AmeriHealth HMO

AmeriHealth
NEW JERSEY

Benefits That Require Pre-Authorization

Your primary care physician or provider contacts the Care Management and Coordination (CMC) team and provides information to support the request for services. The CMC team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The CMC team notifies the physician/provider whether services are approved for coverage. If the CMC team does not have sufficient information or the information evaluated does not support coverage, the physician/provider and member are notified in writing of the decision. Members and providers acting on behalf of the member may appeal the decision. At any time during the evaluation process or the appeal, the provider or member may provide additional information to support the request.

Services that require pre-authorization include but are not limited to:

- All non-emergency hospital admissions (excluding maternity)
- All same day surgery/short procedure unit admissions
- Outpatient therapies: speech, cardiac, pulmonary, respiratory, home infusion, lymphedema
- Other facility services: skilled nursing, home health, hospice, birthing center
- Obesity Surgery
- Day Rehabilitation Programs
- Orthognathic Surgery
- Outpatient radiology services*: MRI/MRA, CT Scan, PET Scan, and Nuclear Cardiac Studies
- Prosthetics and Orthotics-Purchases (including repairs and replacements) more than $500 (except ostomy supplies)
- Durable Medical Equipment-Purchases (including repairs and replacements) more than $500 and all rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)
- Non-emergency ambulance services
- Inpatient Non Biologically Based Mental Health Care
- Inpatient alcohol and substance abuse treatment
- Some medications that have specific uses and are administered in outpatietnt settings or physician offices
- Infusion Therapy Provided in a home setting or outpatient facility
- Routine Costs associated with clinical trials

Members are not responsible for payment of services if the provider does not obtain pre-authorization of services.
*For MRI/MRA, CT Scan, PET Scan, and Nuclear Cardiac Studies, call AIM at the telephone number listed on your ID card.

Inpatient Hospital Stays

During and after an approved hospital stay, the Care Management and Coordination team is monitoring your stay to review whether you receive the most medically appropriate care to see that a plan for your discharge is in place, and to coordinate services that may be needed following discharge.

Utilization Review

To assist AmeriHealth in making coverage determinations regarding the medical necessity and appropriateness of requested services, AmeriHealth uses medical guidelines based on clinically credible evidence. This is called utilization review. Utilization review can be done before a service is performed (precertification/preservice), during a hospital stay (concurrent review), or after services have been performed (retrospective/post-service review). AmeriHealth follows applicable state/federal standards pertaining to how and when these reviews are performed.

AmeriHealth
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AmeriHealth HMO, Inc.
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NJ HMO
Pre-Authorization
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Continuity of Care

Terminated Providers

AmeriHealth offers members continuation of an ongoing course of treatment with a terminated provider (for reasons other than for cause) from the date that AmeriHealth notified the member of the provider termination in the following situations:

- For up to 4 months, if services by your provider are medically necessary.
- In cases of pregnancy and this is your OB/GYN, you may continue receiving treatment from the provider for up to six (6) weeks after your delivery.
- Medically necessary postoperative care may continue with your provider for a period not to exceed six (6) months.
- Medically necessary oncological and psychiatric treatment may continue with your provider for a period not to exceed one (1) year.

All authorized health care services provided during this period of continuation shall be covered by AmeriHealth under the same terms and conditions applicable for participating health care providers.

In order to initiate continuity of care, members may contact our Members Services department.

New HMO Members

New HMO members may continue an ongoing course of treatment with a non participating health care provider for a transitional period from the effective date of enrollment into the plan subject to the requirements set forth herein and in the applicable group master contract.

If the new member is in her second or third trimester of pregnancy at the time of the effective date of enrollment, the transitional period of authorization shall extend through post-partum care related to the delivery.

The non participating provider must agree that all authorized health care services provided during this transitional period shall be covered by AmeriHealth under the same terms and conditions applicable for participating health care providers.

In order to initiate continuity of care, members must complete a Continuity of Care form and submit it to the Care Management and Coordination department. The form will be in the enrollment materials and available through Member Services.

Non participating health care providers (whose services are covered during the transitional period) must agree to be bound by the same terms and conditions as participating providers. The plan is *NOT* required to provide health care services that are not covered benefits.

Emergency Services

An emergency is defined as the sudden and unexpected onset of a medical or psychiatric condition and/or symptoms of substance abuse 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 the absence of immediate medical attention to result in:

1. Placing the member's health or in the case of a pregnant member, the health of the unborn child, in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists when: There is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or her unborn child.

Emergency care includes covered services provided to a member in an emergency, including emergency transportation and related emergency services provided by a licensed ambulance service.

In the event of an emergency, the member should go to the nearest appropriate medical facility. The Primary Care Physician should be contacted as soon as reasonably possible in the event of any emergency occurring either within AmeriHealth's service area or outside of the service area.

Appeals

You have a right to appeal any adverse decision through the appeals process. Instructions for the appeal will be described in the denial notifications and in the Member Handbook and other publications.