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Capitated services

Within the HMO/POS benefit plans, outpatient laboratory services are included in designated (capitated) programs.

Generally, a Primary Care Physician (PCP) must refer Members only to their capitated sites only for these services. Capitated Providers are contracted to provide a full range of services, including treatment of pediatric Members. However, not all capitated Providers treat pediatric patients.

If you are a Provider who is contracted for specialty capitation for one of the above services, you are required to either provide that service on-site or arrange for the service through a subcontractor arrangement in accordance with the terms of your Provider Agreement. It is important that you arrange for provision of the service with a subcontractor and maintain that arrangement to best 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 be completed using the capitated Provider's information.

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

Laboratory services

General guidelines

Laboratory Corporation of America® Holdings (Labcorp) is our exclusive nationally based Provider of outpatient laboratory services.

If you are a Participating Provider, you may bill only for Covered Services that you or your staff perform. Participating Provider 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 to the Participating Provider.

AmeriHealth requires you to direct Members and/or their lab specimens to a participating outpatient laboratory Provider, with the following exceptions:

- In an Emergency;
- As otherwise described in the applicable Benefit Program Requirements;
- As otherwise required by law.

Laboratory name	Laboratory indicator on ID card	Phone number
Abington Memorial Hospital Laboratory	A	215-481-5406
Atlantic Diagnostic Laboratories, Inc.	D	1-866-464-6763
Health Network Laboratories	N	1-877-402-4221
Hospital of the University of Pennsylvania (and Penn Medicine at Radnor)	H	1-800-789-7366
Laboratory Corporation of America® Holdings (Labcorp)	L	1-800-631-5250
Mercy Health Laboratory	M	610-237-4175
Pottstown Memorial Hospital	P	610-327-7522
SMA Medical Laboratories	F	215-322-6590
Thomas Jefferson University Laboratory	T	215-955-6545

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
Aculabs, Inc.	Performs mobile draws in long-term care facilities	732-777-2588
Adaptive Biotechnologies Corporation	NGS MRD testing for lymphoid cancers	1-888-552-8988
Agendia, Inc.	Breast Cancer Risk-of-Recurrence Test – MammaPrint®	1-888-321-2732
ASPiRA Labs, Inc.	Risk assessment testing for ovarian cancer	884-277-4721
Assurex Health, Inc.	GeneSight®	1-888-987-9913
Biodesix, Inc.	VeriStrat® test – proteomic test for non-small cell lung cancer	1-866-432-5930
Brookside Clinical Laboratories	Performs mobile draws in long-term care facilities	610-872-6466
CareDx, Inc.	Organ transplant rejection testing; AlloMap® and AlloSure®	1-888-255-6627
CBL Path, Inc.	Pathology, oncology, genetic testing	1-877-225-7284
Crescendo Biosciences, Inc.	Vectra®	1-877-743-8639
Decipher Corporation	Genomic prostate biopsy/Prostate cancer	1-888-792-1601
DermTech, Inc.	Pigmented Lesion Assay (PLA) – melanoma rule-out test	858-450-4222
DIANON Pathology *Dianon Pathology is a brand used by Dianon Systems, Inc., a wholly owned subsidiary of Labcorp*	Surgical pathology, including uropathology, gastrointestinal pathology, dermatopathology, and breast pathology	1-800-328-2666
Exact Sciences Laboratories, LLC	Colorectal cancer screening and Cologuard®	1-844-870-8870
Foundation Medicine, Inc.	Comprehensive genomic profiling – FoundationOne® CDx (FDA approved)	1-888-988-3639
GeneDx, LLC	Exome and genome sequencing. Diagnostic genetic testing – pediatrics, neurology, rare conditions, and hereditary cancer	1-888-729-1206
Genomic Health, Inc.	Oncotype DX® breast cancer assay	1-866-662-6897
Guardant Health, Inc.	Guardant360® – detects cell-free circulating tumor DNA (ctDNA) in blood specimens of advanced solid-tumor cancer patients and evaluates 74 genes	1-855-698-8887
Institute of Dermatopathology, PC/ AmeriPath® New York, Inc.	Dermatopathology	1-800-553-6621
Integrated Genetics *Integrated Oncology is a brand used by Esoterix Genetic Laboratories, LLC, a wholly owned subsidiary of Labcorp*	Reproductive genetic testing: prenatal and postnatal testing, prenatal diagnostics, genetic testing	1-800-848-4436

Laboratory name	Specialty	Phone number
Integrated Genetics *Integrated Oncology is a brand used by Esoterix Genetic Laboratories, LLC, a wholly owned subsidiary of Labcorp*	Reproductive genetic testing: prenatal and postnatal testing, prenatal diagnostics, genetic testing	1-800-848-4436
Integrated Oncology *Integrated Oncology is a brand used by Accupath Diagnostic Laboratories, Inc. and Esoterix Genetic Laboratories, LLC, wholly owned subsidiaries of Labcorp*	Hematopathology, complex solid tumors, molecular oncology, and genetics	1-800-447-8881
Labcorp	Specialty testing includes genetic testing, molecular oncology, HLA testing, esoteric coagulation, infectious disease, immunoassays, and microbiology	1-800-631-5250
Litholink *Litholink is a wholly owned subsidiary of Labcorp*	Testing and clinical decision support for kidney stone prevention	1-800-338-4333
MDxHealth, Inc.	ConfirmMDx® for prostate cancer, molecular, and epigenetic diagnostics for urologic cancers	1-866-259-5644
MedTox Laboratories *MedTox Laboratories is a wholly owned subsidiary of Labcorp*	Specialized toxicology and medical drug monitoring	1-800-832-3244
Monogram BioSciences *Monogram BioSciences is a wholly owned subsidiary of Labcorp*	HIV and HCV drug resistance assays and molecular oncology	650-635-1100
Myriad Genetics Laboratories, Inc.	myRisk Hereditary Cancer, BRACAnalysis, BRACAnalysis CDx, Colaris Plus, Colaris AP, EndoPredict, myChoice CDx, myPath Melanoma, and Prolaris	1-800-469-7423
Myriad Women's Health, Inc.	Prequel and Foresight	1-888-268-6795
NeoGenomic Laboratories	Oncology genetic testing	1-866-776-5907
Penn Cutaneous Laboratory	Dermatopathology	1-866-337-6522
Penn Cytogenetic Laboratory	Cytopathology	1-800-789-7366
Professional Technicians, Inc.	Performs mobile home draws	215-364-4911
Sequenom Center for Molecular Medicine, LLC d/b/a Sequenom Laboratories is a wholly owned subsidiary of Sequenom Inc. *Sequenom Inc. is a wholly owned subsidiary of Labcorp*	Highly sensitive laboratory genetic tests for noninvasive prenatal testing (NIPT) and carrier screening	1-877-821-7266
Therapath, Inc.	Neuropathology	1-800-681-4338
Veracyte, Inc.	Genomic diagnostics (endocrinology; pulmonology)	650-243-4300

HMO/POS Members

Routine laboratory services for HMO/POS Members should be directed to and processed by the PCP's capitated laboratory site. Please note that 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/Precertification.

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 Customer Service, as Preapproval/Precertification is required to issue a Referral to a nonparticipating laboratory.

Members in a Medicare Advantage HMO plan of one of our Affiliates do not require Referrals to see a specialist. However, Preapproval/Precertification from the Plan is required if care is needed from an out-of-network Provider.

PPO Members

Routine laboratory services for PPO Members must be sent to one of the in-network laboratories. For PPO Members, select laboratory codes may be performed in the Physician's office or outpatient setting in accordance with AmeriHealth claim payment policy. For a complete listing of laboratory codes allowed in the office or outpatient setting refer to *amerihealth.com/medpolicy*. If a laboratory test is not allowed in the office or outpatient setting, it 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.

Note: Members who have out-of-network benefits (e.g., PPO) may choose to use a nonparticipating laboratory for a Medically Necessary service, but they may have greater out-of-pocket costs associated with that service. In addition, the Member will be financially responsible for the entire cost of any service that is noncovered (e.g., experimental/investigational).

EPO Members

All routine laboratory services for Exclusive Provider Organization (EPO) Members must be referred to a participating laboratory. EPO Members do not have out-of-network benefits. Providers can identify AmeriHealth EPO Members by looking for "EPO" printed on their ID cards.

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, use the Find a Doctor tool at *amerihealth.com/get-care/find-doctors-and-hospitals/find-a-doctor.html*. Select the Member's desired location and plan type from the drop-down options, then type "independent laboratory" in the text field next to All Categories to conduct a search.

Keep in mind the following:

- To obtain current capitation information, use the Eligibility & Benefits transaction within Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal.
- 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 Provider Partnership Associate, 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 becomes effective February 1. A change request received January 16 does not become 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 *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 and may process the draw in their own laboratory or deliver the sample to a participating capitated laboratory (HMO) or participating laboratory/hospital (PPO). Some participating 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	Service	Phone number
Brookside Clinical Laboratories	Performs mobile draws in long-term care facilities	610-872-6466
Professional Technicians, Inc.	Performs mobile home draws	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/Precertification. Preapproval/Precertification is required for use of a nonparticipating laboratory. Providers are also required to notify Members that a nonparticipating laboratory may be used, and the Member may be subject to an out-of-network cost-sharing amount.

Contractual obligation to use Participating Providers

When applicable under the terms of your AmeriHealth Agreement, if a Provider directs Members and/or their lab specimens to a nonparticipating laboratory and does not obtain Preapproval/Precertification from AmeriHealth, the ordering Provider is required to hold the Member harmless.

The ordering 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. In addition, further noncompliance may result in immediate termination of your AmeriHealth Agreement.

If a Provider 1) refers a Member to a nonparticipating laboratory for nonemergent services without obtaining Preapproval/Precertification from AmeriHealth to do so; 2) sends a Member's lab specimen to a nonparticipating laboratory without Preapproval/Precertification; or 3) provides or orders noncovered services for a Member, the Provider must inform the Member in advance, in writing, of the following:

- A list of the services to be provided;
- That AmeriHealth will not pay for or be liable for the listed services;
- That the Member will be financially responsible for such services.

To access the *Member Consent for Financial Responsibility for Unreferred/Non-Covered Services Form*, go to *amerihealth.com/providerforms*.

Providers should also be aware of the coverage status of the tests they order and should notify the Member in advance if a service is considered experimental/investigational or is otherwise noncovered by AmeriHealth.

Cardiology Utilization Management Program*

Preapproval/Precertification for the following non-emergent tests and procedures is required through Carelon Medical Benefits Management (Carelon) for all commercial Members for the evaluation of Medical Necessity:

- Cardiovascular tests/diagnostic procedures:
  - Coronary angiography
  - Peripheral arterial ultrasound
- Nonsurgical treatments for obstructive coronary artery disease:
  - Percutaneous coronary intervention (PCI), including:
    - Balloon angioplasty
    - Stents
    - Atherectomy

Note: The following services and associated CPT® codes will be reviewed post-service in accordance with Carelon's clinical criteria:

- Duplex Scan Lower Extremity Arteries
- Duplex Scan Upper Extremity Arteries
- PCI
  - **Exception**: When the results of the coronary angiogram are known, and the coronary angiogram and PCI are not performed at the same time, Preapproval/Precertification of the PCI must be obtained prior to the service being performed.

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal$_{sm}$.** *providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on this utilization management program, please refer to our medical policy at *amerihealth.com/medpolicy*.

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

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

Preapproval/Precertification for genetic/genomic tests is required through eviCore healthcare (eviCore) for all commercial Members.

Please note that the ordering Provider is responsible for submitting Preapproval/Precertification requests for the applicable tests. **Failure to adhere to the Preapproval/Precertification process may result in your AmeriHealth patients receiving a bill for the testing.**

Initiate Preapproval/Precertification for genetic/genomic tests in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transactions tab (under Authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

For laboratory Providers: When a request for genetic/genomic testing is received, laboratories must ensure a Preapproval/Precertification is on file before rendering services. If Preapproval/Precertification is not on file for the Member, it is the laboratory's responsibility to submit a request to eviCore.

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 this utilization management program, please refer to our medical policy at *amerihealth.com/medpolicy*.

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

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 certain AmeriHealth products in New Jersey.

Musculoskeletal Utilization Management Program*

Preapproval/Precertification for the following nonemergency modalities is required through Carelon for all commercial Members:

- Interventional pain management procedures, including the following:
  - Epidural injections
  - Facet joint injections/medial branch blocks
  - Facet joint radiofrequency nerve ablation
  - Implanted spinal cord stimulators
  - Sacroiliac joint injections
- **Spinal surgical procedures.** Cervical, thoracic, lumbar, and sacral (including all concurrent spinal procedures and all associated revision surgeries):
  - Cervical Decompression with or Without Fusion
  - Cervical Disc Arthroplasty
  - Lumbar Disc Arthroplasty
  - Lumbar Discectomy, Foraminotomy, and Laminotomy
  - Lumbar Fusion and Treatment of Spinal Deformity (including Scoliosis and Kyphosis)
  - Lumbar Laminectomy
  - Noninvasive Electrical Bone Growth Stimulation
  - Vertebroplasty/Kyphoplasty
  - Bone Graft Substitutes and Bone Morphogenetic Proteins

- **Surgical procedures of the joint.** Including all associated revision surgeries:
  - Shoulder Arthroplasty
  - Shoulder Arthroscopy and Open Procedures
  - Hip Arthroplasty
  - Hip Arthroscopy and Open Procedures
  - Knee Arthroplasty
  - Knee Arthroscopy and Open Procedures
  - Meniscal Allograft Transplantation of the Knee
  - Treatment of Osteochondral Defects

Carelon will also review the requested setting and level of care (i.e., inpatient vs. outpatient – for spine and select joint services only) to ensure it's appropriate for the patient's procedure based on his or her specific clinical circumstances.

Please note the following important information regarding the Musculoskeletal Utilization Management Program:

- **Sending additional clinical documentation.** Providers can send additional clinical documentation to Carelon by fax to 1-844-425-3738.
- **Requesting a peer-to-peer review.** Providers can request peer-to-peer review by calling 1-866-745-1791.
- **Smoking cessation recommendation.** The AmeriHealth policies and Carelon's orthopedic surgery guidelines contain recommendations for smoking cessation and confirmatory blood work prior to surgical procedures of the spine and joint. Please note that for most surgical procedures of the spine and joint, these are purely recommendations and failure to comply will not result in a denial. The only exception is for revision rotator cuff repair, where smoking cessation and confirmatory blood work are mandatory.

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal.** *https://www.providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on this utilization management program, please refer to our medical policy at *amerihealth.com/medpolicy*.

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

Radiation therapy*

Preapproval/Precertification for nonemergent outpatient radiation therapy services is required through eviCore for all commercial Members. Preapproval/Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

The AmeriHealth Radiation Treatment of Breast Carcinoma guideline indicates that a hypofractionated regimen is the preferred treatment for patients with early stage (T1-2N0) breast carcinoma who meet certain criteria. For these patients, a request for Preapproval/ Precertification of conventional fractionation will require a peer-to-peer call with an eviCore Radiation Oncologist.

Initiate Preapproval/Precertification for nonemergent outpatient radiation therapy in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transactions tab (under Authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

For additional information on nonemergent outpatient radiation therapy services, please refer to our medical policies at *amerihealth.com/medpolicy*.

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

Radiology services

We are contracted with Carelon to perform Preapproval/Precertification for outpatient nonemergent diagnostic imaging services and certain high-technology radiology services for our HMO, POS, and PPO Members.

Ordering Physicians — PCPs or specialists — are required to obtain Preapproval/Precertification from Carelon for the following outpatient nonemergent diagnostic services:

- CT/CTA scans
- CCTA/FFR
- Echocardiography
- MRA
- MRI
- Nuclear cardiology studies
- PET scans
- PET/CT fusion

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal.** *providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

Reviews for the above services will be performed by Carelon, as the AmeriHealth designee, according to Medical Necessity criteria.

To avoid delays and denials due to lack of information supporting medical necessity, Providers must submit the necessary clinical information with the request. For more information and a complete list of our high-technology radiology services, please review our policies at *amerihealth.com/medpolicy*.

Note: If the above-listed services 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/Precertification telephone number listed on the Member's ID card. Ordering Providers should not call Carelon under these circumstances.

For HMO/POS Members, Preapproval/Precertification replaces the need for a PCP Referral. Therefore, the PCP Referral for these services is not needed. The Preapproval/Precertification is valid for 30 days from the initial request date for the service.

For radiology services not included in the previous listing, a Referral is required for claim payment.

Review authorized procedure codes and descriptions

Providers should review the procedure codes and descriptions that have been authorized before performing the service. If the procedures billed are not those that have been authorized, or within the same procedure code grouping of the codes that have been authorized, the service will be denied appropriately for "no authorization on file."

Both ordering and performing Providers can access Carelon's ***Provider****Portal* through PEAR PM or by visiting *providerportal.com*.

The Carelon ***Provider****Portal* is available 7 days a week and offers Providers the following:

- An easy-to-use interface for efficient Preapproval/Precertification requests;
- Printable Preapproval/Precertification summary information sheets for completed requests;
- Online tracking of previous Preapproval/Precertification requests and status of open requests.

If there is a discrepancy between the procedure to be performed and the procedure that received prior authorization/approval, the performing Provider should work with both the ordering Physician and Carelon to address the discrepancy and request any necessary changes to the authorization before rendering service.

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.

Sleep studies

Preapproval/Precertification for sleep studies and continuous positive airway pressure (CPAP) titration studies in a facility setting is required through Carelon for all commercial Members.

DME Providers are required to obtain Preapproval/Precertification for APAP, BPAP, and CPAP (PAP) machines and their replacement supplies (e.g., tubing, water chambers, face masks).

Carelon also incorporates a compliance element to the Preapproval/Precertification process. Usage data will be collected for all Members using PAP therapy. This data will be analyzed by Carelon to determine if the Member has been compliant in using their PAP machine and if a request for Preapproval/Precertification of continued rental and/or supplies will be approved or denied.

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal.** *providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on sleep testing services, please refer to our medical policy at *amerihealth.com/medpolicy*.

Specialty medical drugs

Specialty medical drugs are typically 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 and require Preapproval/Precertification from AmeriHealth.

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.

Direct Ship Drug Program

AmeriHealth offers the Direct Ship Drug Program, through which in-network Physicians can order certain specialty medical drugs that are administered in the office and are eligible for coverage under the Member's medical benefit when Medical Necessity criteria are met. AmeriHealth contracts with specific specialty drug vendors who provide these medications at no cost to our network Physicians. This program is available to all AmeriHealth in-network Physicians.

The advantages of using the AmeriHealth Direct Ship Drug Program include:

- AmeriHealth places the order with the vendor based on the Physician's request and handles all payments for the drugs.
  - *Note:* Member cost-share, copayments, or coinsurance are still appliable, in accordance with the terms of the member's benefit contract.
- Physicians do not have to submit reimbursement forms for the cost of the drugs.
- Physicians do not have to dedicate office space to long-term drug storage.

A complete list of specialty medical drugs that are available through the Direct Ship Drug Program is available on our website at *amerihealth.com/directship*. There Providers will also find drug request forms and instructions for ordering.

Most Cost-Effective Setting Program

AmeriHealth seeks to ensure that our Members receive injectable/infusion therapy drugs in a setting that is both safe and cost-effective for their clinical condition. AmeriHealth reviews the most appropriate setting for commercial Members to receive certain injectable and infusion therapy drugs as part of the Preapproval/Precertification review process.

During the Preapproval/Precertification review, each Member's medical needs and clinical history are evaluated to determine if the drug requested by the Provider is appropriate. As part of our Most Cost-Effective Setting Program, AmeriHealth also reviews the requested treatment setting for certain drugs covered under the Member's medical benefit to ensure that they are administered in settings that are both safe and cost-effective.

Covered settings for drugs in this program include:

- A Physician's office;
- The Member's home, where the drug is administered by an in-network home infusion Provider;
- An ambulatory (freestanding) infusion suite, that is not owned by a hospital or health system in our network.

A hospital outpatient facility will be considered for Members who are receiving an initial dose of any drug in this program. It may also be considered if there is a clinical rationale that requires the Member to receive intensive monitoring and care uniquely available in a hospital outpatient facility. The Provider must submit documentation to AmeriHealth to support any request for ongoing coverage in the hospital outpatient facility. This information will be reviewed and a coverage determination on setting will be made.

For more information about the Most Cost-Effective Setting Program, including a complete list of all drugs on the program, go to *amerihealth.com/providers/policies_guidelines/cost-effective-program.html*.