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Overview

The Clinical Services – Utilization Management (UM) 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 Hospital, Ancillary Facility, or Ancillary Provider Agreement (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 claim payment under the terms of a Member's benefits plan and/or a network Provider's contract.

For a health care service to be covered or payable, it must 1) be listed as included in the benefits plan, 2) be Medically Necessary, and 3) not be specifically excluded from coverage. Most AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, 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 of the requested services and the appropriate setting (e.g., office, inpatient, outpatient) for Covered Services requested by a Member's health care Provider When a Covered Service can be administered in various settings, Providers should request Preapproval/Precertification, as required by the applicable benefits plan, to provide the Covered Services in the most appropriate and cost-effective setting for the Member's current medical needs and condition. The AmeriHealth review for Preapproval/Precertification will be based on the clinical documentation from the requesting health care Provider.

It is not practical to verify Medical Necessity on all procedures on all Covered Services. Therefore, certain procedures may be automatically approved by AmeriHealth, based on the following:

- The generally accepted Medical Necessity of the procedure itself;
- The diagnosis reported;
- An agreement with the Provider performing the procedure.

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

Utilization reviews generally are categorized based on the timing of the review and the service for which a determination is requested.

- **Preapproval/Precertification review.** When a review is required *before* a service is performed, it is a Preapproval/Precertification review.
- **Admission review.** Initial review of the Medical Necessity of an Emergency admission.

- **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.

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

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

The nurses review applicable policies and procedures in the benefits plan, taking into consideration the individual Member's condition and applying applicable policies and procedures to the request. Evidence-based clinical protocols are applied to specific procedures. Depending on the specific service or the fact pattern identified in the request, the service request may be referred to a Medical Director for further review and coverage or payment determination. Independent medical consultants may also be engaged to provide clinical review and advise on coverage or payment determination of specific cases or for specific conditions. 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 appeal rights in accordance with applicable law. All denials are determined by Medical Directors.

The AmeriHealth utilization review program offers the opportunity for peer dialogue regarding coverage decisions based on Medical Necessity by giving Providers direct access to Medical Directors to discuss coverage determinations. The nurses, 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.

Medical Directors and nurses are salaried employees; contracted external Providers and other professional consultants are compensated on a per case basis, regardless of the coverage determination. AmeriHealth does not reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals 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). 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.

Providers are notified in advance when we are planning on performing selective medical review, Members may not be penalized when required selective medical review results in a determination that a service is not Medically Necessary.

Delegation of utilization review activities and criteria

In certain instances, AmeriHealth has delegated utilization review activities to entities with an expertise in medical management of a specific membership population or type of benefits (such as mental health/substance abuse [behavioral health]). A formal delegation and oversight

process is established in accordance with applicable state and federal laws and with the National Committee for Quality Assurance (NCQA) accreditation standards. In such cases, the delegate's utilization review criteria are generally adopted by AmeriHealth for use by the delegated entity.

Clinical criteria, guidelines, and resources

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

- **InterQual®.** A product of Change Healthcare, the InterQual clinical decision-support criteria model is based on the evaluation of intensity of service and severity of illness. Covered Services for which InterQual criteria may be applied include, but are not limited to, the following:
  - Home health care
  - Inpatient hospitalizations*
  - Inpatient rehabilitation*
  - Long-term, acute care facility admissions*
  - Observation
  - Some elective-surgery for inpatient and outpatient procedures

  **An inpatient admission requires an overnight stay, which must be at least 24 hours.*

  Note: An overnight stay is defined as a period of at least 24 hours. Therefore, a patient presenting to the emergency department at 9:00 p.m. and leaving at 11:00 a.m. the following morning is *not* considered an inpatient admission.

  We apply InterQual acute-care guidelines, medical necessity/medical policy criteria, and medical judgement to evaluate medical appropriateness for all Emergency admissions. Admissions that do not meet acute intensity of services and severity of illness guidelines are reviewed by a Medical Director, and coverage or payment may be denied if guidelines are not met. In addition, certain conditions may stabilize over a 24 – 48-hour period and may be appropriate for observation in the hospital outpatient department while diagnostic studies are performed or response to treatment may be monitored. These are typically conditions where there is a need to rule out serious medical illness that would require inpatient admission (e.g., abdominal or chest pain). Observation services do not require Preapproval/Precertification may be subject, at the discretion of AmeriHealth, to review of Medical Necessity, and the AmeriHealth criteria, which requires that the treatment and/or procedures include at least eight hours of observation.*

  The AmeriHealth claim payment policy for facility reporting of observation services supersedes InterQual guidelines. In this instance, the AmeriHealth claim payment policy stating the treatment and/or procedures must* ***include at least eight hours of observation supersedes the InterQual standard of six hours**. For more information on this policy, visit our Medical and Claim Payment Policy Portal.*

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

  When submitting a written request for utilization review, be sure to attach the request or case identifier to the medical records and submit records as instructed. Electronic versions of medical records are acceptable and encouraged. Medical records that arrive with a request or case identifier require less research and are rapidly forwarded to the appropriate team for review.

We may conduct focused evaluations of the Medical Necessity of requests for the use of an inpatient setting for certain elective surgical procedures. Examples include, but are not limited to, laparoscopic cholecystectomies, tonsillectomies, adenoidectomies, hernia repairs, and battery and generator changes. Providers must submit clinical documentation when it is believed that the outpatient setting would not be appropriate and inpatient admission is necessary.

Procedures performed during Emergency admissions where these procedures were performed must also meet InterQual guidelines for acute admission and medical necessity of the procedures.

- **Centers for Medicare & Medicaid Services (CMS) guidelines.** CMS adopts and publishes a set of guidelines for coverage of services by Medicare (for Members in a Medicare Advantage plan of one of our Affiliates). CMS guidelines are also used to help determine coverage for durable medical equipment (DME) services for all products.

  CMS and InterQual guidelines consider elective diagnostic coronary angiography and percutaneous coronary intervention (i.e., balloon angioplasty, brachytherapy, and stents) as outpatient procedures, unless the Provider submits clinical documentation that inpatient admission is required. Such documentation should include the presence of major comorbidities, altered physiologic status, and/or the need for intensive monitoring for at least 24 hours following the procedure.

- **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 applicable for Covered Services including, but not limited to, the following:
  - DME
  - Skilled Nursing Facility (SNF)
  - Infusion therapy
  - Nonemergency ambulance transports
  - Review of potential cosmetic procedures
  - Review of potential experimental or investigational services

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 mean standards that are based on the following: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; Provider specialty society recommendations;

the views of 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 diagnosis or treatment of a covered person's particular condition is recommended.

A drug is not considered experimental/investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the 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®
- Micromedex®

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 the Reliable Evidence* criteria listed below:

- Reliable Evidence exists that the biological product, device, medical and/or behavioral health treatment, or procedure has a definite positive effect on health outcomes.
- Reliable Evidence exists that over time the biological product, device, medical and/or behavioral health treatment, or procedure leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the biological product, device, medical and/or behavioral health treatment, or procedure is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts, regarding the biological product, device, medical and/or behavioral health treatment, or procedure, is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

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

Preapproval/Precertification review

All Participating Providers and facilities must use Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal to initiate the following authorization types: ambulance (land) – non-emergent ambulance transportation (*Note:* Except for ambulance land requests from a facility as part of discharge planning.), AIS therapy, AIS chemotherapy, chemotherapy, durable medical equipment – purchase and rental, Emergency hospital admission notification, home health (dietician, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, infusion therapy, medical/surgical procedures, behavioral health services and specific outpatient physical therapy and occupational therapy services for Medicare Advantage Members.

Requests for medical/surgical procedures can be made up to six months in advance on PEAR PM. In most cases, requests for Medically Necessary care are authorized immediately; however, in some cases authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). PEAR PM submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended status, please call 1-888-YOUR-AH1 (1-888-968-7241) for assistance.

For non-urgent services requiring Preapproval/Precertification, facilities are strongly encouraged to contact AmeriHealth **at least ten business days prior** to the scheduled date of the procedure to ensure documentation of timely Preapproval/Precertification.

The UM 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 Subscriber
- Relationship to Subscriber
- Member ID number
- Group number
- Provider 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
- Current functional level (SNF and rehabilitation only)
- Estimated length of stay (SNF and rehabilitation only)
- Short- and long-term goals (SNF and rehabilitation only)
- Discharge plan (SNF and rehabilitation only)

Note: For potentially cosmetic procedures, photos and test results may be required.

Certain products have specialized Referral and Preapproval/Precertification requirements. Visit the *Preapproval and Precertification* web page to view a list of current services that require Preapproval/Precertification. Please note that these requirements vary by benefits plan and are subject to change.

For your reference, we have published a list of medical services and codes that require Preapproval/Precertification, which is available on the *Medical and Claim Payment Policy Portal*. Select *Policy Bulletins* from the home page and then *Services Requiring Precertification* from the left-hand navigation menu.

Please note there are times when procedures are Preapproved/Precertified but never performed due to various reasons. In such cases, AmeriHealth is responsible for assessing whether the inpatient admission is still medically appropriate. Therefore, we are required to confirm if the Preapproved/Precertified procedures were performed and if not, to validate the Medical Necessity of the admission.

If we are unable to confirm the procedures, the original authorization request will remain open, and payment will not be made.

Genetic/genomic tests, certain molecular analyses, and cytogenetic tests†

Preapproval/Precertification for certain genetic/genomic tests is required through eviCore healthcare (eviCore), a specialty benefit management company, for all commercial Members.

You can initiate Preapproval/Precertification for genetic/genomic tests in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Authorizations option in the Transactions menu.
- **Telephone.** Call eviCore directly at 1-866-686-2649.

In addition, eviCore manages prepayment review for all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, for all commercial Members.

For additional information on eviCore and genetic/genomic tests, please refer to our medical policy on the Medical and Claim Payment Policy Portal.

†Self-funded groups can elect not to include this utilization management program as part of their group health plan.

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 that 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 on the Medical and Claim Payment Policy Portal.

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 FDA approval, drug compendia (e.g., AHFS 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.

Additional information about this program is available on the *Dosage and Frequency Program* page of our website.

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 PEAR PM to verify individual Member benefits. Providers may submit authorization requests for services rendered by an infusion therapy Provider, 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, social work, and dietitian.

Nonemergency ambulance transport

Nonemergency medical ambulance transport services, including hospital to hospital transfers, require Preapproval/Precertification when such a transport meets *all* 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.

Non-emergency land ambulance requests, excluding hospital to hospital transfers, initiated by the ambulance Provider must be submitted through the Authorization Submission transaction on PEAR PM.

Non-emergency air ambulance requests initiated by the ambulance Provider must be called into the UM department. Providers are not able to initiate non-emergency air ambulance requests through PEAR PM at this time.

Visit the *Medical and Claim Payment Policy Portal* to view our policy on nonemergency ambulance transport services.

Obstetrical admissions

Preapproval/Precertification of a maternity admission for a routine delivery is not required. However, obstetricians are encouraged to remind their AmeriHealth Members to self-enroll in the Baby FootSteps prenatal care management program by calling 1-800-598-BABY (1-800-598-2229).

Please note that notification is needed to assure proper claims payment for maternity admissions that exceed the following lengths of stay:

- Vaginal deliveries of 5 days or greater
- Cesarean deliveries of 7 days or greater

If you have an admission that exceeds these parameters, please contact the UM department at 1-888-YOUR-AH1 (1-888-968-7241) to provide notification.

Penalties for lack of Preapproval/Precertification

It is the network Provider's responsibility to obtain Preapproval/Precertification. For a list of current Preapproval/Precertification requirements, visit the *Preapproval and Precertification* web page. 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 from financial penalties if the network Provider does not obtain prior approval.

Admission review

Admission review is the initial review of the circumstances surrounding an Emergency admission to determine whether coverage for inpatient services will be granted. The review examines the severity of the Member's condition based on patient presentation and diagnostic study results, as well as the treatment provided, and whether the patient's condition stabilizes within the first 24 – 48 hours. Admissions to rule out seriously acute conditions or to initiate treatment that can be continued as outpatient or in an alternate setting (example: starting intravenous antibiotics during the first 24 hours to continue treatment in an alternate setting) should be considered for observation level of care.

Hospitals are required to notify AmeriHealth using PEAR PM of all Emergency admissions within two business days of admission. When submitting the initial authorization request for an Emergency inpatient admission, we require that a full 24 – 48 hours of clinical treatment and patient response be provided. This information can be submitted to us via phone or fax. Upon receipt of the required clinical information, we will provide a determination within 24 hours.

Cases that initially present to the ER but are subsequently determined by the treating Provider to require hospital confinement will require further review when payment is being requested for inpatient admission. Once notification of the admission is submitted via PEAR PM, clinical information allowing for utilization review must be provided within 72 hours. In the event such information is not submitted within 72 hours, the case will be deemed withdrawn. Should the hospital receive a denial due to lack of information, the request for an admission review can be resubmitted via fax when the clinical information is available, or the hospital may call 1-888-YOUR-AH1 (1-888-968-7241) and follow the voice prompts for authorizations.

Note: Cases will be handled by a team of nurses on a rotating basis.

Because utilization review and the issuance of determinations will be conducted primarily via fax, we created new fax cover sheets for admission reviews and discharge planning requests. We strongly suggest using these cover sheets to ensure the requests are directed to the appropriate AmeriHealth staff. These fax cover sheets can be found on the *Provider forms* web page.

Upon review of all available information, the AmeriHealth care coordinator may determine that inpatient criteria are not met. A Medical Director will then review the clinical information and may authorize or deny the inpatient admission. A determination will be rendered within 24 hours of receipt of all clinical information. The status of admission review determinations can be found on PEAR PM. Denial of inpatient admission is followed up with a letter describing the rationale for the denial and the Provider's appeal rights.

Under diagnosis related group (DRG) reimbursement, hospitals must provide AmeriHealth with requested clinical updates for Members who remain inpatient at the following checkpoints: 5 days, 10 days, 17 days, and weekly thereafter. The clinical updates will assist in making appropriate discharge planning arrangements and case management Referrals.

Concurrent review for per-diem stay

Concurrent review is the review of a continued stay in the hospital after an admission is determined to be Medically Necessary. Concurrent review is performed when reimbursement is based on a per-diem arrangement.

After initial admission review, the hospital is required to initiate concurrent review on or before the last covered day. The information can be provided by phone or fax and must include:

- Current medical information for the days being reviewed
- Treatment plan
- Current progress on goals
- A discharge plan update

If all pertinent information is provided and the days are Medically Necessary utilizing InterQual criteria, the approval will be verbally communicated to the hospital contact at the time of the review. If sufficient information is not available, the case will be pended until the necessary information is obtained from the hospital. If the AmeriHealth care coordinator is unable to approve additional days, the case will be referred to a Medical Director for Physician review. The Medical Director will review all information and render a determination within one business day.

Throughout the concurrent review process, the care coordinator is continually assessing the potential for discharge needs and communicating with the Provider and hospital Discharge Planning department to facilitate discharge as appropriate.

Concurrent review for DRG stay

Under diagnosis related group (DRG) reimbursement, hospitals must provide AmeriHealth with clinical updates for Members who remain inpatient at day 14 and every 14 days thereafter. Occasionally, more frequent updates may be necessary. The clinical updates will assist in making appropriate discharge planning arrangements and case management Referrals.

Retrospective review of inpatient stays

Authorization is required for an inpatient stay; however, under limited circumstances and by request, the UM team may extend review of a case after services have been provided in order to determine coverage or eligibility for payment. This retrospective (or post-service) review is not a guarantee of payment. These limited circumstances include:

- When a hospital/facility is unaware of a Member’s insurance coverage at the initiation of service. In this scenario, it is the responsibility of the hospital/facility to obtain authorization as soon as that information is obtained.
- If the hospital/facility discovers that a patient is an eligible AmeriHealth Member after he or she is discharged, but he or she was incorrectly classified under different insurance coverage. In this case, the hospital/facility must provide the UM department with the admission “face sheet.”

- If the Member is discharged prior to medical review being completed.

If you are not certain whether authorization for an inpatient stay was obtained, please use PEAR PM to verify the status of the authorization request prior to submitting a claim. To request a retrospective review, please adhere to the following processes:

- **For Emergency admissions.** If you find that notification of an Emergency admission was not given by the hospital to the UM department, you can request a retrospective review through PEAR PM for up to one year in the past from the current date. To do so, use the Authorization Submission transaction.
- **For elective admissions.** If you find that authorization was not obtained for an elective admission, you can initiate a review by calling 1-888-YOUR-AH1 (1-888-968-7241) Monday through Friday, 8 a.m. to 5 p.m., and following the voice prompts.

Note: Please do not send paper copies of the Member's complete medical record for an admission where authorization was not previously obtained. Medical records only need to be submitted in select cases and upon request.

Once our UM team has been notified of the request for retrospective review, we will contact the hospital/facility to request clinical information. In the case of hospitals/facilities for which we have remote access to medical records, we will attempt to obtain the clinical information on our own.

Review of the case and notification of the determination will be made no later than 30 days from when we receive all supporting information that is necessary to perform the review. If the hospital/facility fails to supply clinical information for retrospective review, we may issue an administrative denial for payment.

Please also note the following:

- We will base our determination of Medical Necessity on the information that was available to the hospital/facility at the time of admission.
- The hospital/facility may not bill a Member for services that are determined not to be Medically Necessary during the retrospective review process.

Discharge planning coordination

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

- Assess the Member's anticipated post-discharge problems and needs;
- Assist with creating a plan to address those needs;
- Coordinate the delivery of Member care.

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

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

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

Business hours

Our business hours are Monday through Friday 8 a.m. to 5 p.m. On weekends and holidays, staff is available for urgent discharge planning requests such as placements in skilled nursing facilities between 9 a.m. and 5 p.m. After hours, requests for urgent discharge planning can be left with an answering service and will be responded to on the next calendar day.

Termination of benefits

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

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

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

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

Denial procedures

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

For urgent admissions, if we determine that the information provided by the hospital is insufficient to determine Medical Necessity, the case will be reviewed with the available information. If clinical information is not received within 72 hours of the request for clinical information, the request will be deemed withdrawn. Any information provided after the case is deemed withdrawn will be reviewed and the case will be reconsidered for approval.

For non-urgent (elective) care, the Provider must submit the requested clinical information within 72 hours of such request. In the event that the additional information is not received within this 72-hour timeframe the request will be considered withdrawn.

All determinations are communicated verbally, and written confirmation is sent to the attending Provider, hospital, Primary Care Physician, 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 contractual basis and the clinical rationale for the denial, as well as how to initiate an appeal.

Peer-to-Peer discussion

The requesting Provider (including the attending/ordering Provider, or hospital medical director) may request a Peer-to-Peer with a Medical Director to further discuss the initial UM decision. Peer-to-Peer is an informal process designed to encourage dialogue between the requesting Provider and the Medical Directors and may be requested by an attending/ordering Provider for a Preapproval/Precertification, admission, concurrent, or post-service review denial based on Medical Necessity.

Please note the following:

- For concurrent review denials, the Peer-to-Peer 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 Peer-to-Peer process should be initiated after the hospital or ordering Provider has received notification of the denial but before the service is actually rendered.
- To initiate the Peer-to-Peer process, the attending/ordering Provider, hospital Utilization Management department Providers, or a designated Provider representative (e.g., hospital medical director) may contact a Medical Director by:
  - Completing the *Peer-to-Peer Request Form*;
  - Calling the Provider Phone Line at 1-877-585-5731, prompt 1, Monday through Friday, 8:30 a.m. to 5 p.m.
- A Medical Director will initiate a call to the Provider within five business days from the time the request for a peer-to-peer reconsideration is received. If the Provider cannot be reached, the Medical Director documents the attempt and renders a final determination. Whenever possible, the Medical Director Support Unit staff facilitates "warm call transfers" between Providers and Medical Directors and schedules telephone appointments between Medical Directors and Providers.
- A decision to overturn all or a portion of the initial adverse determination will be communicated in writing to the hospital.

Delays in service

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

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

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

- The Member no longer requires acute hospital services but still has inpatient skilled needs.
- Placement in a skilled or subacute facility is problematic and/or delayed for reasons beyond the hospital's or the control of AmeriHealth.
- The need for a skilled rate is of limited duration (generally fewer than seven days).

- A skilled rate will not be used for Members who would otherwise require long-term SNF placement. The skilled rate will not be used on a retrospective basis when the hospital has received a denial of days.
- If the facility is not contracted for a skilled rate and the Member is no longer receiving services at an acute level, the days may be denied after review by a Medical Director. In these denied cases, the hospital Provider appeals process will apply.

Member decision days

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

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

Observation status

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

- Diagnosis, treatment, stabilization, and discharge can occur within 24 – 48 hours.
- Treatment and/or procedures will require more than eight hours of observation.*
- The clinical condition is changing, and a discharge decision or a transfer to another hospital is expected within 24 hours.
- It is unsafe for the patient to return home or a caregiver is unavailable (arrangements need to be made for a safe and appropriate discharge setting, such as SAC/SNF, home care).
- 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 eight hours.*

The AmeriHealth claim payment policy for facility reporting of observation services supersedes InterQual guidelines. In this instance, the AmeriHealth claim payment policy stating the treatment and/or procedures must **include at least eight hours of observation supersedes the InterQual standard of six hours. For more information on this policy, visit our Medical and Claim Payment Policy Portal.*

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

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

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

Transfers within and between inpatient facilities

Members may be transferred within or between inpatient facilities when Medically Necessary.

Transfers within the same facility

All **nonemergency** transfers within an acute care facility to a psychiatric, rehabilitation, or long-term acute care unit within the same facility must be Preapproved/Precertified by the UM department.

All **Emergency** transfers within a facility from a psychiatric or rehabilitation unit to an acute care unit within the same facility do not need to be Preapproved/Precertified, but the facility must notify the UM department.

Transfers between facilities

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

For inpatient hospital transfers, the second (accepting hospital) is subject to medical necessity guidelines for inpatient hospital transfer, as established in the Medical Policy, as well as InterQual Guidelines.

When services **do** require an overnight stay at the accepting facility, the day of transfer is considered the day of discharge from the transferring facility and the day of admission to the accepting facility. If the admission is non-emergent, the sending facility must Preapprove/Precertify the new admission; if the admission is emergent, the facility must notify the UM department.

The sending facility should contact the UM department to request Preapproval/Precertification when a non-emergent transfer is planned. This cannot be done through PEAR PM. The facility should be ready to provide the name and number of the transferring Provider, facility being transferred to, and reason for transfer.

Appeal options

Appeals for lack of Medical Necessity

Inpatient and outpatient services appeals

Facilities must submit, with the member's consent, the appeal in writing within 180 calendar days of the notice of adverse determination.

For inpatient services the notice is the Utilization Review letter or the Peer-to-Peer Reconsideration decision. The written appeal request must be accompanied by the entire medical record for the case being appealed. Appeals for denials due to Medical Necessity should be mailed to the following address:

AmeriHealth Appeals
259 Prospect Plains Rd, Bldg M
Cranbury, NJ 08512

Upon receipt, a preliminary review will be conducted. If medical necessity is established, a claim adjustment will be processed, and a determination letter will be sent to the Member and facility. If there is no change in disposition at the time of the preliminary review, AmeriHealth will arrange for an appeal review to be conducted by an external, independent, licensed Provider of

the same or similar specialty that typically manages the care under review and who was not involved in the initial adverse determination or facility Peer-to-Peer Reconsideration decision. A determination letter will be sent to the Member and facility containing the decision and a detailed explanation, along with any applicable appeal rights.

The decision to uphold or overturn all, or a portion of, the adverse determination is communicated, in writing, to the facility within 10 calendar days (7 business days) of receipt of the Stage 1 written appeal request and the complete medical record. The written determination of the appeal will include the rationale for the determination where all, or a portion of, the adverse determination is upheld.

Appeals for cosmetic or experimental/investigational services

To appeal a denial for cosmetic or experimental/investigational services, hospitals should follow the same appeals process outlined for lack of medical necessity. Submit the written appeal request, the entire medical record for the case being appealed, along with the appropriate Member authorization and any applicable supporting documentation, to the following address:

Facility Appeals
P.O. Box 13985
Philadelphia, PA 19101

ER services dispute

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

AmeriHealth
Claims Medical Review Department
1901 Market Street, 30th Floor
Philadelphia, PA 19103

Use the *Health Care Provider Application to Appeal a Claims Determination form* to submit provider payment disputes. Submit the completed form to:

AmeriHealth
Provider Claim Appeals Unit
259 Prospect Plains Road
Cranbury, NJ 08512

Other claim and payment reviews

For claims issues that are *excluded* from the Medical Necessity, cosmetic, experimental/ investigational, or ER appeals procedures outlined above, you may use the HCAPPA Appeal or the Non-Medical Necessity Appeal path. You may also submit the request through PEAR PM using the Claim Search transaction. However, using PEAR PM is an informal appeal process and does not include an External appeal right. If you need assistance using the transaction, please review the training materials on the *PEAR Help Center*.

Payment review for lack of Preapproval/Precertification

To request a payment review for services that were denied for lack of Preapproval/Precertification, facilities may initiate a first-level provider appeal on or before the 90th calendar day following receipt of our claims determination. Send the *appeal form*, along with any applicable supporting documentation, to the following address:

AmeriHealth Appeals Unit
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

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

Timely submission of Medicare Advantage Member's medical records

As part of the federally mandated Medicare Advantage Appeals and Grievances process, AmeriHealth is required to obtain a Member's medical record 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 independent review entity (IRE). IREs are contracted with CMS to perform second-level independent reviews of Medicare Advantage Members' appeals.

Upon our request, and in accordance with your Agreement, you must provide copies of medical records for Members in a Medicare Advantage plan of one of our Affiliates to us as required. Further, Providers must submit medical records to us in a timely manner. Receiving timely medical records enables us to submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS requires that both AmeriHealth and the IRE make their determinations with 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 as previously stated.

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

- Facilitating the delivery of appropriate health care services to Members in a Medicare Advantage plan of one of our Affiliates;
- Assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as discussed above), claims adjudication, and other administrative programs;
- Complying with applicable State and federal laws and accrediting body requirements (i.e., National Committee for Quality Assurance);
- Facilitating the sharing of such records among health care Providers directly involved with the Member's care.

Baby FootSteps® maternity program

Our maternity program is designed to educate all pregnant AmeriHealth Members about pregnancy and preparing for new parenthood throughout each trimester. 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 obstetrics (OB) nurse Health Coaches provide telephone support to our Members and their Provider or midwife to help coordinate their benefits and provide information they need for the healthiest delivery possible.

Postpartum programs

Mother's Option

Through this program, all Members who have an uncomplicated pregnancy and delivery have the option of choosing a shorter length of stay in the hospital. To support a smooth and safe transition home, home care visits are available per 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/Precertification*, 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/Precertification* but should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. This visit should occur within 48 hours of discharge.

Uncomplicated cesarean delivery

- **If discharged within the first 96 hours following delivery.** One home health visit is available if desired by the Member. This visit *does not require Preapproval/Precertification*, but it 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 hospital stay is longer than 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/Precertification* but should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. These visits must occur within five days of discharge and may have cost-sharing if the visit does not meet the shortened length of stay requirements.

If additional home health visits are Medically Necessary beyond the described Mother's Option visits, these must be Preapproved/Precertified by calling the Preapproval/Precertifcation department at 1-800-598-BABY (1-800-598-2229).

Comprehensive Major Medical 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 can be done by calling the Preapproval/Precertifcation 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/Precertified by calling 1-888-YOUR-AH1 (1-888-968-7241).

Lactation support coverage

Lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, 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. A list of participating in-network lactation consultants can be found by using the *Find a Doctor tool*.

Health Coaches are also 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).

Breast pump coverage

- 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.
- Members must meet the following requirements to be eligible for the *rental* of a hospital-grade breast pump with $0 cost-sharing:
  - Rental is limited to hospital-grade breast pumps;
  - Service must be Medically Necessary at the Provider's discretion;
  - Rental must be through a participating DME Provider.
- If Medical Necessity is met, Member cost-sharing will not be applied when the Member rents the breast pump from an in-network DME Provider.
- 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 breastfeeding (e.g., cleft palate/lip).
- Only one manual battery-powered, electric breast, or hospital-grade pump is covered per pregnancy.

We cover:

- **Single-user breast pump.** Purchase of one manual or double electric breast pump. The unit will be repaired or replaced if necessary and will not require a prescription, letter of medical necessity, or prior authorization.
- **Multi-user breast pump.** Rental of a multi-user (hospital-grade) breast pump on the recommendation of a licensed health care provider. A doctor's order is required.
- **Breast pump kits.** Purchase of two breast pump kits, appropriate size breast pump flanges or other lactation accessories recommended by a health care provider per birth event.

DME providers must supply members with breast pumps and related equipment within these time frames:

- Single-user breast pumps after the child's birth: within 48 hours of request
- Single-user breast pumps before the child's birth: the later of two weeks before the expected due date or 72 hours after requested
- Multi-user breast pumps: within 12 hours of request

Note: Not all groups have access to all services; therefore, Providers should verify Member eligibility and benefits using PEAR PM.

Preapproval/Precertification for home phototherapy

Preapproval/Precertification through 1-888-YOUR-AH1 (1-888-968-7241) is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be Preapproved/Precertified.