with them in advance. To read policy notifications, follow these instructions:

1. Visit *www.amerihealth.com/medpolicy*.
2. Select *Accept and Go to Medical Policy Online*.
3. Select *Policy Notifications*.

You can also view policy notifications using the NaviNet® web portal by selecting *Reference Tools* from the Plan Transactions menu, and then *Medical Policy*. Notifications are posted frequently, so it is important to check the site often.

Table of Contents

Overview

The Billing section is designed to keep you and your office staff up to date on how to do business with us Included are topics such as submitting Clean Claims, submitting proper codes used for accurate disbursement, and information and requirements pertaining to your National Provider Identifier (NPI). In addition, this section contains important information about electronic transaction channels, including clearinghouse options for electronic claims submission and the NaviNet® web portal, our secure Provider portal that expedites processing and payment.

The NaviNet® web portal

NaviNet, a Health Insurance Portability and Accountability Act (HIPAA)-compliant Web-based connectivity solution offered by NaviNet, Inc., is a fast and efficient way to interact with us to streamline various administrative tasks associated with our Members' health care. By providing a gateway to the systems used by AmeriHealth, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy.

For detailed information on NaviNet, see the *Administrative Procedures* section of this manual.

Clear Claim Connection™

Clear Claim Connection is a Web-based code auditing reference tool designed to mirror how ClaimCheck® evaluates code combinations during the auditing of professional claims. Clear Claim Connection enables AmeriHealth to disclose its claim auditing rules and clinical rationale inherent to the ClaimCheck system. Through this tool, you can view the justifications and clinical rationale on why code combination logic was applied to a professional claim processed in the base claims processing system. Providers can access this tool through NaviNet by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu or on our website at *www.amerihealth.com/providers/claims_and_billing/clear_claim_connection.html*.

Upgrades to ClaimCheck are scheduled twice yearly, typically in the spring and fall. Edits are based on recommendations (sourced) by various nationally accepted authorities, including the American Medical Association, CPT® (Current Procedure Terminology), Centers for Medicare & Medicaid Services (CMS), and national specialty societies.

ClaimCheck and Clear Claim Connection are updated regularly for consistency with medical and claim payment policy, new procedure codes, current health care trends, and/or medical and technological advances. ClaimCheck clinical relationship logic is applied based on the date a claim is processed, reprocessed, or adjusted in our claims processing system. This logic is not applied based on the date the service was performed. Therefore, claims that are reprocessed or adjusted for any reason may receive a different editing outcome from ClaimCheck based on the clinical relationship logic that is in effect at the time the claim adjustment occurs. Notwithstanding the foregoing, it is understood that a specific claim payment policy may supersede the terms of ClaimCheck with respect to the subject of that claim payment policy only. Detailed disclosures of all ClaimCheck code edits are available through Clear Claim Connection, which is accessible through NaviNet.

Billing/reimbursement requirements

Providers are required by the HIPAA Transactions and Code Sets Rules to use only codes that are valid at the time a service is provided from the following coding systems:

- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases – Ninth Revision – Clinical Modification (ICD-9-CM)

National entities, including the American Medical Association, CMS, and the U.S. Department of Health and Human Services (HHS), release scheduled updates to CPT, HCPCS, and ICD-9-CM procedure/diagnosis codes, respectively. We monitor those schedules and react according to the following timeline:

- **CPT:** Biannual release of codes with effective dates of January 1 and July 1.
- **HCPCS:** Quarterly release of codes with effective dates of January 1, April 1, July 1, and October 1.
- **ICD-9-CM:** Biannual release of codes with effective dates of April 1 and October 1.

Note: Timeline reflects schedule of the dictating entity and, therefore, may be subject to change.

CPT and HCPCS billing codes

Procedures must be billed using the five-digit numeric CPT codes from the Physician's CPT manual. Attachments or written descriptions of the services being performed will not be considered a proper billing procedure. Documentation in the Member's medical report must clearly support the procedures, services, and supplies coded on the health insurance form.

Note: Some CPT codes may be included in global fees to facilities and therefore are not eligible for separate reimbursement. You may bill the facility in those instances.

Some services or procedures performed by health care professionals are not found in the CPT coding system. If a specific CPT code cannot be located, check for a reportable HCPCS code. Unlisted procedure codes *should not be used* unless a more specific code is not available.

Unlisted procedure codes

Each section of the CPT coding system includes codes for reporting unlisted procedures. They may be new procedures that have not yet been assigned a CPT code, or they may simply be a variation of a procedure that precludes using the existing CPT code. Because unlisted procedure codes are subject to manual medical review, processing may take longer than usual.

All unlisted/not otherwise classified (NOC) codes must be submitted with the appropriate narrative description of the actual services rendered on the CMS-1500 claim form in order to be processed. For claims that are electronically submitted, refer to the HIPAA Transaction Standard Companion Guides available at *www.amerihealth.com/ediforms*.

For paper-submitted claims, additional information regarding the narrative description of the specific services provided should be submitted on the CMS-1500 claim form in the shaded area extending from field 24A through 24G, directly above the NOC/unlisted procedure code. If a description is not provided, the entire claim will be rejected with a message to resubmit with a narrative description.

For electronically submitted 837P claims, the NOC descriptions should be filled into the Loop 2400 data element SV101-1 – Description.

Pricing procedure for unlisted or NOC services

This pricing and processing procedure for unlisted or NOC Covered Services is used for all products covered under your Provider Agreement.

- We maintain a database of historical pricing decisions for similar services previously reviewed and priced by AmeriHealth. If available, an appropriate fee in this database may be used to price the current claim.
- If the database does not have pricing for the current claim, then the claim is reviewed by us for a pricing decision. We may request that the Provider submits additional information to facilitate pricing the claim. The additional information requested may include, but is not limited to, an operative report, a letter of Medical Necessity, an office note, and/or an actual manufacturer's invoice. Providers should submit additional information only if specifically requested to do so by AmeriHealth. Upon being recommended for payment and processing, claims are priced using our standard pricing methodology, which is designed to consider new procedures, and are processed in accordance with applicable claim payment policies and exclusions and limitations in benefits contracts.
- Providers who disagree with a specific unlisted/NOC service pricing determination should follow the normal appeals process described in the appropriate *Appeals* section of this manual.

Providers are reminded to always use the most appropriate codes when submitting claims. Claims submitted with NOC codes when a valid CPT or HCPCS code exists may be denied.

National Drug Code submissions

Pharmacy and medical claims for all unlisted and nonspecific drug codes (without a corollary CPT or HCPCS code) require submission of a National Drug Code (NDC) in the correct format and location to properly adjudicate these claims consistent with our group benefits plans. If the NDC is not submitted in an 11-digit format or is missing, the claim will not be processed and will be returned to you for correction. The 11-digit format is 5-4-2 and is found on most drug packaging. This format serves a functional purpose: The first segment of the NDC identifies the labeler/manufacturer; the second segment identifies the product, strength, dosage form, and formulation; and the third segment identifies the package size of the drug.

A complete list of unlisted and nonspecific codes that require the submission of an NDC to properly process the claim is available at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Note: Compound drugs should be reported with (1) an unlisted and/or nonspecific (CPT or HCPCS) code and (2) the NDC with the most expensive ingredient.

Report diagnosis codes to the highest degree of specificity

We require that all Providers report diagnosis codes to the highest degree of specificity according to the most current *ICD-9-CM Coding Manual*. This requirement applies to all claims and encounters. It reflects:

- the need for better diagnostic information for quality and medical management;
- the decision to make our coding policy more consistent with other major carriers and with CMS ICD-9-CM coding guidelines;
- the decision by CMS to determine Medicare Advantage premiums based on the severity of illness of enrolled Members. Supporting documentation in the Member's medical record must clearly support the procedures, services, and supplies coded on the claim form.

The following are guidelines for diagnosis coding:

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

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

HIPAA 5010 and ICD-10

- **HIPAA 5010.** The U.S. Department of Health and Human Services stipulates that any health care entity that submits electronic health care transactions, such as claims submissions, eligibility, and remittance advice, must comply with the X12 Version 5010 standards. HIPAA 5010 Companion Guides are available at www.amerihealth.com/ediforms to assist you in submitting HIPAA 5010-compliant transactions.
- **ICD-10.** CMS has delayed the compliance date for the International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes to no sooner than October 1, 2015. All covered entities will be required to comply with ICD-10 by the final effective date determined by CMS. Visit www.cms.gov/icd10 for more information about the delay.

Billing guidelines

Included in this section is billing information specific to certain types of services, including diagnostic ultrasounds, interrupted maternity care, observation services, office-based services, radiologic guidance, routine gynecological exams, and surgery claims.

Diagnostic ultrasounds

Certain participating specialist types are eligible to provide specific diagnostic ultrasounds to HMO and PPO Members. HMO Members do not require a Referral from their PCPs for diagnostic ultrasound services provided by the OB/GYN specialists listed below.

Note: Although these specialists are eligible to provide these services in some Service Areas, we have an arrangement in which we pay the hospital a global payment when the service is provided in the outpatient hospital. In these instances, the Physician's statement of remittance (SOR) will indicate that the Physician must seek reimbursement from the hospital.

The eligible procedure code/diagnosis code combinations are as follows:

Reason for ultrasound	Specialists/ Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Perinatal, maternal fetal medicine (MFM)/office and hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0 – V23.9
Rule out ectopic pregnancy	OB/GYN, reproductive endocrinology and infertility (REI) specialist, and MFM/office and hospital	76815, 76817, 76830, 76856, 76857	633.00 – 633.91, 761.0, 761.4, 635.70 – 635.92, V61.70
Rule out intrauterine pathology	OB/GYN and REI	76831, 58340	As appropriate
First-trimester screening	MFM	76801, 76802, when billed in conjunction with 76813 or 76814	V28.3
Fetal anomalies	MFM	76813, 76814, 76825, 76826, 76827, 76828	As appropriate
Infertility*	Reproductive endocrinologist/office	76830, 76857	256.1, 256.8, 256.9

**Covered Services may vary by the Member's benefits plan.*

Outpatient hospital

Additionally for HMO Members, hospitals that are not the Member's capitated radiology site may perform and be reimbursed for the following listed services. If the hospital is the capitated radiology site for the Member, these Covered Services are included in the capitation payment and no additional payment will be made.

Reason for ultrasound	Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Outpatient hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0 – V23.9
Rule out ectopic pregnancy	Outpatient hospital	76815, 76817, 76830, 76856, 76857	633.00 – 633.91, 761.0, 761.4, 635.70 – 635.92, V61.70
First-trimester screening	Outpatient hospital	76801, 76802, when billed in conjunction with 76813 or 76814	V28.3

Interrupted maternity care

If you provide prenatal visits alone to any AmeriHealth Member, please bill those services with the appropriate CPT code as follows:

- **Fewer than four visits.** If you provided fewer than four visits total, bill in the following way:
  - **First visit:** Bill 99205 (new patient) or 99215 (established patient).
  - **Second and third visits:** Most second and third visits typically require only a level-three office visit. Exclusively billing these visits at higher levels than Medically Necessary is not an appropriate billing practice and is subject to post-payment review.
- **Four to six visits.** If you provided a total of four to six visits, bill *only* 59425.

- **Seven or more visits.** If you provided a total of seven or more visits, bill *only* 59426.

Observation services

When a Physician provides service to a Member at an observation level of care, the Physician should use the following Evaluation and Management (E&M) codes when billing for these services to ensure accurate processing of the claim:

- 99217
- 99218
- 99219
- 99220
- 99234
- 99235
- 99236

We recognize the appropriate use of observation services (i.e., observation status and observation level) to monitor patients and treat medical conditions on an outpatient basis and to evaluate a patient's need for acute inpatient admission. Observation services are outpatient services that include diagnosis, treatment, and stabilization of patients from a minimum of six to a maximum of 24 hours, per InterQual® guidelines.

AmeriHealth uses guidelines for decision-making from InterQual to determine which patients have severity of illness and intensity of service requirements that are appropriate for observation. Observation services can be provided in any location within a facility.

Office-based services

If an office-based service (e.g., an office visit or outpatient consultation) is performed by a professional Provider in an office-based setting within a facility or on a facility campus, the facility is not eligible for reimbursement and should not bill for the service. Only the professional Provider is eligible for reimbursement for the service provided to the Member. The facility is not eligible to receive reimbursement for a room charge even though a professional Provider office may be located within the facility.

Radiologic guidance of a procedure

The following reimbursement methodologies apply to claims processing of radiologic guidance and/or supervision and interpretation of a procedure:

- Radiologic guidance and/or supervision and interpretation are performed by either the same professional Provider who performs the surgical procedure or a different professional Provider.
- Radiologic guidance and/or supervision and interpretation of a procedure that is performed in conjunction with a Covered procedure are eligible for separate reimbursement consideration by AmeriHealth.

When the same Provider performs and reports both the radiologic and the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the Provider. However, both of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service and the procedure for which it is performed must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure performed by the Physician. The medical record must be available to us upon request. Providers should not submit medical records to us unless otherwise requested.

More information about Claim Payment Policy #00.10.36: Radiologic Guidance of a Procedure can be viewed at *www.amerihealth.com/medpolicy*.

Routine gynecological exams

OB/GYNs and capitated PCPs who bill above capitation for routine gynecological exams should report diagnosis code V72.31 with the applicable preventive E&M CPT codes 99384 – 99387 and 99394 – 99397 or with HCPCS codes S0610 and S0612 for reimbursement consideration. Do not bill both a preventive CPT and an annual gynecological exam HCPCS code for the same date of service. Only one will be paid. Problem visits may be billed along with a preventive service code for same date of service, if appropriate.

Routine gynecological exams reported with ICD-9-CM code V72.32 for the CPT codes 99384 – 99387 and 99394 – 99397 are not eligible for additional payment outside the standard capitation amount. HCPCS codes S0610 and S0612 may still be reported with ICD-9-CM code V72.32 when appropriate.

For reference, the diagnosis code narratives are as follows:

- **V72.31:** Routine gynecological examination.
- **V72.32:** Encounter for Papanicolaou cervical smear to confirm findings of a recent normal smear following initial abnormal smear.

For more information, refer to the *OB/GYN* section of this manual.

Surgery claims

Providers are required to follow the appropriate billing procedures as they relate to multiple surgeries, assistant surgery, and co-surgery.

Multiple surgeries

- **Performed on the same date of service.** Surgeons must bill multiple surgical procedures for the same date of service on a single claim.
- **Performed on different dates of service.** To avoid claim underpayments, surgeons must bill multiple surgical procedures for different dates of service as separate claims.

Assistant and co-surgery

For surgical procedures performed by both a primary surgeon and an assistant surgeon or co-surgeon, separate claim submissions are required. The primary surgeon and assistant surgeon or co-surgeon must report separate claims.

- **Performed on same date of service.** Multiple surgical procedures performed on the same date of service must be reported on a single claim (i.e., one claim for each surgeon).
- **Performed on different dates of service.** To the extent that a surgeon, assistant surgeon, or co-surgeon performs multiple surgical procedures on different dates of service, each date of service must be reported on its own claim.

Inappropriate billing may result in erroneous claim payments. For more information regarding assistant surgery, co-surgery, and multiple surgery guidelines, refer to their respective claim payment policies, which are available at *www.amerihealth.com/medpolicy*.

Clean Claims

A Clean Claim is one that does not require further information for processing in accordance with applicable law. Incomplete and inaccurate claims will be returned as non-clean claims. Returned claims are not necessarily a denial of benefits but arise from our need for accurate and complete information.

Additionally, claims that do not have adequate information to identify the billing Provider can be neither processed nor returned.

Clean Claims (both electronic and paper-submitted) must meet the following conditions:

- The service is a Covered Service under the AmeriHealth Member's benefits plan.
- The claim is submitted with all required information on a claim form or in other instructions distributed to the Provider.
- The person to whom the service was provided was an AmeriHealth Member on the date of service.
- We do not reasonably believe the claim was submitted fraudulently.
- The claim does not require special treatment. Special treatment means unusual claim processing is required to determine whether the service is covered.

Clean Claims requirements

The following information must appear correctly for a claim to be considered clean:

- Group Provider NPI*
- performing Provider NPI
- tax ID number
- billing address
- Member's ID number (including applicable prefix and suffix) of the patient on the claim
- Member's name of the patient on the claim

**Be sure the Group Provider NPI is associated with the Group Tax ID number on file at AmeriHealth. Providers may use the Provider Change Form transaction on NaviNet to review current information on file at AmeriHealth.*

Provider NPI requirement

For purposes of processing a claim, you must submit a valid NPI as the primary identifier on the claim. In addition, the performing Provider NPI must be recorded on all claims. This is a required data element in conjunction with HIPAA compliance and other requirements. HMO, POS, PPO, and EPO claims submitted without the NPI of the Physician or other professional Provider performing the procedure or service will be rejected and returned as nonclean claims, which must be resubmitted with the necessary information.

Note: Taxonomy codes are used to distinguish Provider specialties and are required on all claims.

Further information about NPIs and how to bill using NPIs is available on our website at *www.amerihealth.com/npi*.

Member ID numbers on ID cards

To better protect Member identity and privacy, we use a unique Member ID number for external communications to Members, including on all Member ID cards. The Member ID number consists of a 3-character alpha prefix, an 8-position ID number, and a 2-position suffix that defines a Member of the family unit.

To facilitate claims processing, be sure to include the complete Member ID number as it appears on the Member's ID card. AmeriHealth rejects claims not billed with the complete Member ID number and patient date of birth. For timely and accurate claim payment, the full Member ID must be billed as it appears on the Member ID card.

For AmeriHealth PPO, AmeriHealth New Jersey EPO, AmeriHealth Traditional Medical, and CMM Members, it is especially important that you also include the alpha prefix when submitting claims.

For HMO and POS Members, the laboratory indicator (e.g., A, H, L, M, N, T, or Q) located on the front of HMO and POS ID cards should not be included in the Member's ID number.

Place-of-service codes

Participating Providers are required to use the most current place-of-service codes on professional claims to specify the entity where service(s) was rendered. The most frequently submitted place-of-service codes are listed in the following table. Always consult with your vendor or practice management system contact to discuss payer-specific changes to your system.

Place-of-service code	Place-of-service name
11	Office
12	Home
21	Inpatient
22	Outpatient
23	Emergency department/room — hospital
24	Ambulatory surgical center
31	Skilled nursing facility
32	Nursing facility
41	Ambulance — land
42	Ambulance — air or water
65	End-stage renal disease treatment facility
81	Independent lab

Submitting claims

Visit our website at *www.amerihealth.com/edi* for information on claims submission and billing and tools related to these activities. This site makes it easy to find important claims-related information and provides access to electronic billing guidelines, HIPAA Transaction Standard Companion Guides, payer ID grids, and claim form requirements.

CMS-1500 claim submitters

All paper claims received must be submitted on a CMS-1500 claim form. A sample CMS-1500 claim form is included in the *Claims Submission Toolkit for Proper Electronic and Paper Claims Submissions* document, available at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

If you submit claims using the HCFA-1500 claim form, you will continue to receive the Rejected Claim Report for notification of rejected claims. The error description on the Rejected Claim Report will aid you in correcting and resending claims to ensure an expedited remittance.

Electronic claim submitters

If you submit claims electronically, you will continue to receive the unsolicited 277 (U277) for notification of both rejected and accepted claims. The error description on the U277 will aid you in correcting and resending files to ensure an expedited remittance.

For more information, refer to the *Claims resolution* section in this manual. You can also refer to *www.amerihealth.com/ediforms* or contact your Network Coordinator for more information.

Clearinghouse options for electronic claims submission

Your software vendor may be contractually obligated to use a specific third-party clearinghouse vendor for electronic submissions. That clearinghouse can assist you with testing to ensure that your electronic claims submissions are seamless. Many clearinghouse options are available.

Clearinghouses may update their submission rules from time to time. Always contact your clearinghouse for confirmation of up-to-date, specific submission requirements.

If you are interested in submitting electronic claims and have existing practice management software, contact your vendor as they will more than likely have an existing clearinghouse vendor that connects to the gateway AmeriHealth uses to process EDI transactions, which is managed and operated by Highmark, Inc. (Highmark).

Submitting Coordination of Benefits information electronically

Providers may submit Coordination of Benefits (COB) information electronically for professional services using the 837P and 837I formats. For instructions on how to bill electronically, visit *www.amerihealth.com/ediforms*.

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher "first-pass" adjudication rate. This means faster payment to you.

If you have questions about electronic claims submission, please contact Highmark EDI Operations at 1-800-992-0246.

Claims preprocessing

Claims preprocessing validates claim data that is critical for claims processing and payment, prior to AmeriHealth receiving the claim. We incorporated the HIPAA-compliant 837P transactions into the existing Claim Preprocessing System (CPPS) for AmeriHealth HMO, AmeriHealth POS (referred), AmeriHealth PPO, AmeriHealth New Jersey EPO, and AmeriHealth CMM claims.

The benefits of claims preprocessing:

- increased accuracy of claims processing and payment;
- avoidance of payment delays due to missing or inaccurate data;
- error reports that, when appropriate, provide data needed for error correction.

Types of claims preprocessed:

- all electronically submitted HMO, POS (referred), PPO, EPO, or CMM claims in the ANSI X-12 HIPAA-compliant 5010A1 format with a 95044, 93688, or 60061 NAIC code;
- all HMO and POS (referred) claims billed via the CMS-1500 claim form.

If you are having problems with claims rejecting, refer to the *Electronic claim submitters* section in this manual. This information will help you to submit claims successfully.

Claims resolution

The *Claims Preprocessing Edits Claims Resolution Document* highlights rules that are applied to claims and advises on how to remedy rejected claims for resubmission of a Clean Claim. This document is available at *www.amerihealth.com/ediforms* and is updated periodically to reflect new error codes and claims resolution instructions. It is intended to provide guidance on current billing submission errors we have encountered.

When referencing the document, keep in mind the following:

- *Column A* contains the CPPS error code and the general description of why the claim was rejected for paper and electronic claims submissions.
- *Column B* contains the error description reported on the U277 in data element STC12 for electronic claims and the rejected claims report for paper claims submissions.
- *Column C* contains U277 HIPAA Status and HIPAA Category codes for electronic claims submissions only.
- *Column D* contains the claims resolution instructions for 837P Loop/Data elements for electronic claims submissions only.
- *Column F* contains the claims resolution instructions for error resolutions for electronic claims submissions.

Note the following:

- Providers should continue to submit claims according to our guidelines.
- Provider claims will continue to be validated against the existing business rules.

Submission of claims adjustments

When submitting adjustment requests electronically to your Network Coordinator or our Adjustment Department using Microsoft® files (e.g., Excel® or Access®), please submit the following fields:

- AmeriHealth claim ID number
- Member ID number
- date of service from/to
- procedure/service code
- Member first and last name
- Subscriber ID number
- vendor (billing) Provider name and number
- performing Provider name and number
- modifier
- modifier
- modifier
- revenue code
- units billed
- charged (billed) amount
- allowed amount
- payment amount
- expected amount

By submitting your adjustment requests with the fields listed, we will be able to improve the turnaround time and maintain a higher level of service while processing the claim.

Claim Investigation

Professional Providers can access the Claim Investigation transactions on NaviNet by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu. Providers must first locate the claim through

the Claim Status Inquiry transaction. Then providers can link to Claim Investigation. This transaction allows Providers to submit claim adjustments through NaviNet for claims in a paid or denied status. Claims data is available for up to 18 months prior to the current date.

The Claim Investigation Inquiry transaction is also available for Providers to review the status of submitted adjustment requests.

For assistance with these or any other transactions offered through NaviNet, Providers can view the User Guides under Customer Support, or they can contact NaviNet Customer Care at 1-888-482-8057.

Statement of Remittance

The Statement of Remittance (SOR) contains detailed claims information for the payment of claims, claims adjustments, and claims interest payments to Providers. Providers can view their SOR in the following ways:

- **Paper SOR.** A paper SOR is mailed to your address with each remittance.
- **835 SOR.** An 835 SOR is a standardized EDI file format that can be transmitted to Providers if requested. It is also known as an ERA (electronic remittance advice).
- **Online SOR.** You can use the Online SOR Inquiry transaction on NaviNet to view all remittances issued to Providers in your group. SOR information can be viewed for a 13-month rolling calendar. Online SORs have several advantages: You can search for specific SORs by patient account number, statement date, or statement number; obtain greater detail within individual remittances; and easily obtain each claim's summary and line-level detail.

  Access to the Online SOR Inquiry transaction is controlled by your designated Security Officer. Once permission to register for online SORs is granted for a particular user, that individual can use the transaction by selecting *ePayment* from the Plan Transactions menu, then *Online SOR Inquiry*.

Overpayments

If you identify an erroneous overpayment when reviewing your SOR and reconciling it against a Member account, please log on to NaviNet, select *Claim Inquiry and Maintenance* from the Plan Transactions menu, and then *Claims Status Inquiry.* Once the claim is accessed, you can link to Claim Investigation to request a claim retraction through the claims adjudication process. Through this preferred and expedited process, credits and/or retractions will automatically appear on a future SOR.

Occasionally we identify erroneous overpayments, in which case you will receive instructions either in a letter highlighting the specific overpayment or listed on your A/R statement. Follow the specific instructions noted in the letter and/or statement.

Provider claims inquiry

The Provider claims review process will consider HMO, POS, PPO, and EPO claims payment issues concerning the application and correction of coding, claims logic, and other general issues related to claims processing norms. Claims data is available for up to two years prior to the current date.

You can initiate the Provider claims review process in one of the following ways:

- For claims that are in the paid or denied status, use NaviNet. Select *Claim Inquiry and Maintenance* from the Plan Transactions menu, then select *Claim Status Inquiry* to locate the claim, and then you can link to *Claims Investigation*.

- Complete a *Provider Claim Inquiry Form*, available at *www.amerihealth.com/providerforms.* Follow the instructions for submission on the form, and be sure to include the SOR.

Whichever method you choose, be sure to clearly identify the claims issue and be prepared to provide any supporting documentation to help explain your position.

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Overview

The Clinical Services 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 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.

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. 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:
  - home health care
  - 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 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 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: cardiac catheterizations, 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 our 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 and obesity surgery
  - review of potential experimental or investigational services
  - speech therapy
- **Non-certification decisions.** The criteria used to make non-certification decisions are stated in the letters to the Members and Providers, along with instructions on how to request specific guidelines. Providers may request the specific guidelines or criteria used to make specific utilization management determinations by faxing a request to 215-761-9539 or by submitting a request to:

  Request for InterQual Criteria
  Care Management and Coordination Department
  1901 Market Street, 30th Floor
  Philadelphia, PA 19103

Important definitions

"Medically Necessary" or "Medical Necessity"

"Medically Necessary" or "Medical Necessity" refers to, or describes, a health care service that a health care Provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or his or her symptoms and that is, in accordance with the generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and is considered effective for the covered person's illness, injury, or disease. The service is not primarily for the convenience of the covered person or the health care Provider, not more costly than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

Generally accepted standards of medical practice means standards that are based on the following: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; Physician and health care Provider specialty society recommendations; the views of Physicians and health care Providers practicing in relevant clinical areas; and any other relevant factors as determined by the Commissioner and the New Jersey Department of Banking and Insurance through regulation.

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.

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**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 1-888-YOUR-AH1, 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 1-888-YOUR-AH1.

The Clinical Services 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 by using NaviNet to initiate the review of the admission.

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

Certain Surgical Procedures

The following procedures are generally performed on an outpatient basis when elective, and not urgent or emergent:

- thyroidectomy — partial or total
- parathyroidectomy
- recurrent hernia
- temporomandibular joint (TMJ) arthroplasty and discectomy
- arthroscopy (shoulder, elbow, wrist)
- open reduction internal fixation of uncomplicated wrist or finger fractures

We ask that Providers perform these procedures as outpatient; however, if you feel there are medical reasons that would justify an inpatient stay, AmeriHealth New Jersey will review these upon request and approve the inpatient setting if medically appropriate. If we approve these procedures as inpatient and the patient goes home the same day, we will reimburse these procedures as outpatient. You may direct your review requests to the Precertification Department by calling 1-800-275-2583 and saying *Authorizations*.

Note: None of the procedures listed above require Preapproval/Precertification if performed in the outpatient setting.

Medications

For *all drugs* covered under the medical benefit that require Preapproval/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 Preapproval/Precertification. Dosing and Frequency Guidelines are included in the medical policies for such drugs, which are available at *www.amerihealth.com/medpolicy*.

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 to verify individual Member benefits. Providers may submit authorization requests for services rendered by an infusion therapy provider, a prosthetics provider, or a DME provider. Providers *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 and prenotification for a maternity admission for a routine delivery are not required.

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 (Point of Service): 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, even when one is required, subject to our Deductible and Coinsurance, without a Preapproval/Precertification review requirement.

AmeriHealth POS Plus: Members are exempt from all Referral requirements.

PPO: PPO Preapproval/Precertification review requests for services performed by out-of-network Providers are the responsibility of the Member. Members with PPO coverage may obtain out-of-network Covered Services; however, these will be reimbursed at the out-of-network level of benefits. Members may be balance-billed for the difference in reimbursement and the out-of-network Provider's charge.

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 Preapproval/Precertification for the following outpatient nonemergency diagnostic imaging services:

- CT/CTA scans
- MRI

- MRA
- nuclear cardiology services
- PET scans
- PET/CT fusion
- cardiac echocardiography

Members are responsible for Preapproval/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* 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.

Specialist designated as a PCP

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 Clinical Services has approved the treatment plan.

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 primarily of telephonic 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 1-888-YOUR-AH1. 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 usually occurs 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 Clinical Services 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.

For prior authorization requests not related to inpatient stays 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 inpatient 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 Clinical Services 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 within two business days from the date the hospital is notified of the denial.
- To initiate the process, the attending Physician, ordering Physician, hospital utilization management department Physicians or their designated Physician representative (e.g., hospital medical director) may contact an AmeriHealth Medical Director by email or fax or by calling the Physician Referral Line at 1-877-585-5731. The Physician Referral 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 that 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/Precertification and post-service denials, the decision will be completed within ten business days following the request.
- A decision to overturn all or a portion of the initial adverse determination will be communicated in writing to the Provider.

Continuity-of-care

Under the Health Care Quality Act (HCQA), if AmeriHealth or a Provider initiates termination of a Provider contract without cause, the Member may continue an ongoing course of treatment, at the contracted rate, with that Provider for up to four months in cases where it is Medically Necessary for the Member to continue treatment, except as set forth below:

- For pregnant Members, Medical Necessity is deemed to have been demonstrated and coverage of services by the terminated Provider shall continue to the postpartum evaluation of the Member up to six weeks after delivery.
- In the case of post-operative care, coverage of services by the terminated Provider shall continue for a period up to six months.
- In the case of oncological treatment, coverage of services by the terminated Provider shall continue for a period up to one year.
- In the case of psychiatric treatment, coverage of services by the terminated Provider shall continue for a period up to one year.

Preapproval/Precertification and concurrent authorization of Medically Necessary services shall continue for Members when we terminate a contract with a Provider. All authorized health care services during this transitional period shall be covered by AmeriHealth under the same terms and conditions applicable for our Participating Providers.

If we initiate termination of the Provider *with cause* (e.g., breach of contract, a determination of fraud, or, if in the opinion of our Medical Director, the Provider is an imminent danger to a patient or the public health, safety, and welfare), we will not be responsible for health care services provided to the Member by his or her terminated Provider following the date of termination.

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Emergency care

Emergency services are eligible for payment in accordance with the following definition of an Emergency:

> The sudden onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical or surgical attention could result in:
>
> - placing the Member's health, or in the case of a pregnant Member, the health of the Member and/or unborn child, in jeopardy;
> - serious impairment to bodily functions;
> - serious dysfunction of any bodily organ or part.

Emergency transportation and related Emergency services provided by a licensed ambulance Provider constitute an Emergency service.

PCP responsibilities when sending HMO/POS Members to the ER

- Primary Care Physicians (PCP) must provide coverage 24 hours a day, 7 days a week, for their practice.
- HMO/POS Members should not be referred to the emergency room/department (ER) for capitated services.
- All ER Referrals should be documented in the Member's medical record.
- Follow-up care, blood work, and repeated X-rays must be managed and appropriately referred by the PCP.

Member responsibilities when using the ER

- In an Emergency, the Member should proceed to the nearest ER for care, regardless of the Member's physical location.
- There is no requirement for the Member to contact his or her primary Physician or PCP before visiting an ER. However, we encourage Members to contact their primary Physician or PCP before visiting an ER for guidance if the Member is unsure about whether an Emergency condition exists.
- The Member is responsible for any applicable ER Copayment or Coinsurance associated with his or her coverage, unless the ER visit results in immediate Emergency inpatient hospitalization. The Copayment/Coinsurance is not waived in the case of emergent outpatient surgery.
- When the Member is admitted to the hospital from the ER, the Copayment may be waived. The Member's schedule of benefits provides specific information on ER Copayments and Copayment waivers.

Follow-up care

Generally, follow-up care after an ER visit is considered routine care. For commercial Members, routine (nonemergent) follow-up care provided in the ER setting by a Participating Provider is not a Covered Service. Members should not be referred back to the ER for follow-up care services if they can be referred to their primary or specialty care Physician without medically harmful consequences.

Examples of routine follow-up care in the ER include the following:

- patient returns to have a prescription extended that was written in the ER;
- patient returns to the ER for reapplication of bandages, splints, or wraps;
- patient who had a laceration repaired with sutures returns to the ER to have the sutures removed.

When follow-up care provided in the ER setting is denied as a noncovered service, commercial Members may be billed for such noncovered services subject to the terms of your Participating Provider Agreement. This requires, in relevant part, that you give the Member written notice prior to providing the noncovered services indicating that follow-up care in the ER setting is not covered and that the Member will be financially responsible for such noncovered services.

Routine (nonemergent) follow-up care provided in the ER setting by a Participating Provider is not eligible for a separate ER visit payment.

Note: For some New Jersey Members, outpatient follow-up care provided in a Medically Necessary setting (ER, other outpatient Emergency facility, or Physician's office) may be covered. Please verify Member eligibility prior to providing follow-up care in the ER setting to New Jersey Members.

Nonemergency care

HMO/POS Members: HMO/POS plans cover other nonemergent care rendered in the ER when Preapproved by the PCP or obstetrical care Provider. If the Member's condition is nonemergent in nature and care cannot be provided in a timely fashion by the PCP or PCP-referred specialist, the Member may be referred to the appropriate ER of a participating hospital. The PCP must use his or her medical judgment to determine what "timely" care is based on the Member's presenting symptoms.

PPO Members: The Member is responsible for seeking necessary medical care from the appropriate setting and Provider.

For more information on Preapproval requirements, elective admissions, urgent admissions from the Physician's office, or transfers, see the *Clinical Services* section of this manual.

Ambulatory care

Preapproval may be required for select outpatient procedures. Preapproval for those select procedures must be obtained at least five business days prior to the scheduled date of the procedure. For self-referred services covered under POS, it is the Member's responsibility to obtain Preapproval at least five business days before the scheduled date of the procedure.

Go to *www.amerihealth.com/preapproval* for the list of services that require Preapproval. *Note: This list is subject to change upon notice to the Provider.*

Billing multiple services

AmeriHealth requires that professional claims be billed on one CMS-1500 claim form or electronic 837P transaction when two or more procedures or services were performed for the same patient, by the same performing Provider, and on the same date of service. When services rendered on the same date by the same provider are billed on two claims, it is defined as "split-billing".

The only instances when split-billing is acceptable to AmeriHealth are when we specifically require services to be billed on separate claims based on an AmeriHealth policy (i.e., assistant or co-surgery claims). Some examples of split-billing, which is not allowed by AmeriHealth, include:

- two or more procedures or services performed by the same Provider, on the same date of service, on the same patient, and submitted on more than one claim form;
- services considered included in the primary services and procedures as part of the expected services for the codes are billed on separate claim forms.

Providers *must* bill on one claim form for all services performed on the same day, for the same patient, unless there is an AmeriHealth policy that supports split-billing for the services or procedures performed. Failure to do so prohibits the application of all necessary edits and/or adjudication logic when processing the claim. As a result, claims may be under- or over-paid and member liability may be under- or over-stated.

If a service for which there is no policy to support split-billing is inadvertently omitted from a previously submitted claim, the original claim should be corrected.

Note: Do not submit a separate claim for the omitted services, as that will create a split-billed claim and all individually submitted claims will be adjusted to deny.

Radiation therapy

HMO/POS Members: The Member's PCP must issue a Referral for "evaluate or follow-up." All Referrals are valid for 90 days. The PCP may estimate the total number of visits expected based on the initial consult report from the specialist or may indicate "unlimited/as needed."

For POS Members, outpatient radiation therapy does not require Preapproval unless performed at a nonparticipating facility or by a nonparticipating Provider.

AmeriHealth POS Plus and HMO Plus New Jersey Members are exempt from all Referral requirements.

PPO Members: Members can seek out-of-network services for radiation therapy prescribed by a Physician. Services obtained within the AmeriHealth network are paid according to the contracted fee schedule. When Members elect to receive out-of-network radiation therapy, claims are processed according to the out-of-network benefits level.

Blood and blood products

Subject to the terms and conditions of the applicable benefits contract, the administration of blood and blood products is covered for managed care plans under the basic medical benefits when Medical Necessity criteria are met. Note the following:

- Individual Member benefits must be verified for blood products, autologous blood drawing, storage, and transfusion services.
- Not all groups have coverage for blood and blood products.
- Some contracts require Member payment for up to three pints of blood prior to benefit eligibility.
- Coverage may be subject to Preapproval.

Determining whether procedures are cosmetic

In general, all plans require Preapproval for potentially cosmetic procedures. A list of procedures that are, or may be considered to be, cosmetic and thus may not be covered under the Member's plan is available at *www.amerihealth.com/preapproval*. Some procedures, depending on specific medical criteria, may be approved for coverage. For coverage consideration, the Provider must complete the Preapproval process.

Participating Providers should submit their requests through NaviNet prior to services being performed. Failure to obtain Preapproval where required may lead to a denial of payment. Review the medical policy for each potentially cosmetic procedure at *www.amerihealth.com/medpolicy*. The medical policies contain a definition of and our coverage position for each procedure.

Skilled nursing facilities

Skilled nursing facility (SNF) services are covered for HMO, POS, and PPO Members who need skilled or sub-acute care. SNF services are subject to Preapproval and may be subject to certain benefits limits.

All SNF admissions are either arranged by care coordinators or Preapproved through the Preapproval process. SNF admissions are reviewed weekly or more often, if necessary, to facilitate appropriate use of benefits and to promote optimal benefits coverage. SNF reviews may be onsite or by telephone or fax, depending on the arrangement with the individual SNF.

Note: Medicare Advantage HMO Members may be admitted to a SNF from home without admission to an acute-care facility first. Admissions must follow the Preapproval process.

Inpatient hospital

Inpatient hospital benefits are available to HMO, POS, and PPO Members and are subject to Preapproval. In the case of an urgent or emergent admission for an HMO, POS, or PPO Member, the hospital shall notify AmeriHealth within 24 hours.

HMO/POS Members: The attending Physician is required to obtain Preapproval for all non-urgent or nonemergent admissions.

PPO Members: The hospital or attending Physician should Preapprove all non-urgent or nonemergent admissions.

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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 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

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. 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.

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.

Requesting laboratory services

When requesting laboratory services, fill out the laboratory requisition form completely, including the Member's insurance information (Member ID number, address, type of coverage, etc.), the tests you are ordering, his or her diagnosis, and the location where the reports are to be sent. This helps ensure that the laboratory claim will process properly and reduces Member billing issues

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.

Keep in mind the following:

- To obtain current capitation information, use the Eligibility and Benefits Inquiry transaction on NaviNet.
- PCPs may obtain a specimen in the office or send an HMO Member to a drawing station.
- Specialists (including OB/GYNs) *must* send HMO Member specimens to the laboratory capitated by that Member's PCP. Whether specialists obtain the specimen in their office or direct the Member to a draw site operated by one of the capitated laboratories for testing, the study must be performed by the laboratory capitated by the Member's PCP.
- 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. *Note*: If the Member does not present the requisition form when his or her blood is drawn, the Member will be billed by the drawing station.
- **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. These Providers will perform the home draw only and deliver the sample to a participating capitated laboratory (HMO) or participating laboratory/hospital (PPO). Some capitated laboratories also offer home phlebotomy for patients who reside in assisted living or non-skilled nursing homes. This service is covered only as defined by Medicare guidelines.

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

Requesting genetic testing

Genetic testing can identify alterations in an individual's genetic makeup that may indicate the possibility of risk or the presence of disease (i.e., inherited or acquired) or carrier status. Genetics is an extensive and expansive field, and due to its continuously evolving nature, a large number of genetic tests are in the research phase of development at this time.

Keep in mind the following:

- The AmeriHealth laboratory network has extensive genetic testing capabilities; therefore, Providers should refer Members only to participating laboratories for Covered Services
- In the unusual circumstance that a specific test and related services are not available through a participating laboratory, Providers must contact AmeriHealth to obtain Preapproval. Preapproval is required for use of a nonparticipating laboratory.
- When applicable under the terms of your AmeriHealth Agreement, if a Provider uses a nonparticipating laboratory for HMO Members and does not obtain Preapproval from AmeriHealth, the Provider is required to hold the Member harmless. The Provider will be responsible for any and all costs to the Member and shall reimburse the Member for such costs or be subject to claims offset by AmeriHealth for such costs.

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.

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Overview

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

Members are not capitated to a specific behavioral health site. However, for a Member to receive the highest level of benefits, behavioral health services must be coordinated by Magellan.

Note: Magellan is available 24 hours a day, 7 days a week, at 1-800-809-9954.

Emergency admissions

Preapproval for Emergency admissions is not required. When a Member is admitted as an inpatient through the emergency room/department, the hospital is required to notify Magellan within 48 hours or on the next business day.

Obtaining behavioral health services

Providers should instruct Members to call the mental health/substance abuse services telephone number on their Member ID card to access behavioral health services. Magellan will provide information for three to four Participating Providers for Members to contact for services. Members can also search for a behavioral health Provider by logging on to *www.amerihealthexpress.com*.

Preapproval and continuing authorizations are not required for routine and medication management outpatient mental health services under most AmeriHealth benefits plans. However, Preapproval is required for substance and alcohol abuse services, mental health inpatient services, Partial Hospitalization Programs, and Intensive Outpatient Programs. Members must call Magellan once an appointment has been made to ensure that the Preapproval process is properly initiated.

Benefits vary based on plan type and employer group. Not all employer groups use Magellan for behavioral health benefits. Providers should verify benefits and eligibility by contacting Magellan.

Note: When HMO, POS, PPO, and CMM Members receive services from a Magellan Provider, the Provider is responsible for obtaining any required Preapproval.

HMO/referred (in-network) POS Members

In order for HMO/referred (in-network) POS Members to receive in-network mental health and substance abuse benefits, they must use a Magellan HMO/referred (in-network) POS Provider. Members can select any participating Magellan HMO/referred (in-network) POS network Provider directly.

Almost all HMO/referred (in-network) POS inpatient, nonemergency admissions, Partial Hospitalization Programs/Intensive Outpatient Programs, and mental health and substance abuse services must be Preapproved. To Preapprove an admission or Partial Hospitalization Program/Intensive Outpatient Program, contact Magellan.

Preapproval is not required for in-network outpatient non-serious mental health visits or in-network outpatient treatment for drug dependency.

Claims submission

Mental health and substance abuse claims for HMO/referred (in-network) POS Members with Magellan as their behavioral health Provider must be submitted to:

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

For electronic claims submission, use Payer ID 01260.

PPO Members

In order for Members with PPO coverage to receive in-network mental health and substance abuse benefits, they must use the Magellan PPO Provider network.

Almost all inpatient and all in-network PPO Partial Hospitalization Programs/Intensive Outpatient Programs for mental health and substance abuse services must be Preapproved by calling Magellan.

Preapproval is not required for in-network outpatient non-serious mental health visits or in-network outpatient treatment for drug dependency.

Claims submission

Refer to the payer ID grids located at *www.amerihealth.com/edi* for the appropriate claims submission information for PPO Members.

CMM Members

Magellan also manages the mental health and substance abuse benefits for CMM Members. Almost all inpatient and Partial Hospitalization Programs/Intensive Outpatient Programs for mental health and substance abuse services must be must be Preapproved. To Preapprove an admission or Partial Hospitalization Program/Intensive Outpatient Program service, call Magellan at 1-800-809-9954.

Claims submission

Refer to the payer ID grids located at *www.amerihealth.com/edi* for the appropriate claims submission information for CMM Members.

Autism coverage

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

Covered Services include Medically Necessary occupational, physical, speech and psychological therapy, as described in a treatment plan, and behavioral interventions based on the principles of applied behavioral analysis (ABA), as described in a treatment plan. Eligible Members are also covered for related structured behavioral programs for the management of ASD.

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 for Members in Pennsylvania or New Jersey 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.

Table of Contents

Overview

This section provides information on benefits, policies, and procedures specific to obstetrical/ gynecological (OB/GYN) care, women's preventive health services, Baby FootSteps® perinatal case management, and postpartum programs, including the Mother's Option® program. Not all groups have access to all services; therefore, providers should verify Member eligibility and benefits using the NaviNet® web portal or by calling the Provider Automated System at 1-888-YOUR-AH1.

Note: OB/GYN specialists cannot be designated as the HMO/POS Member's Primary Care Physician (PCP).

OB/GYN Emergency coverage

- In emergent situations, Members should proceed directly to a hospital for treatment. HMO/POS Members are instructed to call their PCP (or OB/GYN Provider if pregnant) for instructions in nonemergent situations. The OB/GYN Provider may act as the referring Physician during pregnancy for pregnancy-related conditions.
- Be aware that Member Copayments for emergency room/department (ER) visits (emergent or nonemergent*)* are generally higher than office visit Copayments.

Direct Access OB/GYN℠ for HMO/POS Members

Direct Access OB/GYN allows HMO/POS Members to receive services from any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife
- reproductive health centers
- abortion centers
- mammography centers (screening and diagnostic mammograms and follow-up ultrasounds only)

Although no PCP or OB/GYN Referrals are required when services are provided by network OB/GYN Providers, OB subspecialists, or certified nurse midwives (CNM), plan and specific group restrictions may apply. Check the Member's benefits before providing the following services:

- abortion
- assisted infertility services
- Depo-Provera®
- diaphragm fitting
- intrauterine device (IUD) insertion and removal for contraception

- contraceptive implant insertion and removal
- tubal ligation

OB/GYN electronic Referrals

- OB/GYN Providers, CNMs, and OB/GYN specialists may send HMO/POS Members for additional services.
- Referrals must be sent and retrieved using NaviNet.
- The *OB/GYN Referral Request Form*, available on NaviNet, must be used for the following services:
  - pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans; see "OB/GYN capitation requirements for HMO Members" below for more information;
  - initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).
- OB/GYN Referrals are valid for 90 days from the date of issue.
- Referrals are valid for eligible HMO Members. Members are responsible for payment if they are not eligible HMO Members on the date services are rendered.

AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements.

OB/GYN capitation requirements for HMO Members

There are no capitated programs for PCPs in certain counties in New Jersey. Check the Member's ID card or Eligibility Details screen on NaviNet for more information.

If capitation applies to the Member, adhere to the following procedures:

- Laboratory:
  - All routine laboratory work must be sent to the PCP's capitated laboratory site. The Member's capitated laboratory is indicated on her Member ID card. Further information is also available on NaviNet.
  - Both a Referral and laboratory requisition form must be issued if your patient chooses to receive services at a participating laboratory site other than her PCP's capitated site.
- Ultrasounds:
  - If your patient chooses to receive services at a participating radiology site, other than the PCP's capitated site, a Referral is required. OB/GYN offices and antenatal testing units are not considered part of the HMO radiology network and may not be used for general ultrasound.
  - Nuchal translucency screening ultrasounds (first trimester screening) must be performed by ultrasound units certified for the study. Visit the Nuchal Translucency Quality Review Program website at *www.ntqr.org*. Verify certification before issuing a referral. Participating laboratories provide the accompanying blood tests; therefore, there is no need to send Members out-of-network for these tests.
  - High-risk or follow-up ultrasounds, testing, and consultations for high-risk OB patients may be sent directly to a network HMO maternal fetal medicine Provider without Preapproval.

- Radiology:
  - Diagnostic or screening mammograms and follow-up ultrasounds may be performed at any participating site.
  - Sonohysterograms and hysterosalpingograms are not included in capitation and may be scheduled at any participating radiology facility.
  - If your patient chooses to receive services you have authorized from a Participating Provider or facility other than the PCP's capitated site, a Referral is required.

Preapproval requirements

Prenotification of maternity care and Preapproval of the hospital length of stay is not required.

All requests for services from a nonparticipating Provider must be Preapproved for HMO Members. Referrals to a nonparticipating facility or Provider are not accepted electronically.

- If you determine that a nonparticipating Provider is needed for your patient, submit the request through NaviNet or call Customer Service.
- POS and PPO Members have the option to receive care from an out-of-network Provider but will incur a higher out-of-pocket cost.
- To request an exception for services to be covered at the Member's in-network level, Preapproval is required.

Certain services may require Preapproval, depending on benefits coverage. Go to *www.amerihealth.com/preapproval* for a list of services that require Preapproval.

Please note the following:

- Hospital admissions, other than maternity/surgical procedures require Preapproval. Also note the following:
  - Except for deliveries, the admitting Physician is responsible for obtaining Preapproval at least five days prior to the scheduled admission and notifying the facility of the Preapproval number.
  - A separate Referral to a participating hospital is not required for hospital admissions for participating OB/GYN Providers. The hospital must contact us prior to the admission to verify Member eligibility and the Preapproval number.
- Pre-admission testing and hospital-based Physician services (e.g., anesthesia) are covered under the hospital Preapproval.

Women's preventive health services

Annual gynecological exam

The following services are components of a routine, preventive OB/GYN visit:

- breast examination;
- limited screening history and examination;
- physical exam (breast, abdomen, pelvic, and rectal);
- counseling regarding contraception, human sexuality and dysfunction, menopause, and sexually transmitted diseases;
- Pap test;
- pelvic examination;

- specimen collection and wet mount.

Copayments for routine and nonroutine services

When a Member visits your office for GYN services, you should collect the appropriate Copayment. To verify the correct Copayment, refer to the Member's ID card and NaviNet.

As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), there is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Claim Payment Policy #00.06.02: Preventive Care Services, which includes the list of applicable preventive codes, is available on NaviNet or at *www.amerihealth.com/medpolicy*.

Therefore, in most circumstances for routine annual GYN visits, Copayment should not be collected. However, in cases where *both* a routine annual screening *and* specific problem-focused Evaluation and Management (E&M) services are delivered during the same visit, both routine and nonroutine Copayments may apply. Bill separately for the problem-focused E&M visit only if the services you rendered beyond the preventive visit separately meet Current Procedural Terminology (CPT®) criteria for the E&M code.

Note: Documentation in the medical record must support the services billed.

Contraceptive services

Under Health Care Reform, AmeriHealth is required to pay the cost of certain contraceptive services for eligible Members within non-profit religious organizations. These Members will receive a separate ID card that indicates "Contraceptive Coverage." Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic equivalent under the pharmacy benefit at retail and mail order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an AmeriHealth prescription drug plan.

Requirements/restrictions by State and product line

HMO and POS Members (Split and Plus)

- For covered routine and nonroutine gynecological exams, female Members have the option of coordinating care through their PCP or by self-referral to a Participating OB/GYN Provider, reproductive health center, or CNM.
- All initial Referrals for services related to GYN care may be ordered by the specialist through NaviNet without a Referral from the PCP.
- AmeriHealth POS Plus and HMO Plus Members are exempt from all Referral requirements.

PPO Members

- The highest benefits level is available when network radiology and laboratory sites are used.
- Members may visit any participating specialist without a Referral.
- Members are eligible for one preventive GYN exam and one routine screening Pap test every calendar year.

Medicare Advantage HMO Members

Members have coverage for one routine GYN exam and Pap test annually.

Reimbursement above examination fees

The following procedures are eligible for separate reimbursement (if they are a covered benefit for the Member) when performed during a routine GYN exam:

- administration of Depo-Provera®
- endometrial biopsy
- office ultrasound ONLY with diagnosis of "rule out ectopic pregnancy" (for HMO Members only)
- contraceptive implant insertion and removal*
- diaphragm fitting*
- IUD insertion and removal*

For more information on ultrasounds for New Jersey Members, refer to the *Billing* section of this manual.

**This is not a standard PPO benefit. In addition, some HMO groups do not cover these procedures. However, all contraceptives are covered for Members whose groups are subject to the New Jersey contraceptive mandate. Verify eligibility through NaviNet or the Provider Automated System.*

Breast cancer screening

Mammography screening reminder program

An annual reminder to schedule a yearly mammogram is sent to female managed care Members who are turning 40 as well as females ages 42 through 69 who haven't had a mammography in the last 18 months.

Mammography Referral requirements

Referrals are not required for screening and/or diagnostic mammography from an accredited in-network radiology Provider. Breast ultrasounds also do not require a Referral and may be performed by a participating radiology site or outpatient department of a hospital. Note the following:

- Certain radiology facilities may require a physician's written prescription. You may need to communicate this to your HMO Members asking about mammography. Be sure to provide a prescription for the mammography study if this is a requirement of the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to render mammography services to our Members.
- In northern New Jersey*, HMO Members may have follow-up X-ray studies, ultrasounds, and MRIs at any participating radiology site. Refer to the *Specialty Programs* section for guidelines on radiology.
- In southern New Jersey†, HMO Members may have follow-up X-ray studies at any participating radiology site. Follow-up ultrasounds and MRIs may also be done at any participating radiology site. A valid Referral is required if these procedures are performed at a site other than the capitated site.
- All MRIs require precertification through AIM Specialty Health® (AIM). Refer to the *Specialty Programs* section for additional information about AIM.

**Counties that comprise northern New Jersey are: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren.*

†Counties that comprise southern New Jersey are: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.

Breast Cancer Risk Assessment Tool

Based on the Gail Model, the Breast Cancer Risk Assessment Tool is a computer program developed by the National Cancer Institute that estimates a woman's five-year and lifetime risk of developing breast cancer. The tool is available on *www.amerihealth.com/providers* by selecting *Resources for Patient Management* from the Providers drop-down menu, then *Internet Resources*. Women are advised to discuss their individual risk factors and options for prevention and treatment with their health care Providers. Women who are identified as high-risk may be offered chemoprophylaxis against breast cancer.

Cervical cancer screening

We provide coverage for standard Pap test and liquid-based Pap test technologies, such as ThinPrep® and SurePath®, and for other appropriate studies and procedures, including human papillomavirus (HPV) viral typing. The Member may be responsible for office visit Copayments, and the Member's health plan benefits may be based on specific time frames. For coverage questions, Members should contact Customer Service at the telephone number on their ID card.

We also mail educational materials about the importance of Pap tests to our female managed care Members, ages 21 and older, for whom we have no record of a Pap test within a specified time frame.

Osteoporosis screening

Bone mineral density testing is covered according to Medical Policy #09.00.04: Bone Mineral Density (BMD) Testing, but no more frequently than every two years, except for specific situations. Visit *www.amerihealth.com/medpolicy* to view this medical policy.

To learn about FRAX® (World Health Organization Fracture Risk Assessment Tool), go to *www.shef.ac.uk/FRAX*.

Assisted reproductive technologies coverage

- Verify a Member's benefits coverage through NaviNet or the Provider Automated System. Not all groups are included in the State infertility mandate.
- No Referral is necessary for assisted reproductive technologies (ART) services. Members may be sent by either their PCP or OB/GYN Provider, or they may schedule a visit with the specialist.

Maternity care

First trimester prenatal care correlates well with good maternity outcomes. We urge you to schedule first visits with your pregnant AmeriHealth Members within the first trimester so that folic acid and appropriate counseling can be provided. In addition, we ask you to encourage your pregnant AmeriHealth members to self-enroll in our Baby FootSteps® maternity program by calling 1-800-313-8628, prompt 3.

Notifications of fetal loss

AmeriHealth does not require prenotification of maternity care. However, in the event of an interrupted pregnancy (miscarriage or termination), for a member who is enrolled in Baby FootSteps, please notify us as soon as possible by calling 1-800-313-8628, prompt 3, so we can discontinue maternity-related calls and educational mailings.

Performing antepartum ultrasounds

HMO Members

- Maternal fetal medicine specialists may perform ultrasounds in the office for patients with high-risk pregnancies.
- OB/GYN Providers may perform limited abdominal and transvaginal ultrasounds to rule out ectopic pregnancies. No Preapproval is required if the ultrasound is billed with the appropriate diagnosis code. See the *Billing* section for more information.

PPO Members

- OB and maternal fetal medicine specialists may perform ultrasounds in their offices as medically appropriate.
- Preapproval is not required.

OB services paid above the global fee

OB Providers may perform the following OB services in their offices and be paid above the global fee (or refer to in-network Providers with OB/GYN Referrals):

- glucose tolerance test
- non-stress test
- amniocentesis
- RhoGAM®
- tubal ligation
- 17-alpha hydroxyprogesterone caproate with Preapproval through *www.amerihealth.com/directship*
- external cephalic version
- CNMs*

Note: The home birth global fee includes postpartum home visits.

**CNMs performing home births are eligible for a site-of-service differential.*

Postpartum office visits

Postpartum visits should be scheduled 21 to 56 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing of new mothers and to safely prescribe contraception, if necessary. It also meets National Committee for Quality Assurance guidelines for postpartum care. Visits should be clearly labeled "postpartum care." Members should schedule postpartum visits prior to discharge from the hospital.

Delivery out of the service area

- **HMO Members.** If Members do not deliver in the service area, they must call the Customer Service number on their ID card. Some services may not be fully covered if performed out-of-network.
- **POS Members.** Members have the option to deliver out-of-network and/or out of the service area, but they will be subject to Deductibles and Coinsurance.
- **PPO Members.** Members may access care outside of the service area from out-of-network Providers. Out-of-network services are subject to out-of-network cost-sharing (i.e., Deductible/Coinsurance).

Baby FootSteps® maternity program

Our maternity program is designed to educate all pregnant AmeriHealth Members about pregnancy and preparing for parenthood. The program also helps to 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 OB nurse case managers provide telephone support to our Members and their Physician or midwife to help coordinate their benefits and provide information they need for the healthiest delivery possible.

Note: Some value-added services covered under this program are enhancements to the standard Member benefits and are therefore subject to change at any time upon notice.

Encourage your AmeriHealth patients to self-enroll

Ensuring that maternity Members are enrolled in our Baby FootSteps high-risk perinatal program is imperative for early outreach. We ask that you inform AmeriHealth Members about the Baby FootSteps program and encourage them to call our toll-free number 1-800-313-8628, prompt 3, and leave a message requesting enrollment. During the return call, a case manager will explain the program to the Member and ask her a series of questions to complete the enrollment process.

Our case managers use the information as a means for identifying, tracking, and risk-stratifying all pregnant Members for care management and coordination.

If in subsequent prenatal visits you discover that a maternity Member has not yet self-enrolled in Baby FootSteps, or you feel that she may benefit from case management due to a high-risk pregnancy, you can refer the Member to the program by completing an online physician referral form at *www.amerihealth.com/providerforms*. When you submit this form, we will make certain that Members who need additional support are encouraged to enroll in case management. You can also call 1-800-313-8628 to refer a high-risk maternity Member for case management.

Educational materials

Baby FootSteps materials focus on education. Once enrolled, mothers-to-be will receive a packet detailing information about good self-care during pregnancy and its impact on mother and baby and about potential problems during pregnancy. Benefits information is also provided.

The packet also includes offers for reimbursements for:

- parenting classes (e.g., childbirth preparation, lactation, sibling, exercise), up to $50;*
- lactation consultation, $100 per pregnancy for one visit with any International Board Certified Lactation Consultant (IBCLC).*

Additionally, Members can receive exclusive discounts on the *Saving Baby's Cord Blood*® storage program from CorCell®.

Members may also participate in the following:

- Quit&Fit® tobacco cessation program (see *Free tobacco cessation program*);
- Mother's Option® program (see *Postpartum programs*).

Risk assessment

Members are screened for risk by our case managers during the enrollment process for Baby FootSteps and then are screened again at 28 weeks into their pregnancy by telephone if they are enrolled in case

management. An OB nurse case manager is available to talk to Members, answer questions, and assist with their care throughout their pregnancy.

If complications are detected, Members can expect:

- personalized OB nurse case management;
- individualized education on how to reduce risk factors;
- periodic assessments throughout their pregnancy;
- coordination of home care services as Medically Necessary and ordered by doctor or midwife.

Pregnancy depression screening

A targeted program screens pregnant women enrolled in case management around their 28th week for risk factors associated with depression. Your office may receive calls regarding those Members who screen positive on the 28th week questionnaire or who are judged to be at risk during any other intervention. Case managers will assist you with triage and Referrals to the Member's behavioral health Provider or to Emergency services as required.

Antenatal/Antepartum care

Antenatal case management programs are available for, but not limited to, the following:

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

In addition, the following antepartum services are available:

- skilled nursing visits, which may include:
  - 17-alpha hydroxyprogesterone caproate injections for women who are at complete bed rest and have a history of preterm delivery;
  - self-injection techniques for insulin, heparin, and others;
  - home blood glucose, blood pressure, and urine monitoring;
  - betamethasone injections (initial set only, repeat injections require Medical Director approval);
- nutritional consults/evaluations;
- social service evaluations;
- DME.

Preapproval review of antepartum home care services

Call the appropriate perinatal home health agency for them to obtain Preapproval review of all antepartum home care programs/services, such as, but not limited to:

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

The perinatal agency will then obtain orders for all care to be rendered from the attending Physician/CNM.

Case managers are available to provide support during regular business hours, 8 a.m. to 5 p.m., Monday through Friday by calling 1-800-313-8628.

Free tobacco cessation program

We have teamed up with American Specialty Health to provide a free, comprehensive tobacco cessation program called Healthyroads Quit&Fit®. This program is designed to provide maximum counselor intervention and support and to enhance office-based intervention.

Features of the program include:

- tobacco cessation manual and stress-tobacco connection CD;
- information for mothers-to-be describing the benefits of quitting smoking;
- up to four telephone sessions per month for 12 months, including kick-off, pre-quit, and general assessment sessions;
- a toll-free phone number for calls any time for counselor support;
- lifetime access to *www.quitandfit.com*, which includes online self-guided coaching modules, tools, and trackers for monitoring progress in meeting goals related to tobacco cessation; articles and video classes on a variety of tobacco cessation topics; and an electronic message center to ask questions, receive electronic guides, and receive support from a tobacco cessation coach.

Quit&Fit programs, conducted by experienced, specially trained counselors, are periodically reviewed and evaluated by an editorial board comprised of qualified health professionals.

Pregnant Members can contact a case manager for more information or self-enroll by calling Healthyroads Quit&Fit at 1-877-330-2746.

Quit&Fit is a federally registered trademark of American Specialty Health Incorporated.

Postpartum programs

Mother's Option® program

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

Shortened length of stay (managed care Members)

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 preapproval*, but they 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*, but it 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 preapproval*, 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 Members)

When the standard length of stay is 48 hours (vaginal) or 96 hours (cesarean), one home health visit is available if desired by the Member/Provider. This visit *does not require preapproval*, but it 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.

If additional home health visits are Medically Necessary beyond the described Mother's Option visits, these must be preapproved by calling 1-800-313-8628.

CMM Members. Members who opt for less than 48-hour discharge for vaginal delivery and less than 96 hours for cesarean section are eligible for one home care visit. Prenotification for this visit must be done by calling the maternity department as previously noted.

Individual Health Coverage Basic Plan Members. Members do not have a benefit for home care. Therefore, no postpartum home visits are available.

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 and include:

- wound/incision checks and wound care as needed
- bilirubin checks and home phototherapy
- infant assessments
- blood pressure checks
- IV antibiotics
- home physical therapy

Lactation support programs and breast pump reimbursement through AmeriHealth Healthy Lifestyles℠

- Lactation support services include information about valuable community resources, educational websites, or certified lactation consultants.
- Members may self-refer to any IBCLC and receive a $100 reimbursement through AmeriHealth Healthy Lifestyles℠. Members may submit a receipt listing the date of the visit and the consultant's IBCLC Certification number within 90 days after delivery.
- Case managers are available for initial breast feeding support by telephone. Additionally, they will be able to evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB Provider).
- Managed care Members who obtain a manual/mini-electric breast pump at pharmacies or baby supply stores may submit their receipt to AmeriHealth Healthy Lifestyles for reimbursement up to $50 within 90 days after delivery.
- Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network Provider:
  - detained premature newborn;

- infants with feeding problems that interfere with breast feeding (e.g., cleft palate/cleft lip).

Breast pump coverage under Health Care Reform

As required by the Patient Protection and Affordable Care Act (ACA), Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME Provider with no Member cost-sharing.

Note: The rental of hospital-grade breast pumps requires approval for Medical Necessity. Rentals are available at no cost-sharing only for those Members who require the use of a hospital-grade pump. If approval is obtained for Medical Necessity, Member cost-sharing will not be applied when the Member rents the breast pump from an in-network DME Provider.

Lactation support and counseling under Health Care Reform

Lactation support and counseling, by a trained provider during pregnancy, and/or in the postpartum periods, is currently covered during an inpatient maternity stay as part of an inpatient admission, the postpartum Mother's Option visit, and through the OB postpartum visit and/or pediatrician well-baby visit.

Preapproval for home phototherapy

Preapproval is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be Preapproved.

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Overview

Our Health Management department plans and implements programs that support Members and help Providers achieve the best management of their patients' health. Our preventive health and wellness programs support your efforts to identify and protect your patients against health problems before they develop. Our preventive health initiatives promote:

- regular wellness visits;
- preventive health screenings;
- immunization programs for children, adolescents, and adults;
- healthy behaviors.

Commit2Wellness Programs

The AmeriHealth New Jersey Commit2Wellness programs are designed to help your patients and their families stay well, prevent illness, and benefit from healthy lifestyle choices. From offering incentives to Members to make smart lifestyle choices, to providing them with individualized solutions and information on health issues, we help your AmeriHealth patients understand and follow your treatment plans.

Commit2Wellness℠ Rewards (commercial)

AmeriHealth New Jersey offers an incentive program – Commit2Wellness Rewards – that provides commercial Members with an opportunity to earn Wellness Dollars for healthy behavior. The Commit2Wellness Rewards program replaces the AmeriHealth Healthy Lifestyles℠ program for most AmeriHealth New Jersey Members.

Through the Commit2Wellness Rewards program, eligible Members receive Wellness Dollars upon completion of certain healthy activities, such as having an office visit with their Primary Care Physician or gynecologist, engaging in fitness activities, or attending two nutrition counseling sessions with a registered dietitian.

To redeem Wellness Dollars, Members must first complete an online Personal Health Profile. Completion of this activity alone will earn the Member 25 Wellness Dollars that can be redeemed for debit or gift cards to a variety of retailers. Each Wellness Dollar is worth one actual dollar.

Examples

- **Fitness.** Members can earn 100 Wellness Dollars for engaging in 30 minute sessions of physical activity least three (3) times a week.
- **Weight Management.** Members can earn 100 Wellness Dollars by attending an approved weight-loss program.
- **Tobacco Cessation.** Members can earn 100 Wellness Dollars upon completing a program to stop smoking.
- **Nutrition Counseling.** Members can earn 50 Wellness Dollars for attending two nutrition counseling visits with a registered dietician or Physician.

Members can call 1-888-YOUR-AH1 for more information about the requirements necessary for these incentive programs.

Case management program (commercial)

Case management is a collaborative process that provides eligible commercial Members with health management support through coordinated programs for those 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:

- Alzheimer's/dementia
- autoimmune disorders
- bone marrow/primary stem cell transplant
- cancer (breast, cerebral, colorectal, lung, ovarian, prostate, rare cancers)
- comprehensive complex case management
- cerebrovascular accident
- complex pediatric medical conditions
- frequent admissions for same or similar conditions
- frequent falls/safety issues
- hepatitis C
- joint replacement
- mechanical ventilator
- medication issues, including non-adherence
- Member requiring multiple services in the home
- multiple sclerosis
- neurolomuscular disease (Huntingdon's disease, neurological trauma)
- nutritional deficits
- post-neonatal intensive care
- sickle cell disease
- wound/skin

To refer a commercial 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 commercial 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.

Connections℠ Health Management Program (commercial)

The Connections Program is designed to support your relationships with our commercial Members and to enhance your ability to provide evidence-based care. Recognizing that the Physician-patient relationship is at the heart of patient care, this program has been designed to:

- enhance your ability to provide integrated care for your patients;
- provide Members with evidence-based information so they can understand their diagnoses and their health care options, while actively participating in health care decision-making with you;
- promote integration of care among Members and their families, Physicians, health plan case managers, and community resources;
- provide you with opportunities to improve the effectiveness of testing and treatment compared to national benchmarks.

All commercial Members covered through fully insured employer groups are automatically considered eligible for the Connections Program. Commercial Members covered through certain self-insured employer groups may not be eligible for the program. Members can call Customer Service at 1-888-YOUR-AH1 to verify their eligibility. The Connections Program actively reaches out to commercial Members with identified clinical needs who may benefit from personal health education and support. Eligible commercial Members have access to the program, 24 hours a day, 7 days a week, by calling 1-888-YOUR-AH1.

The Connections Health Management Program is based on objective, evidence-based information from nationally recognized sources. It is provided on a voluntary basis, at no charge to the Member.

Disease management and decision support

Disease management is a process that involves identifying and supporting commercial Members who have certain chronic conditions: asthma, heart failure (HF), coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes. Management of these conditions, through education and support, may be associated with improved health care outcomes. Connections provides commercial Members with educational materials and personal health coaching from trained clinical professionals to help them learn self-care skills and adhere to the treatment plans they develop with their Physicians. The program also places special emphasis on the importance of managing the comorbidities that exist in many patients with a chronic condition.

Decision support services are also offered to eligible commercial Members who are facing treatment decisions related to conditions such as back pain, benign uterine bleeding, osteoarthritis, breast and prostate cancer, CHD, depression, chronic pain, and weight-loss surgery. Health Coaches provide objective, evidence-based information to help patients understand their diagnoses, their available treatment options, and the potential benefits and risks of each option, taking into consideration the Member's preferences. More importantly, Health Coaches help Members work effectively with their Physicians to make *shared decisions* that are right for them. Shared Decision-Making® DVDs are also available, when applicable, at no charge to Members.

Note: Benefits may vary based on State requirements, benefits plan (HMO, PPO, etc.), and/or employer group. Member coverage can be verified by calling Customer Service at 1-888-YOUR-AH1.

**Members covered through self-insured employer groups may not be eligible for the program.*

Keeping Providers informed and connected

Connections Program information is communicated in a variety of ways, including through *Partners in Health Update*SM and the NaviNet® web portal. Physicians can reach Connections by calling 1-888-YOUR-AH1 to communicate any feedback or concerns, request individual Member information, or to refer a commercial Member for health coaching.

The Connections program is based on open and collaborative communication among you, your patients, and Connections Health Management Program staff.

Health coaching

Registered nurse Health Coaches are available through our condition management and case management programs to enhance your ability to provide coordinated care for your Medicare Advantage HMO patients and promote integration of care among these Members and their families, Physicians, and community resources.

Condition management (Medicare Advantage)

To help keep our Medicare Advantage HMO Members healthy, we offer condition management on a voluntary basis at no charge to the Member. Our condition management program is designed to support your relationships with your Medicare Advantage HMO patients and to enhance your ability to provide evidence-based care. Recognizing that the Physician-patient relationship is at the heart of patient care, this program has been designed to:

- enhance your ability to provide integrated care for your Medicare Advantage HMO patients;
- provide Medicare Advantage HMO Members with evidence-based information so they can understand their diagnoses and their health care options, while actively participating in health care decision-making with you;
- promote integration of care among Medicare Advantage HMO Members and their families, Physicians, Health Coach, social workers, and community resources;
- provide you with opportunities to improve the effectiveness of testing and treatment compared to national benchmarks.

Condition management helps to identify and support Members who have certain chronic conditions, including the following:

- asthma
- chronic kidney disease
- chronic obstructive pulmonary disease (COPD)
- coronary artery disease (CAD)
- diabetes
- gastro-esophageal reflux disease (GERD)
- heart failure
- high-risk pregnancy
- HIV
- hyperlipidemia
- hypertension
- inflammatory bowel disease
- maternity management
- metabolic syndrome
- migraine
- musculoskeletal pain
- peptic ulcer disease

Management of these conditions, through education and support, may be associated with improved health care outcomes. Our condition management program offers Medicare Advantage HMO Members

educational materials and personal health coaching from registered nurses to help them learn self-care skills and adhere to the treatment plans they develop with their Physicians. The program also places special emphasis on the importance of managing the comorbidities that exist in many patients who have a chronic condition.

AmeriHealth New Jersey Health Coaches actively reach out to Medicare Advantage HMO Members with identified clinical needs who may benefit from personal health education and support. Eligible Medicare Advantage HMO Members have access to the program 24 hours a day, 7 days a week, by calling 1-800-275-2583. Physicians can also call Health Coaches at 1-800-275-2583 to communicate any feedback or concerns, request individual Member information, or refer a Medicare Advantage HMO Member. Messages are returned within two business days.

Note: Member benefits may vary based on State requirements, benefits plan (HMO, PPO, etc.), and/or employer group. All Medicare Advantage HMO Members covered through fully insured employer groups are automatically considered eligible for condition management. Medicare Advantage HMO Members covered through self-insured employer groups may not be eligible for the program. Providers and Medicare Advantage HMO Members can call Customer Service at 1-800-275-2583 to verify program eligibility.

Visit *www.amerihealth.com/providerconnections* to view Provider rights and responsibilities.

Case management program (Medicare Advantage)

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

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

When a Medicare Advantage HMO Member is referred to case management, his or her Health Coach will contact your office to offer support, with the goal of helping the Member reach the medical treatment goals you have established. The Member's Health Coach 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 and health coaching include, but are not limited to, the following:

- Alzheimer's/dementia
- autoimmune disorders
- bone marrow/primary stem cell transplant
- cancer (breast, cerebral, colorectal, lung, ovarian, prostate, rare cancers)
- comprehensive complex case management
- cerebrovascular accident
- complex pediatric medical conditions
- frequent admissions for same or similar conditions
- frequent falls/safety issues
- hepatitis C
- joint replacement
- mechanical ventilator
- medication issues, including non-adherence
- Member requiring multiple services in the home
- multiple sclerosis
- neurolomuscular disease (Huntingdon's disease, neurological trauma)
- nutritional deficits
- post-neonatal intensive care
- sickle cell disease
- wound/skin

To refer a Medicare Advantage HMO Member to case management, complete the online Physician referral form at *www.amerihealth.com/providerforms.* You may also refer a Medicare Advantage HMO Member by calling us at 1-800-275-2583.

A Health Coach will call your office to discuss the referral with you – it's that simple. 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 to establish, case management will end. The Health Coach will notify you when this has been achieved.

Preventive health initiatives

The Health Management department offers population-based initiatives with the objective of improving patient health outcomes through adherence to nationally recommended preventive health guidelines. These initiatives use various Member and Provider reminders and tools to improve compliance for preventive health services. Some of the preventive initiatives and tools are described within this section.

The *Resources for Patient Management* section of our website, *www.amerihealth.com/providers*, includes direct links to screening tools as well as worksheets and tracking forms for Providers. These tools can help track current and future health screening needs.

Preventive health outreach

We promote recommended preventive services and tests to targeted Member populations. The objective of these population-based initiatives is to improve the adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. We may vary the topics and timing as new evidence-based recommendations are issued and according to population care gaps. Our outreach programs include breast, cervical, and colorectal cancer screening.

Vaccine information statements (VIS)

A VIS is an information sheet – produced by the Centers for Disease Control and Prevention (CDC) in compliance with the National Childhood Vaccine Injury Act of 1986 – which requires that a VIS be used to inform vaccine recipients or their parents about the benefits and risks of vaccines. A VIS must be provided, prior to administration, for any vaccine that is covered under the Vaccine Injury Compensation

Program. The following VIS forms must be used: DTaP, Td, MMR, polio, hepatitis B, Hib, varicella, and pneumococcal conjugate. You must also record which VIS was given, the date the VIS was given, and the VIS publication date.

For copies of VIS forms, visit the CDC website at *www.cdc.gov/vaccines/pubs/VIS*.

Nutrition counseling benefit

Most commercial managed care Members are eligible for up to six fully covered one-on-one nutrition counseling sessions with a participating registered dietitian or primary care Provider per benefit contract year. The purpose of the six nutrition counseling visits is to support our Members in establishing good eating habits that will contribute to a healthier lifestyle. Primary Care Physicians (PCP) may bill for nutrition counseling services above capitation.

A nutrition counseling visit could include:

- an assessment of dietary habits;
- the use of measurement tools, such as the BMI, to assess risks;
- development of strategy and goals to achieve dietary changes;
- ongoing support to maintain dietary changes and re-evaluate goals;
- guidance toward an appropriate exercise program.

HMO Members must use an in-network Provider to take advantage of these benefits and do not need a Referral for these services. PPO and POS Members may use an out-of-network Provider subject to applicable Deductibles and Coinsurance. For all Members, Copayments do not apply when using an in-network Provider for these nutritional counseling services.

Nutrition counseling in a group setting is not eligible for payment. Providers should not bill for medical nutrition therapy with the following codes: 97804, G0271. Only diabetic education services rendered by Providers who are certified by the American Diabetes Association® are eligible for payment with these codes.

Note: Only certain Providers (i.e., PCPs or registered dietitians) are eligible to provide nutrition counseling services. Appointments with nutritionists are not a covered benefit.

Participating registered dietitians can be found using the Provider Finder on our website at *www.amerihealth.com* and also on NaviNet by selecting *Reference Tools* from the Plan Transactions menu, then *Provider Directory*.

Women's health

Baby FootSteps®

Our award-winning maternity program is designed to educate all pregnant Members about pregnancy and preparing for parenthood.

Saving Baby's Cord Blood®

Saving Baby's Cord Blood, through CorCell®, provides Members with the opportunity to preserve blood from their newborn baby's umbilical cord. CorCell offers Members exclusive discounts and convenient payment plans on the collection and storage of cord blood.

For more information on these programs, refer to the *OB/GYN* section of this manual.

Family health

Health Resources for Adoptive Parents and Guardians

For parents who have recently adopted a child, or for those considering adoption, health and safety are important issues. Our *Health Resources for Adoptive Parents and Guardians* booklet provides important information about health, development, immunizations, home and child safety tips, nutrition, bonding and attachment, choosing a daycare or preschool, and adding children to your health insurance plan. Members can download the booklet from our secure Member website, *amerihealthexpress.com*.

Good 2 B Me website

The *Good 2 B Me* website informs preteens and adolescents between the ages of 11 and 17 about major physical, emotional, and social issues. It helps them gain the confidence to make smart choices for their health today and in the years ahead. The site includes information on the following:

- adolescent immunizations and the crucial role they play in protecting kids' health;
- BMI and weight categories, exercise, nutrition, eating disorders, and substance abuse;
- tips and articles for parents on a wide range of adolescent health topics.

We ask that you refer your patients – parents and kids alike – to *www.amerihealth.com/good2bme* where they can find helpful information about preteen and adolescent health issues.

Personal Health Profile

The interactive, online Personal Health Profile (PHP) can help Members identify and learn about possible health risks; discover opportunities for improving overall well-being; and connect to other health resources. Once a Member completes the PHP, he or she will receive a customized summary report that contains an overall health score of 0 to 100. The report includes health risks and suggests ways to increase the PHP score. The PHP is available on our secure Member website, *www.amerihealthexpress.com*.

SilverSneakers®

AmeriHealth New Jersey offers a fitness benefit – Healthways SilverSneakers Fitness Program – to eligible Medicare Advantage HMO Members. SilverSneakers delivers innovative physical activity and social interventions to attract members and keep them engaged in improving their health. The program provides a basic fitness membership that allows participants to:

- access more than 11,000 fitness locations nationwide, including women-only sites;
- use exercise equipment and other amenities such as pools and walking tracks;
- take signature SilverSneakers group fitness classes designed specifically for active older adults and led by certified instructors;
- learn about relevant health topics;
- participate in fun social activities and events;
- receive guidance and assistance from a SilverSneakers Program Advisor™, a dedicated staff member at the fitness location.

Each eligible Medicare Advantage HMO Member receives a mailing from SilverSneakers that includes their personal member ID card and a list of the four fitness locations closest to their home. Members can simply take the ID card to the location of their choice and present it at the front desk. Members who have either not received an ID card or may have misplaced it can call 1-888-423-4632 (TTY: 711), Monday

through Friday, 8 a.m. to 8 p.m. ET, to request that a new ID card be mailed and to obtain their SilverSneakers ID number, which can be used at the location until the new ID card arrives in the mail.

Note: SilverSneakers is a benefit offered to AmeriHealth 65® NJ HMO and AmeriHealth 65® Preferred HMO Members at no additional cost. Medicare Advantage HMO Members who are eligible for the SilverSneakers Fitness Program may not participate in the AmeriHealth Healthy Lifestyles fitness reimbursement program.

Clinical Practice Guidelines

The *Clinical Practice Guidelines* utilize a generally accepted minimum standard of care in the medical profession. Adherence to these guidelines may lead to improved patient outcomes. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, we suggest that you update your practice accordingly.

The guidelines are updated annually based on changes made to nationally recognized sources. Before being incorporated into the guidelines, changes are reviewed by internal and external consultants, as appropriate, and AmeriHealth quality committees.

The *Clinical Practice Guidelines* are available on our website at *www.amerihealth.com/clinicalguidelines*. You may also call the Provider Supply Line at 1-800-858-4728 or use the online request form at *www.amerihealth.com/providersupplyline* to obtain a printed copy.

Note: The guidelines are not a statement of benefits. Benefits may vary based on State requirements, benefits plan (HMO, PPO, etc.), and/or employer group. Member coverage can be verified by calling Customer Service at 1-888-YOUR-AH1.

Table of Contents

Overview

Our pharmacy benefits managers, FutureScripts® and FutureScripts® Secure, handle the administration and claims processing of the AmeriHealth prescription drug programs. As part of our commitment to comprehensive coverage, we offer a wide range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics Committee was formed to oversee our pharmacy policies and procedures and to promote the selection of clinically safe, clinically effective, and economically advantageous medications for our Members. The Committee is comprised of internal and external clinical pharmacists and Physicians in a variety of specialties.

The Pharmacy and Therapeutics Committee periodically reviews and evaluates our drug formularies to ensure their continued effectiveness, safety, and value. The Committee meets on no less than a quarterly basis to review and update the formularies. Physicians are notified of these changes through *Partners in Health Update*℠.

Before you prescribe to Members, we recommend that you become familiar with this section. In it, you will find information about our prescription drug programs, formularies, and prior authorization process.

Prescription drug programs

Select Drug Program®

The Select Drug Program is an incentive-based formulary that includes generic drugs and a defined list of brand drugs. The program is set up with a three-tiered cost-sharing structure: generic formulary, brand formulary, and non-formulary brand. Generic formulary drugs are covered at the lowest formulary level of cost-sharing, brand formulary drugs are covered at a higher formulary level of cost-sharing, and non-formulary brand drugs are covered at the highest non-formulary level of cost-sharing. Coverage for drugs is based on the Member's Benefits Program.

Standard Drug Program

The Standard Drug Program is an open formulary drug program. It consists of a two-tiered Copayment structure, with the generic Copayment being lower than the brand Copayment. However, flat Copayment and Coinsurance options are also offered. Coverage for drugs is based on the Member's Benefits Program, which includes exclusions and other pharmacy edits.

Deductible/Coinsurance Drug Program

- **For Pennsylvania and Delaware Members.** The Deductible/Coinsurance Drug Program is an open formulary program with increased Member cost-sharing. The program includes an up-front Deductible (per person, per calendar year) and Coinsurance, combined with an annual out-of-pocket maximum. Coverage for drugs is based on the Member's Benefits Program, which includes exclusions and other pharmacy edits.
- **For New Jersey Members.** The Deductible/Copayment Drug Program is an open formulary program with increased Member cost-sharing. The program includes an up-front, per person, per calendar year Deductible. Once the Deductible is satisfied, prescription coverage is subject to the applicable prescription Copayment.

Medicare Part D

Medicare Part D, a Medicare prescription drug benefit is designed to help Medicare Beneficiaries gain access to insurance coverage for prescription drugs. It also provides Medicare Beneficiaries who have limited income with extra help paying for prescription drugs.

Medicare Advantage HMO Members who qualify have access to comprehensive coverage with low cost-sharing, which allows them to pay only a small amount for their prescriptions.

Prescribing requirements

Supported by the Patient Protection and Affordable Care Act of 2010 and as required by the Centers for Medicare & Medicaid Services (CMS), prescribing Providers must include their individual (Type 1) National Provider Identifier (NPI) on all prescriptions for Medicare Advantage HMO Members who are covered under Medicare Part D.

Prescriber identifiers are valuable Part D program safeguards. These identifiers are the only data on Part D drug claims to indicate that legitimate practitioners have prescribed drugs for Medicare enrollees. Without valid prescriber identifiers, efforts made by CMS to determine the validity, medical necessity, or appropriateness of Part D prescriptions and drug claims may be limited.

Part D vaccine administration

CMS requires that vaccine administration for Medicare Advantage HMO Members be covered under their Medicare Part D benefits. Part D Members have four options for receiving a vaccination. The available options and how you can collect payment from the Member are as follows:

Where Member receives vaccine	Who administers vaccine	Member payment
Pharmacy	Pharmacist	Member pays his or her pharmacy Copayment/ Coinsurance to the pharmacy.
Pharmacy	Physician	Member pays his or her Copayment/ Coinsurance to the pharmacy for the vaccine. Physician may request the standard fee for the administration up front.
Physician's office	Physician	Physician may request the standard fee for the vaccine and its administration up front.
FutureScripts Secure Direct Ship Specialty Pharmacy Program*	Physician	Member pays his or her pharmacy Copayment/ Coinsurance to the direct ship Provider for the vaccine. Physician may request the standard fee for the administration up front.

**FutureScripts Secure Direct Ship Specialty Pharmacy Program is available under the Member's pharmacy coverage.*

It is important that you routinely ask your Medicare Advantage HMO Members to show their Medicare ID cards. This will ensure the appropriate collection of the Member's responsibility.

When you collect payment directly from the Member for either a Part D vaccine or administration, be sure to provide the Member with a receipt. The Member should then submit the receipt, along with a *Direct Member Reimbursement Form*, to AmeriHealth for reimbursement consideration and to ensure that all out-of-pocket expenses are accurately accumulated toward his or her other pharmacy benefits. Members can request this form by contacting Customer Service.

Note: These procedures do not apply to hepatitis B (for intermediate and high-risk individuals), influenza, and pneumococcal vaccines, which are covered through the Member's Part B (medical) benefits. These three vaccines may continue to be administered and billed as usual. All other vaccines, including childhood vaccines, are covered under Part D and must be billed through the Member's Part D benefits.

Part D vaccine ordering instructions

If a Part D vaccine is needed, there are two ways the Member can get it:

1. **Write a prescription.** The Physician should write a prescription for the Part D vaccine that a Member can take to a retail pharmacy. The Member will be charged the appropriate Part D Copayment/ Coinsurance, and the vaccine will count toward his or her true out-of-pocket (TrOOP) expense. The Member should then bring the vaccine back to the Physician's office for administration. He or she should pay the Physician the full fee for the administration of the vaccine. If the Physician also charges for the office visit, the Member is responsible for the applicable office visit Copayment. The Physician should provide the Member with a receipt for payment of the vaccine administration, and the Member can submit that receipt to his or her Part D carrier for reimbursement consideration.
2. **Use the FutureScripts Direct Ship Specialty Pharmacy Program.** Through this program, the vaccine can be shipped to the Physician's office for administration. See page *13.7* for more information.

Participating pharmacy network

Members should take their Member ID cards to a pharmacy that participates in the FutureScripts or FutureScripts Secure network. Many retail pharmacies in the U.S. are part of this network, including large chains and independently owned pharmacies. When Members are traveling in the U.S., participating pharmacies will accept Member ID cards and dispense medications based on the Member's pharmacy benefits.

Mail order program

Most of our prescription drug programs include a mail order option that offers a convenient, cost-effective way for Members to receive their medications. FutureScripts and FutureScripts Secure process mail order prescriptions for our Members. For a Member to use this benefit, write two separate prescriptions for the Member: One prescription is for the initial supply, which the Member may fill immediately at a retail pharmacy, and the second prescription is for the mail order program and should be written for a 90-day supply of medication. Members receive information on how to fill mail order prescriptions upon enrollment. Shipments through the mail order program are available to all areas in the U.S.

Preventive drugs covered at $0 Copayment

Certain preventive medications, as described in the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), including generic products and those brand products that do not have a generic equivalent, are covered without cost-sharing with a doctor's prescription when provided by a participating retail or mail-order pharmacy. Drug that are considered preventive for certain ages and genders and are covered at a $0 Copayment as listed in the following table:

Drug class	Gender	Ages
Folic acid (prescriptions with 0.4 – 0.8 mg)	Women only	All ages
Iron supplements	All	Children ages 6 months through 1 year
Oral fluoride	All	Children ages 6 months through 6 years
Aspirin to prevent cardiovascular disease	Men Women	45 – 79 55 – 79
Breast cancer chemotherapy prevention	Women	All ages

Tobacco interventions	All	Adults who use tobacco products
Vitamin D supplements	All	65 and over

Contraceptives, mandated by the Women's Prevention Services provision of Health Care Reform, are covered at 100 percent when provided by a Participating Provider for generic products and for those brand products that do not have a generic equivalent. Brand contraceptive products with a generic equivalent are covered at the brand cost-sharing level for the Member's plan.

Note: The $0 Copayment does not apply to Medicare Advantage HMO Members.

Drug formulary information

The Select Drug Program and Medicare Part D use formularies to give Members cost-effective access to covered medications.

Select Drug Program® Formulary

The Select Drug Program Formulary is maintained by the Pharmacy and Therapeutics Committee and is an incentive-based formulary. It includes all generic drugs as well as a defined list of brand drugs that have been selected for formulary coverage based on their medical effectiveness and value. The formulary includes at least two agents to treat each covered disease state. The entire formulary is reviewed over the course of the year for quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. As a result, formulary additions and deletions occur throughout the year.

Before prescribing a medication for Select Drug Program Members, keep in mind the following:

- Members in the Select Drug Program typically pay a fixed Copayment for up to a 90-day supply of drugs listed on the formulary.
- Generic formulary medications are covered at the lowest formulary level of cost-sharing.
- Brand formulary medications are covered at a higher formulary level of cost-sharing.
- Non-formulary brand medications are covered at the highest non-formulary level of cost-sharing.

To help Members understand the Select Drug Program, they have access to educational materials, including the Select Drug Program Formulary Guide. To obtain a copy of the Select Drug Program Formulary Guide, go to *www.amerihealth.com/rx.*

Non-formulary exceptions for Select Drug Program Members

Physicians, on behalf of Members, may request coverage of a non-formulary medication at the formulary level of cost-sharing when all formulary alternatives have been exhausted or when there are contraindications to using the formulary alternatives. The Physician should complete the *Non-Formulary Exception Request* form, providing detail to support the use of the non-formulary medication, and fax it to 1-888-671-5285. The form can be found at *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/index.html*.

If the non-formulary exception request is approved, the Physician will receive written notification, and the drug will be processed at the appropriate formulary level of cost-sharing. If the request is denied, the Member and Physician will receive a denial letter that explains the appeals process, and the Member can receive benefits for the covered non-formulary brand drug at the highest non-formulary level of cost-sharing.

Medicare Part D Drug Formulary

The Medicare Part D Drug Formulary is designed to provide quality pharmaceutical coverage at an affordable cost for Medicare Beneficiaries. With the Medicare Part D Drug Formulary, Members pay a Copayment or Coinsurance at retail pharmacies for up to a 90-day supply of drugs listed on the formulary. Since nonpreferred prescription medications may result in a higher level of cost-sharing for Members, we suggest you review the Medicare Part D Drug Formulary for preferred formulary alternatives, which have a lower level of cost-sharing.

Procedures for Safe Prescribing

AmeriHealth monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures, such as prior authorization, have been established to support safe prescribing patterns.

Prior authorization requirements

We require prior authorization of certain covered, FDA-approved drugs for specific medical conditions. The approval criteria were developed and endorsed by the Pharmacy and Therapeutics Committee and are based on information from the FDA, manufacturers, medical literature, actively practicing consultant Physicians and pharmacists, and appropriate external organizations.

FutureScripts and FutureScripts Secure evaluate requests for these drugs based on clinical data and information submitted by the prescribing Physician and available prescription drug history. Clinical pharmacists determine whether there are any drug interactions or contraindications, whether dosing and length of therapy are appropriate, and whether clinical options have been evaluated.

If the request cannot be approved by applying established review criteria, a FutureScripts medical director reviews the request. If the request is not approved, the drug will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the highest level of cost-sharing.

Commercial Members

For pharmacy-related services, Participating Providers are required to use the appropriate form from *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/index.html* to request prior authorization for Members. You can also call FutureScripts at 1-888-678-7012 to have prior authorization forms faxed directly to your office.

For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, visit *www.amerihealth.com/rx*. The prior authorization process may take up to two business days once information is received from the prescribing Physician. It is important to completely fill out the appropriate form for the drug being requested.

Medicare Advantage HMO Members

For Medicare Advantage HMO Members, the prior authorization process may take up to 72 hours to review and make a determination. An expedited request takes 24 hours. Visit *www.amerihealthmedicare.com/find_a_drug/ah_prior_authorization.html* for a complete list of drugs requiring prior authorization and the appropriate request forms.

Note: The list of drugs requiring prior authorization is subject to change. As the list changes, notification is given through *Partners in Health Update*.

Expiration of prior authorization for narcotic drugs

There is a time limit of 6 to 12 months on prior authorization approvals for narcotic drugs. Prior authorizations will include an expiration date at the time of the approval. If you want your patient to continue the drug therapy after the expiration date, you will need to submit a new request.

Age and gender limits

Age and gender limits are designed to prevent potential harm to Members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature, actively practicing consultant Physicians and pharmacists, and appropriate external organizations. Approval criteria are endorsed by the Pharmacy and Therapeutics Committee.

If the Member's prescription does not meet the FDA age and gender guidelines, it will not be covered until prior authorization is obtained. To request an age or gender limit exception, complete the *General Pharmacy* form and fax it to 1-888-671-5285 for review. The form can be found at *www.futurescripts.com/priorauthorization*.

Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug. The various types are described below:

- **Refill too soon.** With this quantity limit, if a Member used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.
- **Therapeutic drug class.** This quantity limit applies to some classes of drugs, such as narcotics (e.g., short-acting and long-acting). If a Member uses more than one drug within the same class, he or she may be unsafely duplicating medications and would be affected by the total quantity limits for a therapeutic drug class. Members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

To determine if a covered drug for a patient has a quantity limit, call FutureScripts at 1-888-678-7012. For detailed examples of quantity limits and procedures that support safe prescribing visit *www.amerihealth.com/safeprescribing-nj*.

To request a quantity limit exception, complete the *General Pharmacy* form found at *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/index.html* and fax it to 1-888-671-5285 for review.

96-Hour Temporary Supply Program

We are aware that there may be times when an urgent supply is necessary for a medication requiring prior authorization. A one-time, 96-hour supply may be obtained for these medications. **Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved.**

The 96-Hour Temporary Supply Program applies to the following covered medications:

- most medications that require prior authorization;
- migraine medications with quantity limits, such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol NS®, and Zomig® (Preapproval of quantity exception required for amounts over the quantity limits);
- medications that are subject to age limits (Preapproval required for ages outside of recommended ranges).

Under the 96-Hour Temporary Supply Program, if you write a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication and prior authorization has not been obtained, the following steps will occur:

- The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the Member with no out-of-pocket cost-sharing at that time.
- By the next business day, FutureScripts or FutureScripts Secure will contact you to request that you submit the necessary documentation of Medical Necessity for review.

- Once the completed medical documentation is received by FutureScripts or FutureScripts Secure, the review will be completed and the medication will be approved or denied.
  - **If approved:** The remainder of the prescription order will be filled, and the appropriate level of cost-sharing will be applied.
  - **If denied:** Notification will be sent to you and the Member.
- Members with an integrated drug benefit (e.g., Comprehensive Major Medical) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved) at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures.

Note: Some medications are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations. Examples of ineligible medications are Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs.

30-day transition supply (Medicare Part D only)

A new Member who is currently taking medications that are not on the formulary or require prior authorization can receive a one-time, 30-day supply during the first 90 days of enrollment. These medications may require prior authorization or another exception listed in this section.

The retail pharmacy will receive an online message to process the claim, and the Member will be charged the applicable level of cost-sharing for this supply. The Member will receive a letter notifying him or her to contact the prescribing Physician, and the Physician will need to complete a prior authorization or exception request. The prescribing Physician will receive a copy of the letter. Processing of a transition supply request is not a guarantee of approval of the prior authorization or exception request.

Appealing a decision

If a request for prior authorization or an exception results in a denial, the Member, or the prescribing Physician on behalf of the Member, may file an appeal. Both the Physician and the Member will receive written notification of the denial, which will include the reason for denial and how to initiate an appeal. In all cases, the Physician needs to be involved in the appeals process to provide the required medical information for the basis of the appeal.

Pharmacy programs

FutureScripts® Direct Ship Specialty Pharmacy Program

We coordinate with FutureScripts to offer the Direct Ship Specialty Pharmacy Program to Members who have pharmacy coverage through AmeriHealth. Through this program, you can obtain specialty injectables and specialty oral medications that are covered under the pharmacy benefit for your patients.

When using in the FutureScripts Direct Ship Specialty Pharmacy Program, keep in mind the following:

- Quantities for specialty injectables and specialty oral medications will be evaluated to promote appropriate prescribing. In addition, medications obtained through this program may be subject to the Member's benefits exclusions and review of Medical Necessity.
- Refills will be coordinated without additional paperwork.

BriovaRx™ is the exclusive specialty pharmacy provider, administered by FutureScripts® Direct Ship Specialty Pharmacy Program. With the FutureScripts Direct Ship Specialty Pharmacy Program, Members have access to the following services and conveniences:

- **Medication counseling 24/7.** Pharmacists are available to answer any questions about specialty medications, explain how to inject certain medications, and discuss any possible side effects.
- **Educational materials to support improved health.** Members will receive pertinent information about their health condition and specialty medication along with their prescription.
- **Confidential and convenient order and delivery.**
- **Refill reminder service.** Members will receive a phone call before their refill date to schedule the next delivery.

Providers who are considering beginning an AmeriHealth Member on a new specialty medication therapy should call BriovaRx™ at 1-855-4BRIOVA (1-855-427-4682) to enroll the Member.

To get a Member started in the FutureScripts Direct Ship Specialty Pharmacy Program, please call FutureScripts at 1-888-678-7012 or visit *https://www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial.html* and download the *Direct Ship Injectables Form*. If any of your AmeriHealth patients have questions about this transition, please have them call the telephone number listed on their ID card under pharmacy benefits.

Self-injectable drugs

Most self-injectable drugs are covered under the pharmacy benefit. However, injectables that cannot be administered without medical supervision, that are mandated by law, or that are required for Emergency treatment will continue to be covered under the medical benefit at the appropriate level of cost-sharing.

Note: The AmeriHealth Direct Ship Injectables Program facilitates the shipment and precertification (as required) of injectable medications and other injectable drugs that are covered under the medical benefit and are not commonly stocked in a Physician's office. For more information about drugs covered under the medical benefit and the AmeriHealth Direct Ship Injectables Program, go to *www.amerihealth.com/directship*.

Blood Glucose Meter Program

Bayer HealthCare LLC and Abbott Laboratories are the preferred brands of test strips for our prescription drug programs. In addition, they are the only test strips on the Select Drug Program Formulary.

- **For Abbott monitors.** Preferred test strips include FreeStyle®, FreeStyle Lite®, and Precision Xtra®.
- **For Bayer monitors.** Preferred test strips include Contour®, Breeze®2, Elite®, and Autodisc®.

Prior authorization requirements for test strips

We require prior authorization for any test strips that we consider nonpreferred. In other words, if a Member chooses to use a test strip that is not listed above, you will need to complete a prior authorization form on your patient's behalf. If the prior authorization is not approved, the nonpreferred test strips will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the test strips. If the request for the nonpreferred test strips is approved, your patient will be charged the highest level of cost-sharing.

You can download the *Diabetic Test Strips* prior authorization form online at *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/index.html*. Be sure to include supporting documentation for Medical Necessity. If your request contains insufficient information, it may be returned to you or the request may be denied.

Free meters for preferred test strips

Both Abbott and Bayer glucose meters are available at no cost to our Members who are using to one of the preferred test strips. Free meters can be obtained directly from either manufacturer, as detailed in the following information:

- **Abbott Diabetes Care products.** The Abbott Diabetes Care products include the following blood glucose meters:
  - FreeStyle Lite® Blood Glucose Monitoring System
  - FreeStyle Freedom® Lite Blood Glucose Monitoring System
  - Precision Xtra® Blood Glucose and Ketone Monitoring System

  More information about these products is available at *www.abbottdiabetescare.com/products*. To obtain an Abbott meter at no cost, you or your patient should call Abbott Diabetes Care at 1-866-224-8892 or visit their website at *www.meters.abbottdiabetescare.com*.
- **Bayer Diabetes Care products.** The Bayer family of products offers the following blood glucose meters: Contour® Meter; Breeze®2 Meter.

  Learn more about these products at *www.bayerdiabetes.com/sections/ourproducts.aspx*. To obtain a Bayer meter at no cost, you or your patient should call Bayer Diabetes Care at 1-877-229-3777.

If you have questions about the preferred test strips or the Blood Glucose Meter Program, contact FutureScripts at 1-888-678-7012.

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Overview

We consider our relationship with our network Providers a partnership because we share a common goal — improving the quality of the care our Members receive. Since Providers actually deliver care, our role is to assist their efforts and to provide the tools and information they need to maintain a high standard of care. Our Quality Management (QM) department was developed according to this mission.

QM Program goals and objectives

The goals and objectives of the QM Program include the following:

- to improve the quality of medical and behavioral health care and service provided to Members. This is achieved through administrative simplification and an ongoing system of monitoring measurable performance indicators. Indicators are based on high-volume, high-risk, problem-prone services, data from customer satisfaction surveys, complaints/occurrences, and appeals. Other relevant sources are also evaluated to establish goals and benchmarks to promote improvement.
- to maintain a process for adopting and updating both preventive health guidelines and nonpreventive (e.g., acute and chronic) clinical practice guidelines for medical and behavioral health-related conditions. These guidelines are evidence-based and are distributed to AmeriHealth practitioners and Members to facilitate decision making regarding appropriate health care for specific clinical circumstances.
- to maintain the Member Safety Program to improve the safety of medical and behavioral health care and services provided to Members and to promote a reduction in medical and medication errors through a comprehensive program of educational initiatives and through the monitoring of Member safety data;
- to be a resource for Member safety issues with Members, practitioners/Providers, various AmeriHealth departments, and external organizations;
- to ensure a network of qualified practitioners/Providers by demonstrating compliance with all applicable accrediting bodies and regulatory credentialing/recredentialing requirements;
- to include language in practitioner/Provider contracts requiring participation in the QM Program and access to medical records;
- to promote partnerships with practitioners/Providers by communicating quality activities, providing feedback on results of plan-wide and practice-specific performance assessments, and collaboratively developing improvement plans;
- to distribute information on practitioner/Provider performance to promote transparency to customers, inclusive of Members and employers/purchasers, for informed decision making;
- to ensure that the quality of care and service delivered by delegates meets standards established by AmeriHealth and relevant regulatory and accrediting agencies and that delegates maintain continuous, appropriate, and effective quality improvement programs through ongoing oversight activities and regular performance assessments;
- to document and report the results of monitoring activities, barrier analyses, recommendations for improvement activities, and other program activities to the appropriate committees;
- to comply with all regulatory requirements and maintain accreditation and necessary certifications;
- to ensure that the appropriate resources are available to support the QM Program.

For more information about our QM Program, including information about program goals and a report on our progress in meeting these goals, visit our website at *www.amerihealth.com/qualitymanagement*. You may also contact Customer Service at 1-888-YOUR-AH1. Members should call the Customer Service telephone number listed on their ID card.

QM Program activities

Through our QM Program, we monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by Participating Practitioners/Providers and by delegates across our HMO/POS, Medicare Advantage, and PPO product lines. We identify meaningful clinical and service issues that are likely to impact enrolled Members and establish performance indicators, goals, and benchmarks that correspond to topics falling within the scope of the QM Program.

The mechanisms used to identify meaningful clinical and service issues include, but are not limited to:

- the results of analysis of demographics, claims, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions;
- the results of data from internal performance monitoring activities and satisfaction survey results;
- data from complaints and Member appeals and direct input from Members, practitioners/Providers, and AmeriHealth staff.

Through ongoing review of performance data* with respect to established goals, benchmarks, and formal annual evaluations of the effectiveness of the QM Program, AmeriHealth confirms that existing clinical quality, safety, and service improvement initiatives remain appropriate and identifies new topics for inclusion in the program.

**Providers must allow the plan to use performance data in plan Quality Programs for internal plan purposes only.*

Member safety activities

The QM department leads 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 and 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.

The Member Safety Program supports the Partnership for Patient Care, a regional collaborative that promotes best practices and evidence-based medicine to improve the safety and quality of health care at network hospitals. The program uses a regional, strategic, and cohesive approach and an interactive forum to facilitate hospitals' efforts to more rapidly implement best practices.

Member complaint process

The QM department investigates all quality-of-care and service concerns/complaints. All quality-of-care and service concerns/complaints are triaged, categorized, analyzed, and reported on a semi-annual basis. Recommendations are used for practitioner/Provider improvement activities. Complaints are also reviewed from a quarterly, as well as a rolling year, perspective for identification and analysis of potential practitioner/Provider outliers. An outlier is defined as a practitioner, facility, ancillary Provider, or pharmacy benefits manager against whom there are three or more complaints or a complaint that is

assigned a severity level of two or higher. Members may file a concern/complaint by calling Customer Service at the number listed on their ID card, by sending their complaint in writing to us, or by emailing us through our website at *www.amerihealth.com*.

If an AmeriHealth New Jersey Member or the Member's designee is dissatisfied with the AmeriHealth process for managing Member concerns, he or she has the right to complain to the Department of Banking and Insurance using the following contact information:

Consumer Protection Services
Department of Banking and Insurance
Managed Care Complaints and Appeals
Attention: Sylvia Allen-Ware
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329

Main phone: 609-292-5316 or 1-888-393-1062
Fax: 609-633-0807

In addition to submitting a complaint to the Department of Banking and Insurance, the Member or the Member's designee may submit complaints online by selecting the Department of Banking and Insurance's current online complaint form at *www.state.nj.us/dobi/mcfaqs.htm*.

Medicare Advantage HMO grievance

A Medicare Advantage HMO grievance is any complaint or dispute raised by a Medicare Advantage HMO Member or the Member's representative, other than a dispute involving an organizational determination. Medicare Advantage HMO grievances may include disputes regarding such issues as office waiting times, Physician behavior, adequacy of facilities, involuntary disenrollment situations, or coverage decisions by AmeriHealth to process a Medicare appeal request under the standard 30-day time frame rather than as an expedited appeal. A resolution will be issued no later than 30 days after the grievance is received.

Monitoring of continuity and coordination of care

Our goal is for Members to receive seamless, continuous, and appropriate care. On an annual basis, we collect data about coordination of care across settings or transitions in care. Data is collected related to the coordination between medical and behavioral health care. A quantitative and causal analysis of data is conducted to facilitate the identification of improvement opportunities. Based on the results of the analysis, we identify opportunities to improve continuity and/or coordination of care and implement appropriate initiatives to address opportunities for improvement.

Examples of different settings include:

- outpatient facilities
- inpatient facilities
- surgery centers
- nursing homes

Examples of the type of data collected to improve coordination of care and promote collaboration between medical and behavioral health care include:

- exchange of information;
- appropriate diagnosis, treatment, and Referral of behavioral health disorders commonly seen in primary care;
- appropriate use of psychopharmacological medications;
- management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders;
- primary and secondary preventive behavioral health programs.

Examples of transitions in care include:

- changes in the management of care between practitioners (e.g., enrollment or disenrollment in disease management programs);
- changes in which different practitioners become active or inactive in providing care for a Member.

Examples of the type of data collected to promote the identification of improvement opportunities and facilitate the design and implementation of improvement initiatives include:

- discharge planning data;
- surveys of practitioners regarding communication and coordination issues;
- case management data.

QM works with the Care Management and Coordination department to monitor the coordination of the care of Members when they move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety.

PCP to behavioral health Provider communication

We have created a *PCP to Behavioral Health Provider Communication Form* to give Providers the opportunity to communicate vital information to behavioral health Providers when referring patients. This form can be downloaded from our website at *www.amerihealth.com/Providerforms*.

The form can help decrease the incidence of patients arriving for a referred behavioral health service without a full picture of past treatments and methodologies and can aid Providers in discussions with patients about behavioral health treatments. This may also prove helpful in scenarios where a Member has self-referred for service.

The form also enables Primary Care Physicians (PCP) to communicate relevant health information to the behavioral health Provider. Relevant health information includes medication use (to avoid contraindications), past and present medical conditions, allergies, relevant laboratory results, and contact information for the referring Physician.

Physicians must secure patient consent to forward personal information. We recommend that the completed form be given to the Member to take to the behavioral health Provider.

Credentialing/recredentialing

Please refer to the following policy information on credentialing/recredentialing.

Policy

We require Participating Providers to be credentialed and recredentialed at periodic intervals. The credentialing policy applies to contracted PCPs, specialty Physicians, and other allied health practitioners as defined by State or federal law/regulation. Credentialing and recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. All information collected during the credentialing/recredentialing process is kept confidential in accordance with applicable State and/or federal law/regulation and our corporate confidentiality policy.

We reserve the right to determine network need based on existing access and availability standards and participation criteria. In the event that an applicant does not meet either access and availability standards or participation criteria, the application will not be considered. No appeal rights are available as a result of the pre-application determination.

Standards

We select qualified applicants in accordance with our credentialing standards, as well as all applicable State, federal, and accreditation requirements such as:

- State/federal law/regulation;
- U.S. Department of Health & Human Services (HHS) standards;
- Centers for Medicare & Medicaid Services (CMS) standards;
- National Committee for Quality Assurance (NCQA) and other applicable accrediting agencies' requirements.

Practices

Applicants have the right to review information submitted in support of their application with the exception of references or recommendations or other information that is peer-protected. The applicant has the right to correct any material omission and/or erroneous information in writing within 30 calendar days of the request for clarification. Material omissions and/or failure to respond to all questions on the application may result in denial of new or continued participation in our network.

Applicants must have a current unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice his or her specialty in each state in which the practitioner is licensed. Participating practitioners who no longer meet these licensing requirements will be administratively terminated from further participation in the network, based upon contractual requirements that practitioners must meet. Applicants are notified in writing of determinations regarding approval or denial of participation.

Practitioners are recredentialed every 36 months to ensure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with our guidelines and processes and to assess Member satisfaction with the Provider. Failure to complete timely recredentialing may result in administrative termination from the network. We may reinstate a practitioner if all recredentialing requirements are met and the break in credentialing does not exceed 30 calendar days.

Denial appeal and/or review rights

Please see below for important information about the types of denials.

Application denials	No appeal or review rights are available when an applicant fails to submit a timely, completed application.
Administrative denials	Administrative appeal/review rights are set forth in the "Appeal/review process for administrative denials" section. Applicants have a right to appeal to the Credentialing Committee denials of participation that are based on initial credentialing verifications or that are based on the professional conduct or competence of an initial credentialing applicant. See the "Appeal/review process for administrative denials" section. There are no appeal rights for initial credentialing applicants if it is determined that the applicant's license is restricted, subject to probation, proctoring requirements, or other disciplinary action, or otherwise does not meet the participation requirements as previously noted above. The applicant may reapply once the restriction is removed.
Participation denials	A Participating Practitioner who is denied continued participation based on failure to meet recredentialing criteria has appeal rights as set forth in the "Appeal/review process for administrative denials" section. A Participating Practitioner who is denied continued participation based on professional conduct or competence has appeal rights as set forth in the Due Process Policy. Participation denials or summary suspensions are considered Professional Review Actions in accordance with the Due Process Policy. A Participating Practitioner who is denied continued participation based on a license that is restricted, subject to probation, proctoring requirements, or other disciplinary action has a limited right to a review to correct factual inaccuracies regarding the practitioner's licensure status. However, there are no appeal rights if a Participating Practitioner's license is restricted, subject to probation, proctoring requirements, or other disciplinary action. The Participating Practitioner may reapply once the restriction is removed.

Appeal/review process for administrative denials

A credentialing applicant or a Participating Practitioner is notified by certified mail that he or she has been administratively denied. The letter includes a clear rationale for the decision and instructions on how to submit a written request for an appeal or review, as applicable with additional information, as appropriate, within 30 calendar days of the date of the denial notification letter. Appeal or review requests received after 30 calendar days will not be accepted.

The Credentialing Committee reviews the submitted information and makes a determination of the applicant's participation status at the next scheduled Committee meeting following receipt of the appeal request. The practitioner is notified within five business days of the final determination via certified mail.

Practitioners who are denied continued participation may reapply after a period of six months. However, under all circumstances, reapplication time frames are solely at our discretion.

Failure to complete timely recredentialing is considered a voluntary withdrawal from our network and is not subject to an appeal. The practitioner may submit the required information to be reinstated or may submit a credentialing application if the break in service exceeds 30 calendar days.

Credentialing criteria

Please refer to the following credentialing criteria:

- A completed, signed, and dated application includes, but is not limited to:
  - work history for immediate previous five years from the date the application was signed, including month and year, with a written explanation of gaps greater than six months;
  - education and training completed, medical school, residency training, and fellowships;
  - statement of chemical dependency or substance abuse;
  - loss or limitation of license or felony convictions;
  - loss or limitation of hospital privileges or disciplinary action;
  - reasons for any inability to perform the essential functions of the position, with or without accommodation;
  - an attestation to the correctness and completeness of the application;
  - a signed and dated *Authorization for Release of Information* (credentialing warranty).
- Physicians and other health care practitioners must have a current, unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice his or her specialty in each state in which the practitioner is licensed to practice his or her profession and specialty. A copy of current license(s) and applicable certifications must be submitted with the application when required by State or federal law/regulation. Therapeutic optometrists must also have a Therapeutic Pharmaceutical Agent (TPA) license. Chiropractors who perform physical therapy must also have the required adjunctive license as applicable in order to perform those services.
- Primary and specialty care Physicians, including podiatrists, must be board certified in their area of practice. Exception is noted for non-board certified applicants who meet the training requirements and when Member access issues are identified.
- Drug Enforcement Agency and Controlled Dangerous Substances certifications must be included, when applicable.
- Liability insurance coverage specified by the requirements of the State(s) in which the applicant practices is required.
- The applicant must have privileges at a minimum of one participating hospital. Unless required by State law/regulation or when inpatient care is not within the scope of practice, privileges may be waived at our discretion. The applicant must obtain a coverage agreement for inpatient coverage from a Participating Practitioner of the same or similar specialty. The applicant may submit a signed and dated attestation of hospital privileges including a history of loss or limitation of privileges or disciplinary activity in lieu of the hospital verification of privileges.
- Passing scores for site visit and medical record-keeping are required for all primary and OB/GYN practice sites. State and federal laws/regulations and accreditation standards may require site visits for additional specialties.
- Coverage must be provided 24 hours a day, 7 days a week, for our Members. A Participating Practitioner of like or similar specialty should provide coverage.
- Practitioner must provide a report detailing malpractice history during the past five years, beginning with the date of the signature on the application. This includes professional liability claims that resulted in settlements, arbitrations, or judgments paid by, or on behalf of, the practitioner.
- Applicants must be currently eligible to participate in any Medicare/Medicaid or federal program.

Provider termination with cause

We may terminate the Professional Provider Agreement immediately upon notice to the Provider in accordance with the Agreement for causes including, but not limited to:

- Provider's violation of any applicable law, rule, or regulation;
- Provider's failure to meet and maintain our credentialing requirements including, but not limited to, maintaining the professional liability insurance coverage, licensure, and credentialing status;
- Provider action that, in our reasonable judgment, constitutes gross misconduct;
- Provider action that we determine places the health, safety, or welfare of any Member in jeopardy.

We will not sanction, terminate, or fail to renew a Provider's participation for any of the following reasons:

- discussing the process that we, or any entity contracting with us, uses or proposes to use to deny payment for a health care service;
- advocating for Medically Necessary and appropriate care with or on behalf of Members, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternative therapies, consultations, or tests;
- discussing our decision to deny payment for a health care service;
- filing a grievance on behalf of, and with the written consent of, a Member or helping a Member file a grievance.

Participating Provider office standards

Access and availability standards

The QM Program establishes an annual access and availability plan to ensure that its managed care networks are sufficient in number, type, and geographic location of practitioners who practice primary and specialty care as defined by regulatory and accreditation standards. The cultural needs of AmeriHealth Members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Contracting and Provider Network department.

The QM Program also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS), quality of care/service concerns, and telephone service indicators serve as mechanisms to monitor performance. We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Magellan Behavioral Health, Inc., our delegated behavioral health Provider, assesses and monitors access and availability of behavioral health practitioners. Performance against measures such as routine, urgent, and emergent care are assessed on an annual basis in accordance with accreditation standards and regulatory requirements.

Access standards for PCPs and specialists are as follows:

Appointment availability

PCPs

- emergent/immediate – call 911, or go to the nearest emergency room
- urgent – 24 hours
- routine – 2 weeks
- routine physical – 4 weeks

Specialists/chiropractors/podiatrists

- emergent/immediate – call 911, or go to the nearest emergency room
- urgent – 24 hours
- routine – 2 weeks
- OB/GYN routine – within 2 months

Minimum office hours per practice per week

PCPs

- solo – 20 hours
- dual – 30 hours
- group – 35 hours

Specialists/chiropractors/podiatrists

- specialty – 12 hours
- chiropractor – 20 hours
- podiatry offices – 20 hours

PCP, OB/GYN, and high-volume specialists are encouraged to have at least one evening or weekend session/practice per week included in the hours listed.

Maximum patients scheduled per hour per practitioner

- PCPs, podiatrists, and chiropractors – 6 patients
- specialists – 4 patients

Internal waiting time

Patients should be seen within 30 minutes from the time of the scheduled appointment.

Availability

Coverage must be provided 24 hours per day, 7 days per week, for our Members.

Covering practitioner must be a Participating Provider. Providers who use answering machines for after-hours service are required to include:

- urgent/emergent instructions as the first point of instruction;
- information on contacting a covering Physician;
- telephone number for after-hours Physician access.

After-hours phone response

For an urgent/emergent problem, practitioner should respond within 30 minutes.

Patient no-show

If a patient does not show for a scheduled appointment, it should be documented in his or her medical record.

Member rights and responsibilities

Commercial Member rights

A Commercial Member has the *right* to:

- receive information about the health plan, its benefits, services included or excluded from coverage policies, and Participating Practitioners/Providers' and Members' rights and responsibilities. Written and Web-based information that is provided to the Member will be readable and easily understood.
- be treated with respect and be recognized for his or her dignity and right to privacy;
- participate in decision-making regarding his or her health care. This right includes candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage.
- voice complaints or appeals about the health plan or care provided and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.
- make recommendations regarding our Member rights and responsibilities policies by contacting Customer Service in writing;
- choose practitioners, within the limits of the AmeriHealth network, including the right to refuse care from specific practitioners;
- have confidential treatment of personally identifiable health/medical information. The Member also has the right to have access to his or her medical record in accordance with applicable federal and State laws.
- be given reasonable access to medical services;
- receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, or source of payment;
- formulate advance directives. AmeriHealth will provide information concerning advance directives to Members and practitioners and will support Members through our medical record-keeping policies.
- obtain a current directory of participating practitioners in the plan's network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak languages other than English.
- file a complaint or appeal about the health plan or care provided with the applicable regulatory agency and to receive an answer to those complaints within a reasonable period of time. To be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
- appeal a decision to deny or limit coverage, first within the plan and then through an independent organization for a filing fee, as applicable. The Member also has the right to know that his or her doctor cannot be penalized for filing a complaint or appeal on the Member's behalf.
- Members with chronic disabilities have the right to obtain assistance and Referrals to Providers who are experienced in treating their disabilities;

- have candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage, in terms that the Member understands, including an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the Member is unable to easily understand this information, he or she has the right to have an explanation provided to his or her next of kin or guardian and documented in the Member's medical record. AmeriHealth does not direct practitioners to restrict information regarding treatment options.
- have available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and Emergency conditions;
- call 911 in a potentially life-threatening situation without prior approval from AmeriHealth; the right to have AmeriHealth pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;
- continue receiving services from a Provider who has been terminated from the AmeriHealth network (without cause) in the time frames as defined by applicable State requirements. This continuation of care does not apply if the Provider is terminated for reasons that would endanger the Member, public health or safety, breach of contract, or fraud.
- have the rights afforded to Members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;
- receive prompt notification of terminations or changes in benefits, services, or Provider network.
- have a choice of specialists among Participating Providers following an authorization Referral as applicable, subject to their availability to accept new patients.

Commercial Member responsibilities

A commercial Member has the *responsibility* to:

- communicate, to the extent possible, information that AmeriHealth and Participating Providers need in order to care for him or her;
- follow the plans and instructions for care that he or she has agreed on with his or her practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
- review all benefits and membership materials carefully and to follow the rules pertaining to the health plan;
- ask questions to assure understanding of the explanations and instructions given;
- treat others with the same respect and courtesy expected for him or herself;
- keep scheduled appointments or give adequate notice of delay or cancellation.

Medicare Advantage HMO Member rights

A Medicare Advantage HMO Member has the *right* to:

- be treated with fairness, respect, and recognition of his or her dignity and right to privacy;
- confidential treatment of personally identifiable health/medical information. The Member also has the right to have access to his or her medical record in accordance with applicable federal laws.

- see AmeriHealth Providers and get Covered Services within a reasonable period of time;
- know treatment choices and participate with Providers in decisions about his or her health care;
- have a candid discussion of appropriate or Medically Necessary treatment options for his or her medical conditions, regardless of cost or benefits coverage;
- receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin or source of payment;
- use advance directives (such as a living will or a power of attorney);
- voice complaints or appeals about the health plan or care provided and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.
- get information about health care coverage and costs;
- get information about AmeriHealth, its services, its Providers, and Member rights and responsibilities;
- make recommendations regarding the AmeriHealth Member Rights and Responsibilities policy;
- have a choice of specialists among Participating Providers following an authorization Referral as applicable, subject to their availability to accept new patients.

Medicare Advantage HMO Member responsibilities

A Medicare Advantage HMO Member has the *responsibility* to:

- give AmeriHealth and Participating Providers the information they need to provide care (to the extent possible) and to follow the treatment plans and instructions agreed upon;
- act in a way that supports the care provided to others and helps smooth the running of Providers' offices and facilities;
- pay premiums and any cost-sharing that he or she may owe for Covered Services and meet his or her other financial responsibilities as described in the *Evidence of Coverage*;
- understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
- advise the plan of any questions, concerns, problems, or suggestions;
- notify Providers that he or she is enrolled in the health plan when seeking care (unless it is an Emergency);
- notify the health plan if he or she has additional health insurance;
- notify the health plan if he or she moves out of the service area.

Medical recordkeeping standards

A medical record documents a Member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we established medical record standards in 1996 and routinely distribute these standards to PCPs and specialists.

We regularly assess compliance with these standards and monitor the processes and procedures that Physician offices use to facilitate the delivery of continuous and coordinated medical care. We have established a performance goal of 90 percent compliance with our medical record standards. The standards are as follows:

Medical record content

Medical records should include the following content:

- significant illnesses and medical conditions indicated on the problem list;
- documentation of medications – current and updates;
- prominent documentation of medication allergies and adverse reactions. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- past medical history (for patients seen three or more times) easily identified, including serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- for patients 14 years and older, appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times);
- the history and physical documents appropriate subjective and objective information for presenting complaints;
- working diagnoses consistent with findings;
- treatment plans consistent with diagnoses;
- unresolved problems from previous office visits addressed in subsequent visits;
- documentation of clinical evaluation and findings for each visit;
- appropriate notations regarding the use of consultants;
- no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;
- an immunization record for children that is up to date or an appropriate history in the medical record for adults;
- evidence that preventive screening and services are offered in accordance with the AmeriHealth Clinical Practice Guidelines.

Medical record organization

Medical records should be organized as follows:

- Each page in the record contains the patient's name or ID number.
- The record contains the patients personal/biographical data, including his or her address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author identification. Author identification may be a handwritten signature, a unique electronic identifier, or initials.
- All entries are dated.
- The record is legible to someone other than the author.

Information filed in medical records

Ensure that the following information is filed in medical records:

- laboratory and other studies ordered, as appropriate;
- encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
- if a consultation is requested, a note from the consultant is in the record;
- specialty Physician, other consultation, laboratory, and imaging reports filed in the chart and initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement.
- if the reports are presented electronically, or by some other method, a representation of review by the ordering practitioner;
- consultation and abnormal laboratory and imaging study results include an explicit notation in the record of follow-up plans;
- the existence of an advance directive is prominently documented in each adult (18 and older) Member's medical record. Information as to whether the advance directive has been executed is also noted.
- records of hospital discharge summaries, emergency department visits, home health nursing reports, and physical therapy reports maintained in the Member's record.

Ease of retrieving medical records

Medical records are to be made available to us as defined in the Professional Provider Agreement. Medical records are to be organized and stored in a manner that allows easy retrieval.

Confidentiality of information

- Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure.
- Medical records are safeguarded against loss or destruction and are maintained according to State requirements. At a minimum, medical records must be maintained for at least 11 years or age of majority plus 6 years, whichever is longer.
- Medical records are stored in a secure manner that allows access by authorized personnel only.
- Staff receives periodic training in Member information confidentiality.

Maintenance of records and audits

Medical and other records

Providers must maintain all medical and other records in accordance with the terms of their Professional Provider Agreement with AmeriHealth HMO, Inc. and its Affiliates (collectively, "AmeriHealth") and this *Provider Manual for Participating Professional Providers*. Subject to applicable State or federal confidentiality or privacy laws, AmeriHealth or its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over AmeriHealth, shall have access to Provider records, on request, at Provider's place of business during normal business hours, to inspect, review, and make copies of such records.

When requested by AmeriHealth or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, The Provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested timeframes and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, AmeriHealth reserves the right to require Selective Medical Review before claims are processed for payment to verify that claims submissions are eligible for coverage under the benefits plan.

Provider due process and fair hearing

Definitions

Professional Review Action: Any reduction, restriction, suspension, revocation, or denial of a Practitioner's status as a Participating Practitioner with AmeriHealth based on quality and/or professional competence of the Practitioner.

Summary Suspension: Adverse action taken against a Practitioner before a hearing is held. AmeriHealth may initiate a Summary Suspension where we determine that failure to suspend or restrict the Practitioner's participation may result in imminent danger to the health, welfare, or safety of an AmeriHealth Member.

Practitioner: Currently licensed health care Practitioner in an independent practice who contracts with AmeriHealth and who has been credentialed by us.

Procedures

1. Hearings

1.1 Procedural Rights

All hearings shall be conducted in accordance with the procedural safeguards set forth in this Policy to ensure that the affected Practitioner is accorded all rights to which he or she is entitled. Notwithstanding any other provision of this Policy, no Practitioner shall be entitled, as of right, to more than one hearing with respect to a Professional Review Action or Summary Suspension taken against that Practitioner.

1.2 Notice to Practitioner, Request for Hearing and Waiver

The Senior Vice President and Chief Medical Officer or his or her designee shall give prompt written notice of a proposed Professional Review Action or a Summary Suspension to an affected Practitioner. The notice shall provide the reasons for the action and a summary of hearing rights and procedures set forth in Paragraphs 1.2.1, 1.2.2, 1.2.3, 1.3, 1.4, 1.5, 1.6, and 1.7 of this Policy and all subparts thereof. Notice to the Practitioner as set forth herein does not apply when (i) there is no adverse Professional Review Action taken or (ii) a suspension or restriction of clinical privileges does not exceed fourteen (14) days during which an investigation is conducted to determine the need for a Professional Review Action.

1.2.1 Practitioner's Request for Hearing – Form and Time Limit

Any request for a hearing by a Practitioner must be in writing and delivered (by hand delivery or certified mail, return receipt requested) to the person designated in the notice, within thirty (30) days of the date of the notice.

1.2.2 Waiver of Hearing

The failure of a Practitioner to request a hearing to which he or she is entitled by this Policy within thirty (30) days of the date of the Professional Review Action or Summary Suspension and in the manner herein provided shall be deemed a waiver of his or her right to such hearing.

1.2.3 Effect of Waiver of Hearing

When a hearing is waived, the Senior Vice President and Chief Medical Officer or his or her designee shall decide whether a proposed Professional Review Action shall become effective or a Summary Suspension shall remain in effect against the Practitioner. The decision of the Senior Vice President and Chief Medical Officer or his or her designee on a Professional Review Action or Summary Suspension shall become final, binding, and unreviewable with the same force and effect as if a hearing had been requested and duly held and a decision rendered by a Hearing Committee. The decision of the Senior Vice President and Chief Medical Officer or his or her designee shall be communicated in writing to the Practitioner.

1.3 Notice of Hearing

Within thirty (30) days after receipt of a proper request for a hearing, which complies with the provisions of Paragraph 1.2.1 of these procedures, the Senior Vice President and Chief Medical Officer or his or her designee shall schedule and arrange for such a hearing and shall notify the Practitioner in writing of the time, place, and date so scheduled.

1.3.1 Date of Hearing

The hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of notice of the hearing, unless such timing is specifically waived by the affected Practitioner and alternative dates are mutually agreed upon by the affected Practitioner and the Senior Vice President and Chief Medical Officer.

1.3.2 Contents of Notice

The notice of hearing also shall provide a list of the witnesses, if any, expected to testify on behalf of the Plan's Quality Review Department.

1.4 Notice Regarding Practitioner's Witnesses

The Practitioner or his or her representative shall provide to the Chair of the Hearing Committee (as hereinafter defined), in writing, a list of those persons, if any, he or she expects to call as witnesses at the hearing at least ten (10) days prior to the date of the hearing. Failure to identify a witness at least ten (10) days prior to the hearing will result in the exclusion of that witness' testimony absent compelling circumstances.

1.5 Composition of Hearing Committee

The hearing shall be conducted by the Regional Peer Review Hearing Committee ("Hearing Committee"). The Hearing Committee shall be composed of at least five (5) members inclusive of the Senior Vice President and Chief Medical Officer or designee Physician, a Plan Medical Director. The majority of the Hearing Committee will be comprised of Physician peers of the affected practitioner, preferably from one of the Plan's Physician committees. The remainder of the members of the Hearing Committee may be appointed by the Senior Vice President and Chief Medical Officer or his or her designee, who shall then designate one of the members so appointed

to be the Chair of the Hearing Committee. Network Physicians are the only voting members of the Hearing Committee.

1.5.1 Qualifications

No member of the Hearing Committee shall be in direct economic competition with the Practitioner involved. A Hearing Committee member is not disqualified from serving on a Hearing Committee because he or she has heard of the case or has knowledge of the facts involved. The members of the Hearing Committee shall give fair and impartial consideration to the case.

1.6 Conduct of Hearing

The hearing shall be conducted in accordance with the rules set forth herein. If in the course of the hearing a matter arises that this Policy does not address, the Chair of the Hearing Committee is authorized to determine the applicable procedure(s).

1.6.1 Committee Presence

At least five (5) members of the Hearing Committee shall be present when the hearing takes place.

1.6.2 Practitioner Presence

The personal appearance of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her right to a hearing and the right shall be forfeited.

1.6.3 Rights of Parties

During a hearing, each party may:

(a) call, examine, and cross-examine witnesses on any matter determined by the Chair of the Hearing Committee to be relevant to the issues;

(b) introduce exhibits or otherwise present evidence determined by the Chair of the Hearing Committee to be relevant to the issues;

(c) submit written reports including, but not limited to, expert reports or any findings of the Plan committee(s) who investigated the Practitioner in question;

(d) request that a record of the hearing be made by use of a State-certified court reporter. Each party shall bear his or her or its own costs to purchase a transcript;

(e) submit a written statement to the Hearing Committee at the close of the hearing.

If the Practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

1.6.4 Witness Fees

Each party shall bear his or her own fees, costs, and expenses with respect to witnesses testifying or other evidence submitted on his or her behalf.

1.6.5 Procedure and Evidence

The hearing need not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which a

responsible person might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The Chair of the Hearing Committee shall make all determinations regarding the admissibility of evidence. The Chair of the Hearing Committee shall be required to order that oral evidence be taken on oath or affirmation. Any written statement submitted by a party at the close of a hearing shall become part of the hearing record. The Chair of the Hearing Committee may set time limitations for the presentation of evidence and may exclude or limit evidence that is repetitive or cumulative.

1.6.6 Burden of Proof

The Senior Vice President and Chief Medical Officer or his or her designee shall have the initial responsibility to recite the chronology of the case inclusive of any prior decisions, as well as the documents that are being presented as evidence for each case or issue in support of the proposed Professional Review Action or Summary Suspension. The Practitioner shall be obligated to present evidence in response. After the Senior Vice President and Chief Medical Officer or his or her designee has presented evidence in support of the proposed Professional Review Action or Summary Suspension, the Practitioner has the burden of proving by a preponderance of the evidence that the proposed Professional Review Action or Summary Suspension lacks any reasonable basis or that the conclusions drawn there from are arbitrary and capricious.

1.6.7 Hearing Officer

The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure during the hearing, to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

1.6.8 Representation

(a) The Practitioner shall be entitled to be accompanied by and represented at the hearing by a representative or an attorney of his or her choice.

(b) The Hearing Committee and Plan also may have its attorney present during the hearing. The Practitioner or one or all members of the Hearing Committee or the Chair of the Hearing Committee or his or her designee may, if they deem it necessary, consult with their attorney during the hearing.

1.69 Deliberations, Recesses, and Adjournment

The Hearing Committee may, without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and submission of any written statements, including receipt of any new or additional evidence or consultation requested by the Hearing Committee, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened and any representatives of the Practitioner. The Hearing Committee's deliberations may be in person or by telephone conference call.

1.7 Written Report

Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation (the "Report") and shall forward the same together with the hearing record and all other documentation to the Senior Vice President and Chief Medical Officer or his or her designee. The Report shall state the decision of the Hearing Committee with respect to the proposed Professional Review Action or Summary Suspension, the effective date thereof, and a summary of reasons therefore.

1.7.1 Action on Hearing Committee Report

Within five (5) days after receipt of the Report, the Senior Vice President and Chief Medical Officer or his or her designee shall send a copy of the Report to the Practitioner and to his or her representative at the hearing, if any, by hand delivery or certified mail, return receipt requested.

1.7.2 Effect of the Hearing Committee Report

The determination of the Hearing Committee shall be final, binding, and unreviewable.

1.7.3 If a Professional Review Action is deemed final, or if a Practitioner voluntarily relinquishes participation in the Plan or if a Practitioner waives a hearing in exchange for the Plan foregoing an investigation and/or peer review committee action, such actions shall be reported to all appropriate agencies, boards, or other entities in accordance with applicable law/regulation.

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Medical Necessity appeals

We assume an active role in working with Physicians, hospitals, and other health care providers in authorizing and monitoring the utilization of covered health services. All cases with questionable medical appropriateness, delays in service, or reduction in service are referred to and reviewed by a Medical Director.

We shall approve coverage for the case if the request is for a Covered Service, sufficient information has been provided to us, and the services are medically appropriate. If a Medical Director determines that the clinical information provided by the attending Physician is insufficient to support Medical Necessity/appropriateness, coverage for the case may be denied and an appeal would be offered.

All coverage determinations are communicated verbally, and a letter is sent to the Member, attending Physician, hospital, and Primary Care Physician (PCP), when appropriate. Clinical review criteria, medical policy, or other internal guidelines are available and furnished upon request.

All denial notifications, whether verbal or written, include the reason for the denial and information on how to initiate an appeal.

Member or provider on behalf of Member appeals process

There are two broad types of appeals — utilization management and administrative. Utilization management appeals relate to denials based on Medical Necessity, medical appropriateness, or clinical issues. Administrative appeals relate to denials or disputes regarding nonmedical administrative issues, benefits limits, or other contractual terms of the health plan.

Appeals can be pre-service or post-service. Standards for appeal time frames and processes are established by applicable State and federal laws, as well as national accrediting organization guidelines adopted by AmeriHealth. Appeals procedures are subject to change.

Utilization management appeals and administrative appeals are addressed in detail within this section.

Note: The process for self-insured groups, government-sponsored plans, and certain other plans can vary from what is described on the following pages, and the guidelines are not described in this document. The availability of further appeal review through the plan administrator varies. Therefore, you should contact the Member's plan administrator, consult the *Member Handbook*, or Customer Service for information on the appeals process for a self-insured group.

Internal utilization management appeals

AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO, Inc. (AmeriHealth New Jersey) maintain an internal utilization management appeals process for any Member who is dissatisfied with any AmeriHealth New Jersey utilization management coverage decision. The utilization management appeals process provides the Member the opportunity to discuss the decision with an AmeriHealth New Jersey Medical Director/peer reviewer and appeal the adverse benefits 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 internal appeal stage will be completed within the applicable time frames described on the following pages.

Member representatives

A provider or another individual may appeal on behalf of the Member as the Member's authorized representative ("Member designee") if a valid consent or authorization form from the Member is provided to AmeriHealth New Jersey. However, in expedited or urgent care appeals, a valid Member consent or authorization form is 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, we have staff members available to assist and/or represent Members in the appeals process.

Commercial Member appeals filed by providers must be filed within 180 days of receipt of a decision from AmeriHealth New Jersey stating an adverse benefits determination. AmeriHealth New Jersey will not accept provider-on-behalf-of-Member appeal requests that are submitted after the Member appeal filing deadline.

Appeal classifications

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.

Matched specialist review

Decision makers for utilization management appeals are matched specialists — licensed Physicians, psychologists, or other health care professionals in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the initial adverse benefits determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Information for the appeal

At each appeal stage, all information gathered for the appeal will be considered by the decision-makers. This consists of information obtained from our investigation, as well as any additional information submitted by the Member or Member designee. Upon request at any time during the appeal process, we will provide the Member or Member designee a copy of the correspondence, documents, medical records, and other information provided to the decision-makers for internal appeal. We may delete from the copy provided to a Member or Member designee certain information that we consider confidential and/or proprietary.

Full and fair review

The Member or Member designee is entitled to a full and fair review. Specifically, at all appeal levels the Member or Member designee may submit additional information pertaining to the case, to AmeriHealth New Jersey. The Member or Member designee may specify the remedy or corrective action being sought. At the Member's request, AmeriHealth New Jersey will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. AmeriHealth New Jersey will automatically provide the Member or Member designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal that is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or Member designee at no charge.

Appeal stages

As described on the following pages, the Member or Member designee has a maximum of three opportunities to appeal a utilization management coverage decision. There are two internal levels of appeal conducted by AmeriHealth New Jersey: stage I and stage II. After the internal appeals are completed, the Member or Member designee may request an external review to the extent mandated by the State of New Jersey or as determined by other applicable authorities (see "*External Reviews*").

Urgent/expedited care

An urgent/expedited appeal is any appeal for medical care or treatment in which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

Stage I appeals (internal)

A Member, provider, or Member designee may initiate a stage I appeal with an AmeriHealth New Jersey Medical Director/peer reviewer by calling or writing to the AmeriHealth New Jersey Appeals Unit, as outlined in the initial AmeriHealth New Jersey denial letter, or by calling Customer Service at the telephone number listed on the Member's AmeriHealth New Jersey 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. Within the time periods that apply to the stage I appeal review (see below), an AmeriHealth New Jersey Medical Director or Physician designee will conduct a review and a decision will be issued. An AmeriHealth New Jersey Medical Director or Physician designee who has not been previously involved in the decision-making on the case, and who is not a subordinate of the decision-maker, will be the decision-maker for each stage I appeal — whether it is expedited or nonexpedited.

Nonexpedited stage I appeals

Nonexpedited (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 our 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, upon the request of the Member's Physician, and/or when we determine that a delay in decision-making based on nonexpedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed while awaiting a nonexpedited appeal decision. Expedited appeal review will be completed within 72 hours after our receipt of the appeal, with approximately 24 hours allotted to the stage I expedited appeal and approximately 48 hours to the stage II expedited appeal.

The Member, Member designee, and other providers, as appropriate, will be notified of the AmeriHealth New Jersey Medical Director's decision on the stage I expedited appeal verbally or by fax within 24 hours after receipt of the expedited appeal. At that time we will also provide notice of the opportunity to

go forward 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 appeals (internal)

If the Member is dissatisfied with the outcome of the stage I appeal, the Member or Member designee may file a stage II appeal by calling or writing to us within 60 days of receipt of the stage I decision letter. Directions for filing a written or verbal stage II appeal are outlined in the stage I 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 decision-making on the case and who are not subordinates of those previously involved. The Member or Member designee may appear before the panel or participate by conference call or other appropriate technology.

The Member may also ask us 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. If requested by the Member or Member designee, we 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.

Nonexpedited stage II appeals

For nonexpedited (or standard) stage II appeals, we will send an acknowledgment 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 decision letter providing written notice of the stage II decision and an explanation of appeal rights, as appropriate, will 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, upon the request of the Member's Physician, and/or when we determine that a delay in decision-making based on nonexpedited appeal time frames could seriously jeopardize the Member's life, health, or ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed while awaiting a nonexpedited appeal decision. Expedited appeal review will be completed within 72 hours after our receipt of the appeal, and the final 48 hours (approximately) of that period are allotted for completion of any expedited stage II appeal that occurs after an expedited stage I appeal.

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 our 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.

External reviews

If the Member is dissatisfied with the outcome of the stage II appeal, the Member or Member designee may initiate an external review 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. However, other authorities may be designated to conduct external review for Members of self-funded plans or health plans for government employees.

For plans subject to New Jersey State-mandated requirements, the Member or Member designee may initiate the external review within 120 days of receipt of the stage II determination to an IURO. 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 to 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.

To request an external review, follow the instructions in the decision letter for the AmeriHealth New Jersey stage II appeal. A Member who has questions or is enrolled in a self-funded plan or plan for government employees should check with the plan administrator or benefits manager regarding external review procedures that may be available.

Also, note that the appeals 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 on the Member's ID card.

Members or Member designees with written Member consent/authorization have the right to appeal coverage determinations within 180 days by calling 1-877-585-5731, or by writing to:

AmeriHealth New Jersey Appeals Department
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

Medicare Advantage HMO appeals and grievance processes

Medicare Advantage HMO appeals (AmeriHealth 65® NJ HMO)

An AmeriHealth 65 NJ HMO Member, the Member's appointed representative, or the provider on behalf of the Member may request an appeal of any coverage decision about payment for or the failure to arrange or to continue to arrange for, what the Member believes are Covered Services under AmeriHealth 65 NJ HMO including noncovered Medicare benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.

A decision about medical care that has not already been rendered is called a pre-service appeal. Pre-service appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 30 calendar days after the appeal is received; an extension of up to 14 calendar days is permitted for a pre-service appeal if the Member requests it, or if the AmeriHealth New Jersey Medical Director finds that the delay is in the best interest of the Member, without harm to the Member's health.

The Member or his or her appointed representative should mail the written appeal to:

AmeriHealth 65 NJ HMO Member Appeals Department
P.O. Box 13652
Philadelphia, PA 19101-3652

If the Member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard 30-day pre-service appeal process, an expedited appeal of a pre-service request may occur at the request of the Member, the Member's appointed representative, or at the request of the Member's Physician. Expedited appeals are resolved as expeditiously as required by the Member's health condition, but in no more than 72 hours upon receipt of the appeal request. All Member requests for an expedited appeal with Physician support or requests for an expedited appeal from a Physician are automatically handled as expedited appeals.

The Member or his or her appointed representative should contact us by telephone or fax:

AmeriHealth 65 NJ HMO:	1-877-585-5731
TTY/TDD:	1-888-857-4816
Fax:	609-662-2480

A decision about payment for care is called a post-service appeal and must be resolved no later than 60 calendar days after the appeal is received.

If the original denial is upheld after review by us, the case is forwarded for review and determination by an independent review entity (IRE), who is contracted by the Centers for Medicare & Medicaid Services (CMS).

Timely submission of Medicare Advantage HMO Members' medical records

As part of the federally mandated Medicare Advantage Appeals and Grievances process, AmeriHealth New Jersey is required to obtain a Member's medical record in order to make a determination of coverage. Should we uphold our determination, we are required to forward the Member's appeal file, which includes medical records, to an IRE. An IRE is contracted with CMS to perform second-level independent reviews of Medicare Advantage Members' appeals. Medical records must be submitted to us in a timely manner. By doing so, we can submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS also requires that both AmeriHealth New Jersey and an IRE make their determinations within 72 hours for an expedited appeal and within 30 days for a standard appeal. If a Member requests an expedited review, we will immediately send a request to the provider for medical records. We must receive the records within 24 hours for an expedited appeal and within ten days for a standard appeal. If an appeal is sent to an IRE, the IRE may request additional records, which are required to be sent under the same time frames.

Upon our request, and in accordance with your agreement, you must provide us with copies of a Medicare Advantage HMO Member's medical records as requested.

Other reasons we may require the timely submission of medical records include:

- facilitating the delivery of appropriate health care services to Medicare Advantage HMO Members;
- assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as previously discussed), claims adjudication, and other administrative programs;

- complying with applicable State and federal laws and accrediting body requirements (e.g., National Committee for Quality Assurance);
- facilitating the sharing of such records among health care providers directly involved with the Member's care.

Skilled nursing facility and home health discharges

There is a special type of appeal that applies only to discharges when coverage will end with a Skilled Nursing Facility (SNF), home health, or comprehensive outpatient rehabilitation facility services. Members receive notice two days before coverage ends. If the Member thinks his or her coverage is ending too soon, the Member may appeal no later than noon the day before coverage ends. The appeal should be sent to:

Healthcare Quality Strategies, Inc.
557 Cranbury Road, Suite 21
East Brunswick, NJ 08816
Phone: 1-800-624-4557 or 732-238-5570

If the Member makes this type of appeal, his or her stay may be covered during the time period Healthcare Quality Strategies, Inc. (HQSI) uses to make its determination. The Member must act very quickly to make this type of appeal, and it will be decided quickly.

Hospital discharges

Another special type of appeal applies only to hospital discharges. If the Member thinks his or her coverage of a hospital stay is ending too soon, the Member may appeal directly and immediately to HQSI. If the Member makes this type of appeal, his or her stay may be covered during the time period HQSI uses to make its determination.

Medicare Advantage HMO grievance

A Medicare Advantage HMO grievance is any complaint or dispute raised by a Medicare Advantage HMO Member or the Member's appointed representative, other than a dispute involving a coverage determination. Medicare Advantage HMO grievances may include disputes regarding such issues as office waiting times, Physician behavior, adequacy of facilities, or involuntary disenrollment situations. A decision will be issued no later than 30 calendar days after the grievance is received. An extension of up to 14 calendar days is permitted if the Member requests or if AmeriHealth New Jersey requires more information and the delay is in the best interest of the Member. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the best interest of the Member.

Medicare Part D appeals and grievances

Medicare Part D appeals

An AmeriHealth 65 NJ HMO Member, the Member's appointed representative, or the Member's prescribing Physician on behalf of the Member may appeal our decision not to cover a drug, vaccine, or other Part D benefit. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause. There are two types of appeals:

- ***Standard appeals*** are resolved as expeditiously as the Member's health condition requires, but no later than seven calendar days after we receive the appeal request. The Member or his or her appointed representative should mail the written appeal to:

  AmeriHealth 65 NJ HMO Member Appeals Department
  P.O. Box 13652
  Philadelphia, PA 19101-3652

- ***Expedited appeals*** are resolved within 72 hours upon receipt of the appeal, or sooner if the Member's health condition requires. The Member or his or her appointed representative should contact us by telephone or fax at:

AmeriHealth 65 NJ HMO:	1-800-645-3965
TTY/TDD:	1-888-857-4816
Fax:	215-988-2001

If the original denial is upheld after the review by AmeriHealth 65 NJ HMO, the Member or the Member's appointed representative has the right to ask for a review and determination by an IRE, which is contracted by CMS.

Medicare Part D grievances

A grievance is any complaint other than one that involves a coverage determination. The Member may file a grievance if he or she has any type of problem with AmeriHealth 65 NJ HMO or one of our network pharmacies that does not relate to coverage for a prescription drug. Grievances must be decided no later than 30 calendar days after receiving the complaint. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the Member's best interest.

Note: These procedures may change due to changes in applicable State and federal laws and regulations.

Administrative appeals

We maintain an administrative appeals process for any Member who is dissatisfied with our decision regarding claims or noncovered benefits. The administrative appeals process gives Members the opportunity to appeal adverse claims and noncovered benefits determinations. Each level of appeal is completed promptly, within the applicable time frames outlined on the following pages.

Member representatives

While decisions regarding claims and noncovered benefits may be appealed by the Member, such decisions may also be appealed by a provider or other individual acting on behalf of the Member as the Member's designee if a valid consent or authorization form from the Member is provided to us. We also have staff members available to assist and/or represent Members in the appeals process.

Appeal classifications

Appeals of decisions regarding claims or noncovered benefits may also be referred to as pre-service appeals or post-service appeals. A pre-service appeal is for benefits that are covered only if precertified or Preapproved before medical care is obtained; all other appeals are post-service.

Appeal stages

As described on the following pages, the Member or Member designee has access to two internal stages of appeal — level I and level II. The level II appeals process is final unless the Member or Member designee chooses to contact appropriate external authorities as directed in the level II decision letter (see "Level II appeals" below).

Appeal decision-makers and time frames

Decision-makers for administrative appeals are individuals with no previous involvement in the decision at issue and are not subordinates of such individuals. Review of an administrative appeal is completed and a written decision letter issued for each level of appeal within 15 calendar days of receipt of a first- or second-level request for a pre-service administrative appeal and within 30 calendar days of receipt for a request for a post-service administrative appeal.

Information for the appeal review

At each appeal stage, all information gathered for the appeal review is considered by the decision-makers. This includes information obtained from our investigation, as well as any additional information submitted by the Member or Member designee. Upon request at any time during the appeal process, we will provide the Member or Member designee a copy of the correspondence, documents, medical records, and other information provided to the decision-makers for internal appeal review. We may delete from the copy provided to a Member or Member designee certain information that we consider confidential and/or proprietary.

Level I appeals

The Member or Member designee must request a level I appeal within 180 days of receipt of notice of a denied claim or a noncovered benefit. Instructions for filing a level I appeal are included in the notice letter. The Member or Member designee may call Customer Service at the telephone number on the Member's ID card or send a written appeal to:

AmeriHealth New Jersey Appeals Unit
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

The level I decision-maker will review all information obtained for the appeal from the Member and other sources. We will issue a written decision letter according to the time frames outlined previously.

Level II appeals

If the Member is not satisfied with the level I appeal decision, the Member or Member designee may request a level II appeal within 60 days of receipt of the level I decision letter. The level II appeal will be reviewed by a three-person committee of decision-makers. When arranging the committee meeting, we will notify the Member or Member designee of the meeting date, meeting procedures, and the Member's rights at the hearing. The Member and/or the Member designee also has the right to ask us to have a member of our staff who is not involved in the case represent the Member. We will issue a written decision letter according to the time frames outlined previously. The decision is final unless the Member or Member designee contacts the Department of Health and Senior Services and/or the Department of Banking and Insurance (DOBI) as directed in the level II decision letter.

Note: Members enrolled in self-funded plans, government-sponsored plans, and certain other plans are advised that their plans may have appeals procedures for administrative appeals decisions that are different than those previously stated. Members should check with the plan administrator or benefits manager for information regarding differences in policies, procedures, and benefits decisions for their plan.

Also, note that the appeal procedures previously stated 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 number on the Member's ID card.

Provider claims appeal process

We maintain a provider claims appeal process to resolve disputes between carriers and Participating Providers relating to payment of claims. If a provider is dissatisfied with a claim decision following the submission of a complaint regarding the claim decision, the provider may appeal the claim decision under the AmeriHealth New Jersey provider claims appeal process. A provider who has received initial audit findings from the Corporate and Financial Investigation Department related to a claims payment determination may initiate the provider claims appeal process described on the following pages. The AmeriHealth New Jersey provider claims appeal process has two levels.

The New Jersey Senate Bill 2824, known as the Health Claims Authorization, Processing, and Payment Act (HCAPPA) requires submission of the form for all AmeriHealth New Jersey provider claim appeals.

First-level provider appeals

In accordance with the provisions of HCAPPA, a health care provider may initiate a first-level provider appeal. The appeal must be initiated on or before the 90th calendar day following receipt of our claims determination using the *Health Care Provider Application to Appeal a Claims Determination* form, as specified by the New Jersey DOBI. Along with the DOBI form, the provider should submit any additional relevant information in support of the appeal. A copy of this form is available on our website at *www.amerihealth.com/pdfs/providers/interactive_tools/forms/appeals_claim_form.pdf*.

Send the claim form and any supporting documentation to:

AmeriHealth New Jersey
Provider Claim Appeals Unit
P.O. Box 7218
Philadelphia, PA 19101

Appeal arbitration

If the provider disputes the appeal determination made by the carrier, the provider may initiate an arbitration request through the New Jersey Program for Independent Claims Payment Arbitration (PICPA) by completing the PICPA form within 90 calendar days of receipt of the appeals decision. Claims are eligible for arbitration *only* if the original appeal was filed on the *Health Care Provider Application to Appeal a Claims Determination* form.

No dispute will be accepted for arbitration unless the payment amount in dispute is $1,000 or more; however, a health care provider may aggregate his own disputed claim amounts for the purposes of meeting the requisite threshold requirements. No dispute pertaining to Medical Necessity that is eligible to be submitted to the Independent Health Care Appeals Program shall be subject to arbitration. For more information on the PICPA, visit *https://njpicpa.maximus.com*.

For more information regarding New Jersey provider appeals and arbitration processes, refer to the State of New Jersey DOBI website at *www.state.nj.us/dobi/chap352/352implementnotice.html*.

The provider claims appeal process has been modified in accordance with the Health Claims Authorization, Processing, and Payment Act.

Provider initial claims review process

Refer to the *Billing* section of this manual for information.

ER services appeals

ER claims that do not meet the AmeriHealth criteria for an 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, complete an *Emergency Room Review Form* (available at *www.amerihealth.com/providerforms*), attach the Member's medical record, and submit to:

Claims Medical Review – Emergency Room Review
AmeriHealth New Jersey
Attn: Appeals
259 Prospect Plain Road, Building M
Cranbury, NJ 08512

Provider complaints

A complaint is an expression of dissatisfaction regarding any aspect of the coverage, operations, or management of AmeriHealth New Jersey. Providers who are dissatisfied with any such aspect, including, but not limited to, our medical policy, network contracting, credentialing, capitation payments, or claims payment processes may call Customer Service at 1-888-YOUR-AH1. Most complaints can be resolved by Customer Service; however, some complaints may need to be forwarded to the appropriate area for further review and resolution. For example, complaints related to credentialing are forwarded to the Credentialing department for investigation and resolution.

Service-related complaints are forwarded to the responsible supervisor for review and action. Complaints regarding claims processing, payment, or adjustments are forwarded to the Adjustment Unit for resolution. The Adjustment Unit reviews the inquiry and adjusts the claim as appropriate. If during review the staff in the Adjustment Unit determines that the claim was adjudicated correctly, the provider is notified of the outcome of the review and given instructions for filing an appeal (see *Provider claims appeal process*).

The third-party websites mentioned throughout the manual are maintained by organizations over which AmeriHealth exercises no control, and accordingly, AmeriHealth disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

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