Table of contents

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 commercial 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.
- 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 directed back to the ER for follow-up care services if they can be directed 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/Precertified 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 nonemergent medical care from the appropriate setting and Provider.

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

Ambulatory care

Preapproval/Precertification may be required for select outpatient procedures. Preapproval/Precertification 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/Precertification at least five business days before the scheduled date of the procedure.

Go to *www.amerihealthnj.com/html/providers/policies.html* for the list of services that require Preapproval/Precertification. *Note:* This list is subject to change upon notice to the Provider.

Radiation therapy

Preapproval/Precertification through eviCore healthcare (eviCore) is required for nonemergent outpatient radiation therapy services for all commercial New Jersey Members.

HMO/POS Members: For commercial HMO/POS Members, the 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/Precertification 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 benefits contracts require Member payment for up to three pints of blood prior to benefit eligibility.
- Coverage may be subject to Preapproval/Precertification.

Determining whether procedures are cosmetic

In general, all plans require Preapproval/Precertification 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.amerihealthnj.com/html/providers/policies.html*. Some procedures, depending on specific medical criteria, may be approved for coverage. For coverage consideration, the Provider must complete the Preapproval/Precertification process.

Participating Providers should submit their requests through Practice Management on the Provider Engagement, Analytics & Reporting (PEAR) portal prior to services being performed. Failure to obtain Preapproval/Precertification 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/Precertification and may be subject to certain benefits limits.

All SNF admissions are either arranged by care coordinators or Preapproved/Precertified through the Preapproval/Precertification process. SNF admissions are reviewed as often as necessary to facilitate appropriate use of benefits and to promote optimal benefits coverage.

Inpatient hospital

Inpatient hospital benefits are available to HMO, POS, and PPO Members and are subject to Preapproval/Precertification. In the case of an urgent or Emergency admission for an HMO, POS, or PPO Member, the hospital shall notify AmeriHealth within 48 hours or on the next business day.

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

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