Aetna Better Health®

d/b/a Aetna Better Health of New Jersey

Provider Manual

Contact Information
Provider Relations Department: **1-855-232-3596**
aetnabetterhealth.com/nj

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH® OF NEW JERSEY 8
Welcome 8
Aetna Medicaid and Schaller Anderson 8
About Aetna Better Health of New Jersey 8
Experience and Innovation 8
Meeting the Promise of Managed Care 9
About the New Jersey Medicaid Managed Care Program 9
About the Medicaid Managed Care Program 9
Disclaimer 10
Aetna Better Health of New Jersey Policies and Procedures 10
Eligibility 10
Model of Care 10
About this Provider Manual 10
About Patient-Centered Medical Homes (PCMH) 11

CHAPTER 2: CONTACT INFORMATION 11

CHAPTER 3: PROVIDER RELATIONS DEPARTMENT 14
Provider Relations Department Overview 14
Provider Orientation 14
Provider Inquiries 14
Interested Providers 14

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION 15
Provider Responsibilities Overview 15
Unique Identifier/National Provider Identifier 15
Appointment Availability Standards 15
Telephone Accessibility Standards 16
Covering Providers 18
Verifying Member Eligibility 18
Secure Web Portal 18
Member Care Web Portal 19
Preventive or Screening Services 19
Mental Health/Substance Abuse 20
Laboratory and Radiology Results 20
Educating Members on their own Health Care 20
Emergency Services 20
Urgent Care Services 20
Primary Care Providers (PCPs) 20
Specialty Medical Providers 21
Specialty Providers Acting as PCPs 21
Other Types of Specialty Providers 22
Self-Referrals/Direct Access 22
Nursing Facility (NF) and Special Care Nursing Facility (SCNF) Providers 22
Home and Community Based Services (HCBS) 22
Home Delivered Nutrition Program Providers 23
Supportive Living Facilities 23
Out of Network Providers 23
Second Opinions 24
Provider Requested Member Transfer 24

Medical Records Review 24
Medical Record Audits 26
Access to Facilities and Records 26
Documenting Member Appointments 26
Missed or Cancelled Appointments 26
Confidentiality and Accuracy of Member Records 26
Health Insurance Portability and Accountability Act of 1997 (HIPAA) 27
Member Privacy Rights 27
Member Privacy Requests 28
Advance Directives 28
Cultural Competency 28
Health Literacy – Limited English Proficiency (LEP) or Reading Skills 29
Individuals with Disabilities 30
Clinical Practice Guidelines 30
Office Administration Changes and Training 30
Continuity of Care 30
Credentialing/Re-Credentialing 31
Licensure and Accreditation 31
Discrimination Laws 31
Financial Liability for Payment for Services 32
Covered Services 32
Non-covered Services 32
MLTSS Members 32
Qualified Medicare Beneficiaries 32
Monitoring Gaps in MLTSS Care 32

CHAPTER 5: COVERED AND NON-COVERED SERVICES 34
Covered Services 34
Non-Covered Services 43
Premiums and Copayments for NJ FamilyCare C and D Members 44
Behavioral Health Services 46
Non-Participating Providers 48
Post-Stabilization Services 48
Medical Necessity 48
Emergency Services 48
Pharmacy Services 48
Emergency Transportation 48
Laboratory Services 49
Hysterectomy 49
Sterilization 49
Dental Services – Information for Non Dentists 49
Orthodontia 50
Emergency Dental Services 50
Vision Services – March Vision 51
Interpretation Services 51

CHAPTER 6: BEHAVIORAL HEALTH 51
Mental Health/Substance Abuse Services 51
Referral Process for Members Needing Mental Health/Substance Abuse Assistance 52
Primary Care Provider Referral 52
Availability 53
Behavioral Health for Members with Special Needs 53

How to Request Prior Authorizations 53
Medical Necessity Criteria 53
Concurrent Review 53
MCG Guidelines 54
Behavioral Health Guidelines 54
Coordination Between Behavioral Health and Physical Health Services 54
Office Based Addiction Treatment (OBAT) Services 54
Medical Records Standards 54

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES 55
Member Rights 55
Member Responsibilities 57
Member Rights Under Rehabilitation Act of 1973 58

CHAPTER 8: ELIGIBILITY AND ENROLLMENT 59
Eligibility 59
Our Members 60
Health Benefits Coordinator (HCB) 60
Open Enrollment 60
Disenrollment 60
Re-Enrollment 60
ID Card 60
Sample ID Card 61
Verifying Eligibility 62

CHAPTER 9: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT 62
New Jersey Specific Requirements for Vaccines under EPSDT 62
Periodicity Schedule 63
Identifying Barriers to Care 63
Educating Members about EPSDT Services 63
Provider Responsibilities in Providing EPSDT Services 63
PCP Notification 65
Provider Incentives 65
Direct-Access Immunizations 65
EPSDT Service Details 65
Provider Monitoring 67

CHAPTER 10: MEMBERS WITH BEHAVIORAL HEALTH AND SPECIAL NEEDS 67

CHAPTER 11: DENTAL SERVICES 69
Dental Services Covered under the Medical Benefit 70
Dental Vendor 71
Dental Specialists and Specialty Care 71
Requirements for Dental Providers using Mobile Dental Services 71
Definitions 71
EPSDT Dental Services and Fluoride Varnish Program 72
Utilization Management for Dental Care 73
Second Dental Opinion 73
Continuity of Care for Dental Services 73
Dental Care for Members with Special Needs 73
Special Considerations for Orthodontia 76
Grievances and Appeals for Dental Services or Issues 80
Dental Forms 81

CHAPTER 12: MEDICAL MANAGEMENT 81
Tools to Identify and Track At-Risk Members 81
Predictive Modeling 81
Initial Health Screen (IHS) 82
Care Management Business Application Systems 82
Medical Necessity 82

CHAPTER 13: CONCURRENT REVIEW 82
Concurrent Review Overview 82
MCG Guidelines 83
Behavioral Health Guidelines 83
Discharge Planning Coordination 83
Discharge from a Skilled Nursing Facility or Nursing Home 83

CHAPTER 14: PRIOR AUTHORIZATION 83
Emergency Services 84
Post-stabilization Services 84
Services Requiring Prior Authorization 84
Exceptions to Requirements for Prior Authorizations 84
Provider Requirements 84
How to Request Prior Authorizations 85
Medical Necessity Criteria 85
Timeliness of Decisions and Notifications to Providers, and/or Members 86
Decision/Notification Requirements 86
Prior Authorization Period of Validation 87
Out-of-Network Providers 87
Notice of Action Requirements 87
Continuation of Benefits 88
Prior Authorization and Coordination of Benefits 88
Self-Referrals 88

CHAPTER 15: CARE MANAGEMENT 89
Overview 89
Emergency Room Redirection 90
Face-to-Face Program 90
Pharmacy Lock-In Program 90
Lead Case Management 90
Special Programs for the Elderly and Disabled, including members in MLTSS 91

CHAPTER 16: QUALITY MANAGEMENT 91
Overview 91
Identifying Opportunities for Improvement 93
Potential Quality of Care (PQoC) Concerns 94
Performance Improvement and Quality Improvement Projects (PIPs/QIPs) 94
Peer Review 94
Performance Measures 94
Satisfaction Survey 95
Member Satisfaction Surveys 95
Provider Satisfaction Surveys 95
External Quality Review (EQR) 95
Provider Profiles 95
Clinical Practice Guidelines 96

CHAPTER 17: PHARMACY MANAGEMENT 96

Pharmacy Management Overview 96
Prescriptions, Drug Formulary and Specialty Injectables 96
Prior Authorization Process 97
Step Therapy and Quantity Limits 97
CVS Caremark Specialty Pharmacy 97
Mail Order Prescriptions 98
New Jersey Prescription Drug Monitoring Program 98

CHAPTER 18: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT) 99
Advance Directives 99
Patient Self-Determination Act (PSDA) 99
Physician Orders for Life Sustaining Treatment (POLST) Act 99

CHAPTER 19: ENCOUNTERS, BILLING AND CLAIMS 100
Encounters 100
Billing and Claims 102
Online Status through Aetna Better Health of New Jersey's Secure Website 104
Calling the Claims Inquiry Claims Research Department 104
Claim Resubmission 105
Instruction for Specific Claims Types 105
Remittance Advice 106
Claims Submission 107
Encounter Data Management (EDM) System 108
Claims Processing 108
Encounter Staging Area 108
Encounter Data Management (EDM) System Scrub Edits 108
Encounter Tracking Reports 108
Data Correction 109

CHAPTER 20: GRIEVANCE AND APPEAL 109
Grievances 109
Provider Grievances 110
Utilization Management Appeals on behalf of a Member 110
Medicaid Fair Hearing 113
External Appeal 113
Provider Appeals 114
Oversight of the Grievance and Appeal Processes 114

CHAPTER 21: FRAUD, WASTE, AND ABUSE 115
Fraud, Waste and Abuse 115
Special Investigations Unit (SIU) 115
Reporting Suspected Fraud and Abuse 115
Fraud, Waste and Abuse Defined 116
Elements to a Compliance Plan 117
Relevant Laws 118
Administrative Sanctions 120
Remediation 120
Exclusion Lists & Death Master Report 120
Additional Resources 120

CHAPTER 22: MEMBER ABUSE AND NEGLECT 121
Mandated Reporters 121
Children 121
Vulnerable Adults 121

Reporting Identifying Information 121
Examinations to Determine Abuse or Neglect 122
Emergency Room Criteria 122
Examples, Behaviors and Signs 122
Additional Resources 123
CHAPTER 23: FORMS 123
CHAPTER 24: CONTRACT COMPLIANCE 124

CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH® OF NEW JERSEY

Back to Table of Contents

Welcome

Welcome to Aetna Better Health Inc., a New Jersey corporation, d/b/a Aetna Better Health® of New Jersey. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those New Jersey residents who need us most.

Aetna Medicaid and Schaller Anderson

Aetna expanded its Medicaid services in 2007, when it purchased Schaller Anderson, an Arizona-based, nationally recognized health care management company with more than two decades of Medicaid experience.

When Schaller Anderson was formed in 1986, Medicaid managed care was a new concept that had not been tried anywhere else in the country on the scale that the state had adopted. Schaller Anderson's founders were key visionaries in the development of the Arizona Health Care Cost Containment System (AHCCCS). The program soon became a model for states moving into Medicaid managed care.

About Aetna Better Health of New Jersey

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves just over 3 million individuals. Aetna Medicaid affiliates currently own, administer or support Medicaid programs in 15 states. Aetna Better Health of New Jersey opened in 2015 and is currently active in all 21 counties.

Aetna Medicaid has more than 25 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve both successful health care results and maximum cost outcomes. Aetna Medicaid has particular expertise in serving high-need Medicaid members, including those who are dually eligible for Medicaid and Medicare.

Experience and Innovation

We have more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care management and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in access to care by facing the challenges of health literacy and personal barriers to healthy living.

Today Aetna Medicaid owns and administers Medicaid managed health care plans for more than three million members. In addition, Aetna Medicaid provides care management services to hundreds of thousands of high-cost, high-need Medicaid members. Aetna Medicaid utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

Meeting the Promise of Managed Care

Our state partners choose us because of our expertise in effectively managing integrated health models for Medicaid that provide quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks. Aetna Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have particular expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, people with behavioral health issues and long-term care recipients.

Aetna Medicaid distinguishes itself by:

- More than 30 years' experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations
- More than 30 years' experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 25 years' experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of a number of capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since the inception of CHCS in 1995
- Local approach – recruiting and hiring staff in the communities we serve

About the New Jersey Medicaid Managed Care Program

The Division of Medical Assistance and Health Services (DMAHS), an agency under the Department of Human Services, administers the state-and federally- funded Medicaid and NJ FamilyCare programs for certain groups of low- to moderate- income adults and children. There are four different plans: A, B, C, and D. Through these programs, DMAHS serves about 1.7 million New Jersey residents:

- Medicaid provides health insurance to very low income adults, parents/caretakers and dependent children, pregnant women, and people who are aged, blind or disabled. These programs pay for hospital services, doctor visits, prescriptions, nursing home care, and other healthcare needs, depending on which Medicaid program the person is eligible for.
- NJ FamilyCare is a program for uninsured children whose family income is too high for them to qualify for "traditional" Medicaid but not high enough to be able to afford private health insurance. Some low-income uninsured parents/caretakers and uninsured childless adults may also be eligible for NJ FamilyCare. Most members covered in NJ FamilyCare receive a benefit based on Medicaid; FamilyCare Plan D is not a Medicaid benefit and has certain non-covered services. Some FamilyCare plans require co-payments for certain benefits.

About the Medicaid Managed Care Program

The Medicaid Managed Care Program, administered by DMAHS, has oversight of the managed care medical assistance program within the New Jersey Department of Human Services (DHS) and administers all Medicaid/NJ FamilyCare Program benefits provided through Aetna Better Health of New Jersey. Aetna Better Health of New Jersey was chosen by DHS to be a New Jersey managed care organization, an entity which arranges for care and services by specialists, hospitals, and providers and whose functions include member engagement, outreach and education, grievances and appeals.

Aetna Better Health of New Jersey is offered in all 21 counties of the state.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and your Aetna Better Health of New Jersey Provider Agreement, including all requirements described in this Manual, in addition to all federal and state regulations governing a provider. While this Manual contains basic information about Aetna Better Health of New Jersey, DMAHS requires that providers fully understand and apply DMAHS requirements when administering covered services.

Please refer to **http://www.state.nj.us/humanservices/dmahs/home/index.html** for further information on the DMAHS.

Aetna Better Health of New Jersey Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to ensure all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed.

Eligibility

To be eligible for New Jersey Medicaid, a person must:

- Be a resident of New Jersey and be a U.S. Citizen or qualified alien (most immigrants who arrive after August 22, 1996 are barred from Medicaid for five years, but could be eligible for NJ FamilyCare and certain programs for pregnant women)
- Meet specific standards for financial income and resources

In addition, a person must fall into an eligibility category such as:

- Families with dependent children
- Childless adults
- People who are sixty-five (65) years of age or older, blind, or permanently disabled
- Pregnant Women
- Individuals who meet nursing home level of care
- Foster children and youth
- Individuals registered with the Division of Developmental Disabilities

Model of Care

Integrated Care Management

Aetna Better Health of New Jersey's Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next twelve (12) months, and offer them intensive care management services built upon a collaborative relationship with a single clinical Case Manager, their caregivers and their Primary Care Provider (PCP). This relationship continues throughout the care management engagement. We offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer.

Integrated Long Term Care Management

Aetna Better Health of New Jersey's Integrated Long Term Care Management (ILTCM) program uses a person-centered care management approach and provides Long-Term Services and Supports (LTSS) to our aging and disabled members in the most integrated and least restrictive care environment possible. Our ILTCM program recognizes the complex medical, psychological, and social issues which must be addressed for our members and we help coordinate the response to their needs and desires. Our model for LTSS is driven by the unique needs of the member. Services and supports are integrated and coordinated to the fullest extent possible, including the use of services and support not covered by Medicaid and community resources/referral networks.

About this Provider Manual

This Provider Manual serves as a resource and outlines operations for Aetna Better Health of New Jersey's NJ Medicaid and NJ FamilyCare Programs. Through the Provider Manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health of New Jersey. Medical, dental and other procedures are clearly denoted within the Manual.

Aetna Better Health of New Jersey will update the Provider Manual at least annually and will distribute bulletins as needed to incorporate any changes. Please check our website at www.aetnabetterhealth.com/newjersey for the most recent version of the Provider Manual and/or updates. The Aetna Better Health of New Jersey Provider Manual is available in hard copy form or on CD-ROM at no charge by contacting our Provider Relations Department at 1-855-232-3596. Otherwise, for your convenience, Aetna Better Health of New Jersey will make the Provider Manual available on our website at www.aetnabetterhealth.com/newjersey.

About Patient-Centered Medical Homes (PCMH)

A Patient-Centered Medical Home (PCMH), also referred to as a "health care home", is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The PCMH features a personal care clinician who partners with each member, their family and other caregivers to coordinate aspects of the member's health care needs across care settings using evidence-based care strategies that are consistent with the member's values and stage in life. If you are interested in becoming a PCMH, please contact us at 1-855-232-3596.

CHAPTER 2: CONTACT INFORMATION

Back to Table of Contents

Providers who have additional questions can refer to the following phone numbers:

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Aetna Better Health of New Jersey	1-855-232-3596 (follow the prompts in order to reach the appropriate departments) Provider Relations Department Member Services Department (Eligibility Verifications) www.aetnabetterhealth.com/newjersey	Individual departments are listed below	8 a.m.-5 p.m. EST Monday-Friday 8 a.m.-5 p.m. EST Monday-Friday 24 hours / 7 days per week
Aetna Better Health of New Jersey – Care Management	1-855-232-3596 (follow the prompts in order to reach the appropriate departments)	Individual departments are listed below	
Aetna Better Health of New Jersey – Behavioral Health / Mental Health	1-855-232-3596 (follow the prompts in order to reach the appropriate departments)	Individual departments are listed below	
Aetna Better Health of New Jersey Prior Authorization Department	See Program Numbers Above and Follow the Prompts	Individual departments are listed below	24 hours / 7 days per week
Aetna Better Health of New Jersey Compliance Hotline (Reporting Fraud, Waste or Abuse)	1-855-282-8272	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health of New Jersey Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	1-800-338-6361	N/A	24 hours / 7 days per week

Aetna Better Health of New Jersey Department Fax Numbers	Fax Number
Member Services	1-844-679-6853
Provider Relations	1-844-219-0223
Care Management	1-860-975-1045
Medical Prior Authorization	1-844-797-7601
Behavioral Health	1-860-975-1045
Community Resource	**Contact Information**
New Jersey QUITLINE	1-866-NJSTOP (1-866-657-8677) Website: njquitline.org

Contractors	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
LIBERTY Dental Plan – Dental Vendor manages the dental network and does utilization management for all services covered under the dental benefit.	1-855-225-1727	N/A	8 a.m.-8 p.m. EST Monday-Friday
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired.	Please contact Member Services at 1-855-232-3596 (for more information on how to schedule these services in advance of an appointment)	N/A	24 hours / 7 days per week
March Vision – Vision Vendor	, 1-888-686-0274 TTY 1-877-627-2456	N/A	8 a.m.-5 p.m. EST Monday-Friday
Lab – Quest Diagnostics www.questdiagnostics.com/home.html	Please visit the website for additional information.	Please visit the website for additional information.	Please visit the website for additional information.
Lab – LabCorp www.labcorp.com	Please visit the website for additional information.	Please visit the website for additional information.	Please visit the website for additional information.
Durable Medical Equipment – DME	Please see our online provider search tool for details surrounding DME providers. www.aetnabetterhealth.com/newjersey	N/A	N/A
Radiology – N/A Aetna Better Health of New Jersey currently does not use third-party vendors for radiology authorizations. Please contact our health plan directly at 1-855-232-3596 and follow the prompts for more information.	N/A	N/A	N/A

CVS Caremark – Pharmacy Vendor For prior authorizations, pharmacies will call our health plan directly at 1-855-232-3596 and follow the prompts.	1-855-232-3596 (Aetna Better Health of New Jersey)	1-855-296-0323	8 a.m.-5 p.m. EST Monday-Friday

Agency Contacts & Important Contacts	**Phone Number**	**Facsimile**	**Hours and Days of Operation (excluding State holidays)**
NJ Department of Human Services Division of Medical Assistance and Health Services	1-800-356-1561	N/A	N/A
Emdeon Customer Service Email Support: hdsupport@webmd.com	1-800-845-6592	N/A	24 hours / 7 days per week
Health Benefits Coordinator (HBC)	1-800-701-0710	N/A	N/A
NJ Relay	Dial 711	N/A	24 hours / 7 days per week
Reporting Suspected Abuse, Neglect or Fraud			
The Division of Youth and Family Services (DYFS) Child Abuse Hotline	1-800-792-8610	N/A	24 hours / 7 days per week
State Central Registry (SCR) Hotline (Abuse)	1-877 NJ ABUSE (1-877-652-2873)	N/A	24 hours / 7 days per week
The National Domestic Violence Hotline	1-800-799-SAFE (7233	N/A	24 hours / 7 days per week
The New Jersey Department of Health (DOH)	1-877-582-6995	1-609-943-3479	24 hours / 7 days per week
The New Jersey Medicaid Fraud Division of the Office of the State Comptroller's Office (MFD) (Fraud)	1-888-9937-2835		
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	1-800-HHS-TIPS (1-800-447-8477)		
The New Jersey Insurance Fraud Prosecutor	1-877-55-FRAUD		

CHAPTER 3: PROVIDER RELATIONS DEPARTMENT

Back to Table of Contents

Provider Relations Department Overview

Our Provider Relations Department serves as a liaison between the Health Plan and the provider community. Our staff is comprised of Provider Liaisons and Provider Service Representatives. Our Provider Liaisons conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Relations Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Advise of an address change
- View recent updates
- Locate Forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- Submit a prior authorization
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a Tax ID or National Provider Identification (NPI) Number change
- Obtain a secure web portal or member care Login ID
- Review claims or remittance advice

Our Provider Relations Department supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards. Our staff is responsible for the creation and development of provider communication materials, including the Provider Manual, Periodic Provider Newsletters, Bulletins, Fax/Email blasts, website notices, and the Provider Orientation Kit.

Provider Orientation

Aetna Better Health of New Jersey provides initial orientation for newly contracted providers within 180 days after they join our network; orientation is also available to providers prior to joining our network and before they see members. In follow up to initial orientation, Aetna Better Health of New Jersey provides a variety of provider educational forums for ongoing provider training and education, such as provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health of New Jersey website navigation), distribution of Periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at www.aetnabetterhealth.com/newjersey.

Provider Inquiries

Providers may contact us at 1-855-232-3596 between the hours of 8 a.m. and 5 p.m., Monday through Friday, or email us at AetnaBetterHealth-NJ-ProviderServices@aetna.com for any and all questions including checking on the status of an inquiry, complaint, grievance and/or appeal. Our Provider Relations Staff will respond within 48 business hours. Providers can also contact our Plan by visiting the Availity Provider Portal. See Secure Web Portal section on page 18.

Interested Providers

If you are interested in applying for participation in our Aetna Better Health of New Jersey network, please visit our website at www.aetnabetterhealth.com/newjersey and complete the provider application forms (directions will be available online). If you would like to speak to a representative about the application process or the status of your application, please contact our Provider Relations Department at 1-855-232-3596. To determine if Aetna Better Health of New Jersey is accepting new providers in a specific region, please contact our Provider Relations Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of New Jersey
Attention: Provider Relations
3 Independence Way, Suite 400
Princeton, NJ 08540

Please note this is for all types of providers including HCBS, MLTSS, Ancillary, Hospital and others. Please contact LIBERTY Dental Plan if you are a dental provider and are interested in becoming part of their network. Applications will be reviewed and responded to within 45 days (excluding holidays).

CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION

Back to Table of Contents

Provider Responsibilities Overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout the Manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the NJ Medicaid and NJ FamilyCare Programs, your Provider Agreement and requirements outlined in this Manual. Aetna Better Health of New Jersey may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual.
Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including, but not limited to the Division of Medical Assistance and Health Services (DMAHS), Medicaid Fraud Division (MFD), Department of Health (DOH), Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector General (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully within their scope of practice regarding treatment, management, discussion of medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered, including all relevant risk, benefits and consequences of non-treatment. Providers must also assure the use of the most current diagnosis and treatment protocols and standards established by the New Jersey Department of Health (DOH) and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities including, but not limited to, individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

Unique Identifier/National Provider Identifier

Providers who provide services to Aetna Better Health of New Jersey members must obtain identifiers. Each provider is required to have a unique identifier and qualified providers much have a National Provider Identifier (NPI) on or after the compliance date established by the Centers for Medicare and Medicaid Services (CMS).

Appointment Availability Standards

The Table below show the standard appointment wait times for primary and specialty care. The table also reflects the standard for acceptable wait time in the office when a member has a scheduled appointment.

Acceptable Appointment Wait Time Standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventative & Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within twenty-four (24) hours	Within seventy-two (72) hours	Within twenty-eight (28) days (1)	No more than forty-five (45) minutes
Specialty Referral	Within twenty-four (24) hours	Within twenty-four (24) hours of referral	Within seventy-two (72) hours	Within four (4) weeks	No more than forty-five (45) minutes
Dental Care	Within forty-eight (48) hours (2)	Within three (3) days of referral		Within thirty (30) days of referral	No more than forty-five (45) minutes
Mental Health/Substance Abuse (MH/SA)	Same day	Within twenty-four (24) hours		Within ten (10) days	No more than forty-five (45) minutes

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventative & Routine Care	Wait Time in Office Standard
Lab and Radiology Services	N/A	Within forty-eight (48) hours	N/A	Within three (3) weeks	N/A

(1) Non-symptomatic office visits include, but are not limited to, well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.
(2) Emergency dental treatment no later than forty-eight (48) hours or earlier, as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider.

Physicals:	
Baseline Physicals for New Adult Members:	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Child Members and Adult Clients of DDD:	Within ninety (90) days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals:	Within four (4) weeks for routine physicals needed for school, camp, work, or similar.

Prenatal Care: Members shall be seen within the following timeframes:
Three (3) weeks of a positive pregnancy test (home or laboratory)
Three (3) days of identification of high-risk
Seven (7) days of request in first and second trimester
Three (3) days of first request in third trimester

Initial:	
Initial Pediatric Appointments:	Within three (3) months of enrollment
Aged, Blind & Disabled Members:	Each new member will be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within ten (10) business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children.

Aetna Better Health of New Jersey's waiting time standards require that members, on average, should not wait at a PCP's office for more than forty-five (45) minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating a member with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health of New Jersey monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health of New Jersey providers for the purpose of rendering medical advice or determining the need for emergency and other after-hours services, including authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent and/or emergent health care issues are held to the same accessibility standards regardless of whether after hours coverage is managed by the PCP, current service provider or the on-call provider.

All Providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24- hours-a-day, 7-days-a-week. In addition, we encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. We routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern whereby a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver and provider grievances regarding afterhours access to care to determine if a PCP is failing to comply on a frequentbasis.

Providers must comply with telephone protocols for all of the following situations:

- Answering member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by amember.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs.
- Triage for medical and dental conditions and special behavioral needs of noncompliant individuals who have intellectual disability or dementia.
- Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues— within thirty (30) to forty-five (45) minutes; same day for non-symptomatic concerns; fifteen (15) minutes for crisis situations.
- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

A telephone response should be considered acceptable/unacceptable based on the following criteria:
Acceptable – an active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The answering service either:
    - Connects the caller directly to the provider;
    - Contacts the provider on behalf of the caller and the provider returns the call;or
    - Provides a telephone number where the provider/covering provider can be reached.
- The provider's answering machine message provides a telephone number to contact the provider/covering provider.

Unacceptable:

- The answering service:
    - Leaves a message for the provider on the PCP/covering provider's answering machine;or
    - Responds in an unprofessional manner.
- The provider's answering machine message:
    - Instructs the caller to go to the emergency room for care, regardless of the exigencies of the situation, without enabling the caller to speak with the provider for non-emergent situations.
    - Instructs the caller to leave a message for the provider.
- Calls receive no answer;
- Listed number is no longer in service;
- Provider is no longer participating in the contractor's network;
- Caller is on hold for longer than five (5) minutes;
- Answering Service refuses to provide information for survey;
- Telephone lines are persistently busy despite multiple attempts to contact theprovider.

Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no fewer than those for non-members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Relations representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards and work to correct the barrier to care.

Covering Providers

Our Provider Relations Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of New Jersey. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the fee schedule. Failure to notify our Provider Relations Department of covering provider affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility or who were not assigned to the primary care provider's panel (unless, s/he is a physician covering for the provider).

Member eligibility can be verified through one of the following ways:

- **Telephone Verification:** Call our Member Services Department to verify eligibility at 1-855-232-3596. To protect member confidentiality, providers are asked for at least three pieces of identifying information, such as the member identification number, date of birth and address, before any eligibility information can be released.
- **Monthly Roster:** Monthly rosters are found on the Secure Website Portal. Contact our Provider Relations Department for additional information about securing a confidential password to access the site. Note: rosters are only updated once a month.

Additional member eligibility requirements are noted in Chapter 8 of this Manual.

Secure Web Portal

Availity is the destination where health plans connect with their providers for meaningful collaboration. Through a sophisticated multi-payer Portal and Intelligent Gateway solution, Availity simplifies complex provider engagement processes like HIPAA transactions, provider demographic data management, clinical data exchange, and much more. Built on a powerful, intelligent platform, we put data to work through business solutions that strengthen communications, improve financial performance, and simplify processes and systems. The following information can be attained by using Availity:

- Member Eligibility Search – Verify current eligibility of one or more members.
- Panel Roster – View the list of members currently assigned to the provider as the PCP.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Look-up Tool – Search for provider authorizations by member, provider, authorization data or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
    - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
    - Review Prior Authorization requirement by specific procedures or service groups
    - Receive immediate details as to whether the codes are valid, expired, a covered benefit or have prior authorization requirements and any noted prior authorization exception information
    - Export CPT/HCPS code results and information to Excel
    - Ensure staff work from the most up-to-date information on current prior authorization requirements

- Authorization Submission – Submit an authorization request on-line. Three types of authorization types are available:
    - Medical Inpatient
    - Outpatient
    - Durable Medical Equipment – Rental
- Gaps in Care – Based on Healthcare Effectiveness Data and Information Set (HEDIS) data for members, this shows HEDIS measures for which a member has no claim – Providers can check the status of the member's lack of compliance with any of the HEDIS measures. A "Yes" means the member has measures that they are not compliant with; a "No" means that the member has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of New Jersey that allows providers access to the member's care plan, other relevant member clinical data, and secure interaction with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:
For their Practice:

- Providers can view their own demographics, addresses and phone and fax numbers for accuracy.
- Providers can update their own fax number and email addresses.

For their Patients:

- View and print member's care plan* and provide feedback to the Case Manager via secure messaging.
- View a member's profile which contains:
    - Member's contact information
    - Member's demographic information
    - Member's Clinical Summary
    - Member's Gaps in Care (individual member)
    - Member's Care Plan
    - Member's Service Plans
    - Member's Assessment responses*
    - Member's Care Team: List of member's Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
    - Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications and utilization data with the ability to drill-down to the claim level*
    - High-risk indicator* (based on existing information, past utilization, and member rank)
    - Conditions and Medications reported through claims
    - Member-reported conditions and medications* (including Over the Counter (OTC) drugs, herbals, and supplements)
- View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their member panel*
- Access secure messaging between provider and Case Manager
- Look up members not on their panel (provider is required to certify treatment purpose as justification for accessing records)

* Any member can limit provider access to clinical data except that Members flagged for 42 C.F.R. Part 2 (substance abuse) must sign a disclosure form and list specific providers who can access their clinical data.

Preventive or Screening Services

Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female members may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral)
- Age and risk appropriate health screenings.

Mental Health/Substance Abuse

Mental Health/substance abuse (BH/SA) services are collectively referred to as Behavioral Health in Aetna Better Health of New Jersey. Inpatient and outpatient services are covered within the plan for members in Managed Long Term Services and Supports (MLTSS) and members registered with the Division of Developmental Disabilities. Members may self-refer to any outpatient behavioral health provider within our network without a referral from their PCP. Some services require authorization. Acute care hospital admissions for Behavioral Health are also covered for members in Medicaid and FamilyCare. For all other Behavioral Health services, coverage is through Medicaid fee for service. When Aetna Better Health does not cover the BH/SA benefit, they can self refer to any provider within the Medicaid network. To assure coordination of care and when medically necessary, Providers are responsible for notifying a member's MH/SA provider of the findings of his/her physical examination and laboratory/ radiological tests within twenty-four (24) hours of receipt for urgent cases and within five (5) business days in non-urgent cases. Providers must send the mental health/substance abuse provider a copy of the member's medical consultation and diagnostic results for services that are managed by the MCO as well as services that remain FFS.

Laboratory and Radiology Results

Providers are responsible to notify members of laboratory and radiology results within twenty-four (24) hours of receipt of results in urgent or emergent cases. You may arrange an appointment to discuss laboratory/radiology results within twenty-four (24) hours of receipt of results when it is deemed that face-to-face discussion with the member/authorized person may be necessary. Urgent/emergency appointment standards must be followed. Rapid strep test results must be available to the member within twenty-four (24) hours of the test. Routine results: You are required to establish a mechanism to notify members of non-urgent or non-emergent laboratory and radiology results within ten (10) business days of receipt of the results.

Educating Members on their own Health Care

Aetna Better Health of New Jersey does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and,
- The member's right to participate in decisions regarding his or her medical and behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest urgent care or emergency department.

Urgent Care Services

As the provider, you must serve the medical needs of our members; you are required to adhere to the all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "Find a Provider" link on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health of New Jersey will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)

The primary role and responsibilities of PCPs include, but are not limited to:

- Providing primary and preventive care and acting as the member's advocate;
- Initiating, supervising and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and transitioning young adult members from pediatric to adult providers as appropriate;
- Maintaining the member's medical record.

Primary Care Providers (PCPs) are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services and maternity services, if applicable.

Primary Care Providers (PCPs), in their care coordination role, serve as the referral agent for specialty and referral treatments and services provided to members assigned to them and should attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, providers or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals; and
- Coordinating the medical care for the programs the member is assigned to, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects
    - Follow-up for all emergency services
    - Coordination of inpatient care
    - Coordination of services provided on a referral basis, and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

Primary Care Providers (PCPs) are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Specialty Medical Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should provide services to members upon receipt of a written referral from the member's PCP or from another Aetna Better Health of New Jersey participating specialist. This can be in the form of a prescription, doctor's order or note. Specialists are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

Primary Care Providers (PCPs) should only refer members to Aetna Better Health of New Jersey network specialists. Authorization is not required for referrals to participating specialists. If the member requires specialized care from a provider outside of our network, a prior authorization is required. For members with a chronic, complex condition needing care outside of the network over a prolonged period of time, referrals covering multiple visits ("standing referral") may be provided, subject to the approval of the Chief Medical Officer (CMO).

Specialty Providers Acting as PCPs

In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period of time and exceeds the capacity of the nonspecialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis etc.)
- When a member's health condition is life threatening or so degenerative and/or disabling in nature as to warrant a specialist serving in the PCP role.
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the member vulnerable or at risk for not receiving proper care or services.

Aetna Better Health of New Jersey's Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone and after-hours standards noted in Chapter 2. This includes arranging for coverage 24-hours-a-day, 7-days-a-week.

Other Types of Specialty Providers

Similar to physician specialists, non physician specialty providers are responsible for providing services in accordance with the accepted community standards of care and within their scope of practice. Specialty providers should provide services to members upon receipt of a written referral from the member's PCP or from another Aetna Better Health of New Jersey participating physician specialist and should obtain prior authorization when required before providing treatment. Evidence of referral is required to process prior authorization for services, including physical therapy, occupational therapy, speech therapy, chiropractic and other clinical services. Referral can be in the form of a prescription, doctor's order or note.

Specialty providers are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

Self-Referrals/Direct Access

Members may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, dental care, and services provided by Women's Health Care Providers (WHCPs), including family planning services. The member must obtain these self-referred services (with exception below) from an Aetna Better Health of New Jersey provider.

Members have direct access to WHCP services, including family planning services. Members have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health of New Jersey's network, and can obtain maternity and gynecological care without prior approval from a PCP. Family planning services do not require prior authorization and may be accessed from any qualified provider regardless of their participation status with Aetna Better Health of New Jersey.

Nursing Facility (NF) and Special Care Nursing Facility (SCNF) Providers

Nursing Facilities (NF) or Special Care Nursing Facilities (SCNFs) provide long term services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. SCNFs provide additional services or other levels of care to meet the special needs of members.

NFs and SCNFs are responsible for making sure that members residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, members must be seen by their PCP once every thirty (30) days for the first ninety (90) days and at least once every sixty (60) days thereafter.
- Members who become eligible while residing in a NF or SCNF must be seen by their PCP within the first thirty (30) days of becoming eligible, and at least once every sixty (60) days thereafter.

Members in a nursing facility (NF or SCNF) must contribute a Share of Cost, also known as "Patient Pay", to the facility based on the amount determined by the State. The Plan receives Share of Cost information from the State on monthly files. These dollars will be subtracted from NF or SCNF claims that come in for members in Custodial or Nursing Home stay. Share of Cost is not deducted on short term skilled stays (acute, subacute or skilled rehabilitation).

Home and Community Based Services (HCBS)

Home and Community Based Providers are obligated to work with Aetna Better Health of New Jersey Case Managers. Case Managers will complete face-to-face visits with our members, in their residence, every 3 months and provide assessments annually or with a change in condition. Based on the assessment, Case Managers will then identify the appropriate services that meet the member's functional needs, including determining which network provider may be availability in order to provide services to the member in a timely manner. Upon completion, the Case Managers will then create authorizations for the selected providers and fax/e-mail these authorizations accordingly. Case Managers will also follow up with the member the day after services were to start to confirm that the selected provider started the services as authorized.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term rehabilitation or nursing facility stay for the member. While services may have been authorized for caregivers and agencies, providers should not bill for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing. New authorizations are needed whenever a member has an interruption in HCBS for a hospital, rehabilitation or nursing facility stay.

Example:
Member is authorized to receive forty (40) hours of Personal Assistant per week over a 5-day period. The member is receiving eight (8) hours of care a day.

The member is admitted into the hospital on January 1st and is discharged from the hospital on January 3rd. There should be no billable hours for January 2nd, as no services were provided on that date since the member was hospital confined for a full twenty-four (24) hours.

Caregivers would not be able or allowed to claim time with the member on the example above, since no services could be performed on January 2nd. This is also true for any in-home service.

Personal Assistants and Community Agencies are responsible for following this process. If any hours are submitted when a member has been hospitalized for the full twenty (24) hours, the Personal Assistants and Agencies will be required to pay back any monies paid by Aetna Better Health of New Jersey. Aetna Better Health of New Jersey will conduct periodic audits to verify this inappropriate billing is not occurring.

Home Delivered Nutrition Program Providers

All Home Delivered Nutrition program providers must ensure compliance with New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012. All food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines". Additionally, the State Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually or as often as deemed necessary. Follow-up inspections are conducted and/or legal action is initiated when conditions warrant.

Supportive Living Facilities

Supportive living facilities are obligated to collect room and board fees from members (includes alternative residential settings). Room and board includes but is not limited to:

- Debt service costs
- Maintenance costs
- Utilities costs
- Food costs (includes three meals a day or any other full nutritional regimen)
- Taxes
- Boarding costs (includes room, hotel and shelter-type of

expenses) Federal regulations prohibit Medicaid from paying room and

board costs.

Please be aware that:

- Payments issued by Aetna Better Health of New Jersey are always the contracted amount minus the member's room and board;
- The room and board agreement identifies the level of payment for the setting, placement date and room and board amount the member must pay and is completed by the Aetna Better Health of New Jersey Case Manager at the time of placement;
- The room and board amount may periodically change based on a member's income; and
- The Room and Board agreement form is completed at least once a year or more often if there is a change in income.

Note – Home and Community Based Services (HCBS) providers may not submit claims when the member has been admitted to a hospital, rehabilitation facility or nursing facility. The day of admission or discharge is allowed, but the days in between are not covered. Providers submitting claims in the days in between may be subject to a Corrective Action Plan (CAP) for improper billing.

Out of Network Providers

When a member with a special need for services is not able to be served through a contracted provider, Aetna Better Health of New Jersey will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the State's medical transportation program when no providers that can meet the member's special need are available in a nearby location. If needed, our Contracting Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development process

for recruitment to join the provider network. The member may be transitioned to a network provider (once identified) when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Second Opinions

A member may request a second opinion from a provider within our network without prior authorization. Providers should refer the member to another network provider within an applicable specialty for the second opinion. Requests for a second opinion with an out of network provider require prior authorization and are managed as any other request for an out of network provider.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health of New Jersey member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Medicaid Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

1. The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:

Aetna Better Health of New Jersey
Provider Relations Manager
3 Independence Way, Suite 400
Princeton, NJ 08540

2. The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.

3. Upon request, the provider shall provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna Better Health of New Jersey will work with the member to inform him/her on how to select another primary care provider. If the request relates to a member who has special needs, the member's Case Manager should be contacted to assist the member with the transition and address whether the member's special needs (medical or behavioral) require additional intervention for their needs to be met.

Medical Records Review

Aetna Better Health of New Jersey's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA), the Medicaid Managed Care Quality Assurance Reform Initiative (QARI) and state requirements. These are the minimum acceptable standards within the Aetna Better Health of New Jersey provider network. Below is a list of Aetna Better Health of New Jersey medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of New Jersey Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of New Jersey members immediately and completely available for review and copying by the Department and/or federal officials at the provider's place of business or forward copies of records to the Department upon written request without charge. Providers must also make member records available to Aetna Better Health for Quality monitoring, Utilization Management and Care Management activities.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only. Requirements for different types of providers are sometimes different, such as those for facilities and MLTSS providers.

All medical records, where applicable and required by regulatory agencies, must be made available electronically. When a provider receives a request from Aetna Better Health of New Jersey to supply medical records, these records must be sent to us within 14 days of our request. If the request comes from the state of New Jersey or other government entity, records must be sent within the time

frame specified, even if sooner than 14 days. Aetna Better Health of New Jersey does not reimburse health care providers for expenses related to providing copies of patient records or documents, unless required by state or federal law.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements for practitioners:

- Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number or other relevant unique identifier)
- Documentation of identifying demographics including the member's name, address, telephone number, employer (as applicable), Medicaid Identification Number, gender, age, date of birth, marital status, next of kin, preferred language, racial or ethnic considerations and, if applicable, guardian or authorized representative
- Compliance with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse (for members 12 and older seen 3 or more times), allergies and adverse reactions to medications (or absence of allergies noted prominently), hospitalizations, surgeries and emergent/urgent care received
- Immunization records (also recommended for adult members if available)
- Dental history, if available, and current dental needs and/or services
- Current problem list (The record shall contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions and health maintenance concerns are identified in the medical record.)
- Patient visit data — Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination — appropriate subjective and objective information obtained for the presenting complaints
    - Plan of treatment
    - Diagnostic tests
    - Therapies and other prescribed regimens
    - Follow-up — Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit; specific time to return is noted in weeks, months, or as needed; unresolved problems from previous visits are addressed in subsequent visits
    - Referrals, recommendations for specialty, behavioral health, dental and vision care and results thereof
    - Other aspects of patient care, including ancillary services
- Fiscal records relating to services rendered to members, regardless of whether the records have been produced manually or by computer
- Recommendations for specialty care, as well as behavioral health, dental and/or vision care and results thereof
- Current medications (therapies, medications and other prescribed regimens — drugs prescribed as part of the treatment, including quantities and dosages, entered into the record; if a prescription is telephoned to a pharmacist, the prescriber's record has a notation to the effect)
- Documentation, initialed by the member's PCP, to signify review of:
    - Diagnostic information including:
        - Laboratory tests and screenings;
        - Radiology reports;
        - Physical examination notes; and
        - Other pertinent data.
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Notation of any cultural/linguistic needs of the member
- Documentation on the medical record of all tests given for mammography and prostate cancer screening, positive findings and actions taken to provide appropriate follow-up care
- Documentation of any functional or cognitive deficits, their impact on performing activities of daily living (ADL) and instrumental activities of daily living (IADL) and the formal and informal supports utilized by the Member to address identified needs
- Hospital discharge summaries (discharge summaries are included as part of the medical record for (1) hospital admissions

that occur while the patient is enrolled in Aetna Better Health of New Jersey and (2) prior admissions as necessary)

- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed and behavioral health history
- Documentation as to whether or not an adult member has completed advance directives and location of the document (New Jersey advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated)
- Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care
- Signatures — entries are signed and dated by the responsible licensed provider; the responsible licensed provider countersigns care rendered by ancillary personnel; alterations of the record are signed and dated
- Provider identification — entries are identified as to author
- Legibility — again, the record must be legible to someone other than the writer

Medical Record Audits

Aetna Better Health of New Jersey conducts routine medical record audits of all types of providers to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, to meet our administrative responsibilities or to review potential quality of care issues. Providers must respond to these requests promptly within thirty (30) days of request. Medical records must be made available to DMAHS for quality review upon request and free of charge. CMS may also request to review records.

Access to Facilities and Records

Providers are required retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health of New Jersey for inspection, evaluation and audit for the longer of:

- A period of five (5) years from the date of service; or
- Three (3) years after final payment is made under the provider's agreement and all pending matters are closed
- For medical records, ten (10) years following the Member's most recent service or until the Member reaches the age of 23 years (N.J.A.C. 11:24-10.5).
- If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later

Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record. You may access our website to electronically verify member eligibility or call the Member Services Department at 1-855-232-3596.

Missed or Cancelled Appointments

Providers must:

- Document in the member's medical record and follow-up on missed or canceled appointments, including missed EPSDT appointments.
- Conduct affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards.
- Notify our Member Services Department when a member continually misses appointments.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and ensure the accuracy of any information that identifies an Aetna Better Health of New Jersey member. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas.

Specifically, our network providers must:

- Maintain accurate medical records and other health information
- Help ensure timely access by members to their medical records and other health information
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information.

Provider must follow all requirements and the voluntary provision of medical records to any entity must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (http://www.hhs.gov/ocr/privacy/).

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy rules and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities, specifically inclusive of providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) established national standards for managing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit http://www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records as well as confidential provider and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA and have periodic refresher training;
- Consider a patient sign-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shredding bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer as well as education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
    - The individual's past, present or future physical or mental health or condition.
    - The provision of health care to the individual.
    - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Other important considerations:

- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number and others).
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of New Jersey.
- Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.
- Under the Privacy Rule, providers may disclose a member's PHI to Aetna Better Health for quality-related health care operations without additional consent

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or Q&A, please visit the following site at http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm

Member Privacy Rights

Aetna Better Health of New Jersey's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations as well as applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations) Part 164 and other relevant sections of HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of New Jersey personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise their privacy rights through a privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of New Jersey's practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or a deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of New Jersey in writing.

Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult members. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under state law to make decisions regarding medical care and any provider's written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

New Jersey advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences. Each one includes written instructions relating to the provision of health care when the individual is incapacitated or otherwise unable to communicate preferences.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health of New Jersey expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health of New Jersey has developed effective provider education programs that encourage respect for diversity, foster skills to facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial,

and linguistic challenges that members encounter. We develop and implement proven methods for responding to these challenges in all of our programs and policies.

Provider education includes training about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices)
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people withdisabilities
- Physical and programmatic barriers that adversely impact the ability of people with disabilities in accessing meaningful care

Our Provider Service Representatives will conduct initial cultural competency training during provider orientation meetings. The *Quality Interactions®* course series is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to patients in ethnic and other minoritypopulations
- Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit:
http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

To increase health literacy issues, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health of New Jersey supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between members and providers. Providers and their office staff should periodically refresh their knowledge base by reviewing the course again.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of New Jersey is required to ensure that members with Limited English Proficiency (LEP) have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons with LEP are often excluded from programs for which they are eligible, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with Limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation and sign language services to members. To assist providers with this requirement, Aetna Better Health of New Jersey makes its telephonic language interpretation service available to providers in order to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs.

Our language interpreter vendor provides interpreter services at no cost to providers and members.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, the Aetna Better Health of New Jersey Member Services Representatives will assist the member via a three-way call to communicate in the member's nativelanguage.

- For outgoing calls, Member Services Staff will dial the language interpretation service and
    - Use an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health of New Jersey staff (e.g., Case Managers) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of New Jersey to link with an interpreter.

Aetna Better Health of New Jersey provides alternative methods of communication for members who are visually impaired, including large print and/or other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health of New Jersey offers sign language and over-the-phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of New Jersey at 1-855-232-3596 for more information on how to schedule these services in advance of an appointment.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Periodic provider office visits will be conducted by our Provider Relations staff to ensure that network providers are compliant.

Clinical Practice Guidelines

Aetna Better Health of New Jersey has Clinical Practice Guidelines and treatment protocols available to providers to support appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member;
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or,
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Practice Guidelines are available on our website at www.aetnabetterhealth.com/newjersey/providers/guidelines .

Office Administration Changes and Training

Providers are responsible for notifying our Provider Relations Department about any changes in professional staff at their offices (physicians, physician assistants or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Relations Department to schedule staff training.

Continuity of Care

Providers terminating their contracts without cause are required to provide a sixty (60) day notice before terminating with Aetna Better Health of New Jersey in writing. Providers must also continue to treat our members until the treatment course has been completed or care is transitioned to another qualified provider. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of New Jersey is not responsible for payment of services rendered to members who are not eligible.

You may also contact our Care Management Department for assistance. Continuity of care services rendered after termination require prior authorization (except in the cases of pregnancy, as set forth above) and will be paid at the contract rate, except for care provided by primary care physicians under a capitation agreement. Primary care physicians are not entitled to capitation payments after the termination date and will be paid at the Aetna Better Health of New Jersey fee schedule. Any capitation payments remitted to the physician after the termination date must be refunded to Aetna Better Health of New Jersey.

Credentialing/Re-Credentialing

Aetna Better Health of New Jersey uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers, with additional standards as required by the state of New Jersey. The majority of the process uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Professional providers (practitioners) and most other types of providers can use CAQH whereas MLTSS non-traditional providers are credentialed and re-credentialed through Aetna Medicaid's dedicated unit.

The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing Data Source Program allows providers to use a standard application and a common database to submit one application to one source, and to update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. The Council for Affordable Quality Healthcare (CAQH) gathers and stores detailed data from more than 600,000 providers nationwide.

All new providers (with the exception of hospital based providers), including providers joining an existing participating practice with Aetna Better Health of New Jersey, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Please note you may NOT treat members until you are credentialed. Specialty practitioners must also be board certified.

Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

Discrimination Laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law;
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.);
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable laws, rules and regulations, and, as provided for in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member on the basis of health status.

Financial Liability for Payment for Services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of New Jersey. However, a network provider may collect deductibles, coinsurance or copayments from members in accordance with the terms of the member's benefit. Providers must make certain that they:

- Do not hold members liable for payment of any fees that are the legal obligation of Aetna Better Health of New Jersey; providers must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of New Jersey for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved Member Handbook.
- Do not bill a member for medically necessary services covered under the plan.
- Clearly advise a member, prior to furnishing a non-covered service, that the service is not covered and that the member has responsibility to pay the full cost of the services; written consent must be documented (in the form of an Advance Beneficiary Notice or similar agreement) to show that the member was aware that the service would not be covered and has agreed to receive the service and pay for its cost.
- Do not balance bill the member with dual coverage under Medicare except as indicated in the explanation of benefits from Aetna Better Health of New Jersey.
- When referring a member to another provider for a non-covered service, ensure that the member is aware of his or her obligation to pay in full for such non-covered services.

Covered Services

Balance billing of members enrolled in Aetna Better Health of New Jersey through FamilyCare A, B, C, or D for covered services, whether the member is covered as their primary or secondary coverage, is strictly prohibited in New Jersey by both state and federal regulation, except for authorized cost sharing or non-covered services. If you receive a claim denial, or what you deem to be an underpayment, please follow the instructions on your explanation of benefits regarding the appropriate next steps. This includes any services that are covered by Aetna Better Health with or without authorization.

Non-covered Services

If you offer a service that is not covered by Aetna Better Health, or the authorization for such services has been denied and appeals have been exhausted, you may offer our member the option to pay out of pocket. If you do, the member must sign an informed consent in advance that clearly explains that they are agreeing to pay for these services and waiving their balance billing rights. You may be asked to present this form at a later time if the health plan deems it appropriate.

MLTSS Members

All aforementioned balance billing protections apply to members enrolled in the NJ FamilyCare MLTSS program, except where a cost-sharing responsibility has been pre-determined by the State of New Jersey.

Qualified Medicare Beneficiaries

Please note that per State of New Jersey and Medicare regulations, members with both Medicaid and Medicare coverage cannot be asked to sign any consent to pay privately for a covered service. Doing so may result in state sanctions.

Monitoring Gaps in MLTSS Care

A Gap in (MLTSS) Care is the difference between the number of hours scheduled in a member's plan of care and the hours that are actually delivered to that member on any given day.

Aetna Better Health of New Jersey contractually requires that all providers, both self-directed and agency providers, submit a non-provision of service log monthly, which identifies every time service is not provided as scheduled. This log may be submitted through our on-line portal system at any time or may be faxed to the MLTSS Care Management Department. Each provider of essential Home and Community Based Services (HCBS) is required to submit by the 5th business day of the current month a report identifying all occurrences of non-provision of service for the previous month. This includes any provider working under a participant direction entity. Providers are educated on this process when they contract with the plan, and re-education occurs as the need arises.

Any gap in care reported to the MLTSS Case Manager will be documented in the web-based care management application. A member may file a grievance for any gap in care. Upon learning of any reported gap in care, the MLTSS Case Manager immediately contacts the member, acknowledges the gap, works with the provider and provides detailed explanation to the member regarding the reason for the gap. Most importantly, the MLTSS Case Manager then works with the provider or, if necessary, another provider to resolve the gap and allow the member's immediate needs to be met to address the member's safety.

All non-provision of service gap report documents are provided to the Manager of MLTSS or their designee. These logs include the county code for the provider, the service type, the member preference level at the time of the occurrence and the member preference level as determined by the last documented care manager event, the reason the gap occurred and the resolution. The gap report identifies the original hours authorized, the hours provided to resolve the gap and the length of time before services were provided. The log also identifies if the member preference level was met and why and if the total authorized services were replaced and why. If unpaid caregivers are used to fill the gap, that information is collected as well. Upon receiving the non-provision of service log, the Manager of MLTSS or their designee reviews the reports and identifies whether the gaps are true gaps or whether the non-provision was not a true gap due to the fact that:

- The member was not available to receive the service when the caregiver arrived at the member's home at the scheduled time
- The member refused the caregiver when s/he arrived at the member's home, unless the caregiver's ability to accomplish the assigned duties was significantly impaired by the caregiver's condition or state (for example drug and or alcohol intoxication on the part of the caregiver)
- The member refused service
- The member and regular caregiver agreed in advance to reschedule all or part of a scheduled service.

All non-provision of service gaps and true gaps are reported to the MTLSS Case Manager so that they can be entered into the web-based care management application.
All non-provision of service logs are reviewed and assigned as either non-provision of service or true gaps. They are tracked, aggregated, reviewed, analyzed and trended quarterly for presentation to the Manager of MLTSS or their designee. The number and types of gaps, providers and provider types are reviewed to identify any patterns of non-provision of services. Each month, the total number of service gap hours are calculated along with the total percentage of gap hours per member per month and compared with the previous month.

Information is looked at in aggregate and by provider agency. For example, if a particular agency is found to have recurring gaps, a recommendation would be made for the Provider Relations Department to work with that agency to identify strategies to reduce the occurrence of gaps. Continued high numbers of gaps in service may result in referral to the Quality Management Oversight Committee, from which a corrective action plan might be put in place for that agency. Provider Relations will also intervene if a case manager has reported gaps in care that were not reported by the servicing provider. This is a contract compliance issue and a corrective action plan will be required.

Network management may be involved if gaps in care are occurring in certain areas or for a certain service as it may mean that additional contracted providers are necessary to meet the needs of the member population. In this case, the Network Department would be requested to identify and contract with additional services providers to allow the members improved access to care that can meet their needs.

Should gaps in care result in a quality of care concern, the information will be reported to our Quality Management Department, who will investigate the gap and determine if a corrective action plan is necessary or if there is additional action that must be taken. The Quality Management Department will be involved if it is identified that a particular gap resulted in a critical incident or if a particular worker or agency was frequently causing gaps. In these types of cases, the Quality Department may work with the designated fiscal agency or the service provider agency to further investigate and take appropriate action. This action may include reporting the provider to the state, requiring a corrective action plan or recommending contract termination. The Credentialing Department reviews provider history of grievances, potential quality of care issues and critical incidents as a part of the credentialing or re-credentialing process. All critical incidents are tracked and trended and are a part of the credentialing file. In addition, as part of the standard credentialing process, the Credentialing Department utilizes the Office of the Inspector General Sanctioned Practitioners list to identify any providers that have been sanctioned or barred from providing Medicare and Medicaid services.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

Back to Table of Contents

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) administers the benefits for recipients of Medicaid and NJ FamilyCare A, B, C and D.

The tables on the next few pages show what services Aetna Better Health of New Jersey and Medicaid Fee-for-Service (FFS) covers. Members under NJ FamilyCare C or D may have to pay a copayment at during their visit. All services must be medically necessary, and the provider may have to ask for a prior approval before some services can be provided.

Services noted under "Medicaid FFS" are not the responsibility of Aetna Better Health of New Jersey. If a member requires these services, please have them call our Member Services Department so we can help them find a provider.

Covered Services

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Abortion and related services	FFS	FFS	FFS	FFS
Acupuncture	Covered	Covered	Covered	Covered
Allergy testing	Covered with prior	Covered with prior	Covered with prior	Covered with prior
Audiology	Covered	Covered	Covered	Covered
Blood and plasma products	Covered	Covered	Covered	Covered
Bone mass measurement (Bone density)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Case/care management	Covered	Covered	Covered	Covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Chiropractor services Check with your PCP for clearance (Manual manipulation of spine)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization Copays may apply to NJ FamilyCare C and D	Covered with prior authorization
Clinic services	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D	Covered
Colorectal screening exams	Covered Member age 50 and over may self-refer to network	Covered Member age 50 and over may self-refer to network	Covered Member age 50 and over may self-refer to network	Covered Member age 50 and over may self-refer to network
Court-ordered services	Covered Call Member Services for more information.	Covered Call Member Services for more information.	Covered Call Member Services for more information.	Covered Call Member Services for more information.
Dental services LIBERTY Dental Plan - Member may self-refer to network providers. The following services require prior authorization and include: crowns, bridges, full dentures, partial dentures, gum treatments, root canal, complex oral surgery and	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D (No copay for diagnostic and preventive care)	Covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Orthodontic services LIBERTY Dental Plan	Covered Age limits apply (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)
Diabetic education	Covered with prior authorization (in home)	Covered with prior authorization (in home)	Covered with prior authorization (in home)	Covered with prior authorization (in home)
Diabetic supplies and equipment	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Durable Medical Equipment (DME)/assistive technology devices	Covered Prior authorization required for certain items	Covered Prior authorization required for certain items	Covered Prior authorization required for certain items	Covered Prior authorization required for certain items
DCP&P residential treatment	FFS	FFS	FFS	FFS
Educational or special remedial services	FFS	FFS	FFS	FFS

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and immunizations (0–21 yrs. of age)	Covered	Covered	Covered	Covered
Emergency room care	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D	Covered
Emergency ground and air medical transportation (Ambulance)	Covered	Covered	Covered	Covered
Routine eye exams and optometrist services March Vision	Covered Member may self-refer one routine eye exam per year.	Covered Member may self-refer one routine eye exam per year.	Covered Copays may apply to NJ FamilyCare C and D Member may self-refer one routine eye exam per year.	Covered Member may self-refer one routine eye exam per year.
Eyeglasses (lenses and frames) Members may self-refer March Vision	Covered Generic frames or $100 allowance for name-brand frames.	Covered Generic frames or $100 allowance for name-brand frames.	Covered Generic frames or $100 allowance for name-brand frames.	Covered Generic frames or $100 allowance for name-brand frames.
Family planning basic services (Self-referral reproduction health procedures/ devices)	Covered Member may self-refer to participating OB/GYN. FFS when furnished by a non-participating doctor.	Covered Member may self-refer to participating OB/GYN.	Covered Member may self-refer to Participating OB/GYN. FFS when furnished by a non-participating doctor.	Covered Member may self-refer to participating OB/GYN. FFS when furnished by a non-participating doctor.
Federally Qualified Health Care Centers (FQHCs)	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D	Covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Genetic testing and counseling	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Hearing exams	Covered	Covered	Covered	Covered
Hearing aids and batteries	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Hemodialysis	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
HIV/AIDS testing	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.
Home health care	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization.	Covered with prior authorization
Hospice	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Immunizations	Covered	Covered	Covered	Covered
Infertility testing and services	Not covered	Not covered	Not covered	Not covered
Inpatient hospitalization (acute care, rehabilitation and special hospitals)	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.
Lab tests and X-rays Members will be notified of results within 24 hours for urgent and emergent cases and within 10 business days for routine cases	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Mammograms (Screening)	Covered Member may self‑refer. Baseline for women 35–39 and annual for women 40+.	Covered Member may self‑refer. Baseline for women 35–39 and annual for women 40+.	Covered Member may self‑refer. Baseline for women 35–39 and annual for women 40+.	Covered Member may self‑refer. Baseline for women 35–39 and annual for women 40+.
Medical day care	Covered with prior authorization	Covered with prior authorization	Not covered	Covered with prior authorization
Medical supplies	Covered Some items require authorization	Covered Some items require authorization	Covered Some items require authorization	Covered Some items require authorization
Methadone and Methadone maintenance	Methadone for pain management is covered by Aetna Better Health; Methadone maintenance for substance abuse treatment is covered by FFS.	Methadone for pain management and substance use treatment is covered by Aetna Better Health;	Methadone for pain management is covered by Aetna Better Health; Methadone maintenance for substance abuse treatment is covered by FFS.	Methadone for pain management and substance use treatment is covered by Aetna Better Health;
Nuclear medicine	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Nurse Practitioners/ Certified Nurse Midwives	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D	Covered
Nursing Facility Services, i.e. rehabilitation in this setting	Covered	Covered	Covered	Covered
Obstetrical/ maternity care	Covered Member may self‑refer.	Covered Member may self‑refer.	Covered Member may self‑refer. Copays may apply to NJ FamilyCare C and D	Covered Member may self‑refer.
Organ transplant evaluation	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Organ transplants (Includes donor and recipient costs. Experimental organ transplants not covered)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Orthotics	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Outpatient hospital services	Covered with prior authorization excluding mental health visits.	Covered with prior authorization	Covered with prior authorization excluding mental health visits. Copays may apply to NJ FamilyCare C and D	Covered with prior authorization excluding mental health visits.
Outpatient surgery, same day surgery, ambulatory surgical center	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Pain management services	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Pap smears and pelvic exams	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.
Parenting/child birth education	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.
Personal care (in home) / aide services	Covered with prior authorization with limitations	Covered with prior authorization with limitations	Not covered	Covered with prior authorization with limitations
Podiatry care – medically necessary (office-based, non-surgical)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization. Copays may apply to NJ FamilyCare C and D	Covered with prior authorization
Podiatry care - routine preventive (Office-based, Non-surgical)	Not covered	Not covered	Not covered	Not covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Podiatry care - surgical	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Post-acute care	Covered	Covered	Covered	Covered
Prescription drugs	Covered Drug formulary	Covered Drug formulary	Covered Drug formulary. Copays may apply to NJ FamilyCare C and D	Covered Drug formulary
Preventive health care and counseling and health promotion	Covered	Covered	Covered	Covered
Primary Care Provider (PCP) visits	Covered	Covered	Covered Copays may apply to NJ FamilyCare C and D	Covered
Private duty or skilled nursing care	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Prostate screening exams	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer
Prosthetics	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Radiation/ chemotherapy/ hemodialysis	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Radiology scans (MRI, MRA, PET)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Rehabilitation/ cognitive rehabilitation (Outpatient occupational therapy/physical therapy/speech therapy)	Covered	Covered	Covered	Covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B, C and D	MLTSS
Respite care	Not covered	Not covered	Not covered	Covered with prior authorization
Second medical/ surgical opinions	Covered Prior authorization for nonpar provider	Covered Prior authorization for nonpar provider	Covered Prior authorization for nonpar provider	Covered Prior authorization for nonpar provider
Skilled nursing facility care (LTC)	Covered with prior authorization	Covered with prior authorization	Not covered	Covered with prior authorization
Sleep apnea studies	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Sleep therapy	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Smoking cessation products	Covered	Covered	Covered	Covered
Speech tests	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Thermograms and thermography	Covered with Prior authorization	Covered with Prior authorization	Covered with Prior authorization	Covered with Prior authorization
Transportation - Emergency, including ground and air transport	Covered	Covered	Covered	Covered
Transportation ambulance, invalid coach (non-emergency)	FFS	FFS	FFS	FFS
Transportation - non-emergency (bus, train, car service, etc.)	FFS Contact LogistiCare	FFS Contact LogistiCare	FFS Contact LogistiCare	Covered with Prior Authorization
Urgent care	Covered Care required within 24 hours.	Covered Care required within 24 hours.	Covered Care required within 24 hours.	Covered Care required within 24 hours.

Behavioral Health				
Adult Rehabilitation	FFS	Covered with prior authorization	Not covered	Covered with authorization
Atypical antipsychotic drugs within the Specific Therapeutic Drug Classes H7T and H7X	Covered prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance abuse conditions each month. Drugs with weekly prescriptions willbe counted as one per month.	Covered prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance abuse conditions each month. Drugs with weekly prescriptions willbe counted as one per month.	Covered prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance abuse conditions each month. Drugs with weekly prescriptions willbe counted as one per month.	Covered prior authorization may be required from your provider if you need more than four prescriptions for mental health and/orsubstance abuse conditions each month. Drugs with weekly prescriptions willbe counted as one per month.
Inpatient psychiatric hospital services	Covered with authorization	Covered with authorization	Covered with authorization	Covered with authorization
Inpatient substance use disorder (diagnosis, treatment and detoxification)	Covered with authorization	Covered with authorization	Covered with authorization	Covered with authorization
Intermediate Care Facilities/ Intellectual Disability (ICF/ID)	FFS	FFS	Not covered	FFS
Outpatient Mental Health	FFS	Covered with prior authorization	FFS	Covered with authorization
Outpatient substance use disorder (diagnosis, treatment and detoxification)	FFS Limited benefit	Covered with prior authorization	FFS Limited benefit	Covered with authorization

Non-Covered Services

Members will be responsible for the cost of these services if they choose to receive them.

For NJ Medicaid members, these services are not included:

- All services your Primary Care Provider (PCP) or Aetna Better Health of New Jersey say are not medically necessary
- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental organ transplants and investigational services

- Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinic), drugs, lab, radiological and diagnostic services, and surgical procedures
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient, including guest meals and lodging, telephone charges, travel expenses, take home supplies and similar costs
- Respite care (Members who qualify for MLTSS services may receive respite care as part of the MLTSS service package)
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by New Jersey law
- All claims that come directly from services provided by or in federal institutions
-
- Free services provided by public programs or voluntary agencies (should be used when possible)
- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military
- Payments for services provided outside of the United States and territories (pursuant to N.J.S.A. 52:34-13.2 and section 6505 of the Affordable Care Act of 2010, which amends section 1902(a) of the Social Security Act)
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker's compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or receives benefits and whether or not a third-party gets a recovery for resulting damages
- Any benefit that is covered or payable under any health, accident or other insurance policy
- Any services or items furnished that the provider normally provides for free
- Services billed when the health care records do not correctly reflect the provider's procedure code

For NJ FamilyCare B, C and D members, these additional services are not included:

- Intermediate Care Facilities/Intellectual Disability
- Residential treatment center psychiatric programs
- Religious nonmedical institutions care and services
- Custodial care
- Special remedial and educational services
- Experimental and investigational services
- Rehabilitative services for substance abuse
- Court-ordered services
- Radial keratotomy
- Nursing facility services, except when the admission is for rehabilitative services

Premiums and Copayments for NJ FamilyCare C and D Members

Premiums for NJ FamilyCare C and D Members

A premium is a monthly payment a member pays in order to obtain health care coverage. Only certain NJ FamilyCare C and D members make these payments. The state's Health Benefits Coordinator (HBC) will tell the member if they have to pay. Eskimos and Native American Indians under the age of 19 do not have to make monthly payments.

This payment will go toward the member's family cost-share, which is computed once every 12 months. Family cost-share is based on the member's total family income. Members who do not pay their monthly premium will be disenrolled from the program.

Copayments for NJ FamilyCare C and D Members

A copayment (or copay) is the amount a member must pay for a covered service. Only certain NJ FamilyCare C and D members have copays. The HBC will tell the member if they have copays. The amount of the copay is also on the member's ID card. Alaska Natives and Native American Indians under the age of 19 do not have copays.

The NJ FamilyCare C members who have copayments are:

- Children under the age of 19 with family incomes above 150 percent and up to and including 200 percent of the federal poverty level

The NJ FamilyCare D members who have copayments are:

- Parents/caretakers with family incomes above 150 percent and up to and including 200 percent of the federal poverty level

- Children under the age of 19 with family incomes above 200 percent and up to and including 350 percent of the federal poverty level

After a member exceeds their family cost-share, there will be no copay when receiving additional services. The member will receive a new member ID card once their family cost-share is met.

NJ FamilyCare Ccopayments

Service	NJ FamilyCare C copayment
Outpatient hospital clinic visits	$5 for each visit that is not for preventive services
Emergency room services covered for Emergency Services only (triage and medical screenings always covered)	$10 per visit
Physician services	$5 per visit (except for well-child visits, lead screening and treatment, immunizations in accordance with American Academy of Pediatrics recommended schedule, prenatal care or pap smears)
Independent clinic services	$5 per visit except for preventive services
Podiatrist services	$5 per visit
Optometrist services	$5 per visit
Chiropractor services	$5 per visit
Drugs	$1 for generic drugs, $5 for brand name drugs
Nurse midwives	$5 per visit except for prenatal care visits
Dentist	$5 per visit except for diagnostic and preventive services
Nurse Practitioners	$5 per visit except for preventive services

NJ FamilyCare Dcopayments

Service	NJ FamilyCare D copayment
Outpatient hospital clinic visits including diagnostic testing	$5 per visit except for preventive services
Emergency room services (triage and medical screenings are covered)	$35 per visit.
Physician services	$5 per visit except for well-child visits in accordance with American Academy of Pediatrics recommended schedule, lead screening and treatment, immunizations, prenatal care and Pap smears
Podiatrists services	$5 per visit

Optometrist services	$5 per visit
Chiropractor Services	$5 per visit
Drugs	$1 per generic drug. $5 for brand name drugs
Nurse midwives	$5 per visit except for prenatal care visits
Nurse Practitioners	$5 per visit except for preventive services
Dental services	$5 per visit except for diagnostic and preventive services

Behavioral Health Services

Most NJ Medicaid and NJ FamilyCare member can receive mental health and substance abuse services from any Medicaid-approved provider by using their ID card. Members who are clients of the Division of Developmental Disabilities (DDD) and members in Managed Long Term Supports and Services (MLTSS) will receive mental health and substance abuse services from Aetna Better Health of New Jersey.

Below are a list of covered mental health and substance use services for DDD and MLTSS members:

- Inpatient psychiatric hospital care
- Adult mental health rehabilitation (AMHR)
- Acute partial hospitalization, partial hospitalization and partial care services for mental health and/or co-occurring conditions
- Outpatient independent clinic and outpatient hospital based services for mental health and/or co-occurring conditions
- Services provided by independent practitioners who provide outpatient BH services to individuals with a mental health and/or co-occurring conditions
- Partial care
- Opioid treatment services including laboratory services to support medication assisted therapies
- Inpatient medical detox/medically managed inpatient withdrawal management (hospital) ASAM 4 WM
- Non-medical detox/non-hospital based withdrawal management ASAM 3.7 WM
- Substance use disorder short term residential ASAM 3.7
- Substance Use Disorder Long Term Residential (LTR) ASAM 3.5
- Ambulatory withdrawal management with extended on-site monitoring/ambulatory detox ASAM 2 WM
- Substance use disorder partial care ASAM 2.5
- Substance use disorder intensive outpatient (IOP) ASAM 2.1
- Substance use disorder outpatient ASAM 1
- Opioid treatment services (methadone maintenance)
- Opioid treatment services (non-methadone maintenance)

Aetna Better Health of New Jersey covers inpatient psychiatric admissions to an acute care hospital and inpatient medical detox (ASAM 4) for all Medicaid and NJ Family Care members.

AUTHORIZATION INFORMATION FOR PARTICIPATING PROVIDERS

Mental Health Services	PA Requirement
Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization	Yes authorization
Adult Mental Health Rehab (AMHR)	Yes authorization
Inpatient Psychiatric Hospital Care	Yes authorization
Outpatient Mental Health Hospital	No authorization
Outpatient Mental Health Independent Clinic	No authorization
Partial Care	Yes authorization

Substance Use Disorder Services	PA Requirement
Ambulatory Withdrawal Management (ASAM 2-WM)	No authorization
Non-Medical Detox/Non-Hospital Based Withdrawal Management (ASAM 3.7 WM)	Yes authorization
Medically Managed Intensive Inpatient Withdrawal Management. Inpatient Medical Detox (ASAM 4-WM)	Yes authorization
Substance Use Disorder Short Term Residential (ASAM 3.7)	Yes authorization
Substance Use Disorder Long Term Residential (ASAM 3.5)	Yes authorization
Substance Use Disorder Partial Care (ASAM 2.5)	Yes authorization
Substance Use Disorder Intensive Outpatient (ASAM 2.1)	Yes authorization
Substance Use Disorder Outpatient (ASAM 1.0)	No authorization
Opioid Treatment Services Methadone Maintenance (ASAM OTS)	No authorization
Opioid Treatment Services Non-Methadone Maintenance (ASAM OTS)	No authorization

*Requirements are subject to change. Specific codes can be searched to confirm authorization requirements by utilizing our prior authorization tool.

Non-Participating Providers

Any request for services for a non-participating provider requires an authorization.

For additional information about behavior health services and provider responsibilities and important information, please review Chapter 4.

Post-Stabilization Services

Post-stabilization services are covered services related to an emergency medical condition that are provided after the member is stabilized in order to maintain the stabilized condition or to improve or resolve the condition. Aetna Better Health of New Jersey covers post-stabilization services whether provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of New Jersey or its providers authorized the services OR
- When a request was made to Aetna Better Health for authorization, but Aetna Better Health did not respond within one hour of the request OR
- When Aetna Better Health could not be contacted for prior authorization

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of New Jersey's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness, condition or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth. Medically necessary services are those for which there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member.

You can view a current list of the services that require authorization on our website at www.aetnabetterhealth.com/newjersey.
If you are not already registered for the secure web portal, download an application from the New Jersey Providers section of the site.
If you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Relations Department at 1-855-232-3596.

Emergency Services

Aetna Better Health of New Jersey covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. All medical screening services are covered regardless of admitting symptoms or discharge diagnosis. If a screening examination leads to a clinical determination that an emergency condition exists or if the member had symptoms of sufficient severity to warrant emergency attention under the prudent layperson standard, all services related to the screening examination are covered. The care of women who present at any emergency room in active labor is covered. Out-of-area care is covered in emergency situations for members who remain enrolled. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect or when foster home placement of a child occurs after business hours are covered.

Aetna Better Health of New Jersey will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Pharmacy Services

You can find a comprehensive description of covered services in Chapter 17.

Emergency Transportation

If a member has an emergency and has no way to get to a hospital, please have them call 911. The plan covers ambulance rides on the ground and air transport in a medical emergency for all members. Members can receive other transportation services through Medicaid Fee-For-Service. To find out how a member can get a ride to their doctors appointment, please have them call LogistiCare at 1-866-527-9933. If they have any problems with the services they receive, please have them call the LogistiCare Complaint Hotline at 1-866-333-1735.

Laboratory Services

The major provider of laboratory services for Aetna Better Health of New Jersey is Quest Diagnostics, which has a national contract. LabCorp, which includes MedTox for lead testing, and BioReference Laboratories are also contracted with the plan. Please check the provider directory for other participating laboratories. Prior authorization is required for all genetic testing, which should be sent to a contracted lab if available

Hysterectomy

Hysterectomy is a covered service if it is indicated for medical treatment other than sterilization. Any claims (hospital, operating physician, anesthesiologist, clinic, etc.) involving hysterectomy procedures must have a properly completed Hysterectomy Receipt of Information form (FD-189) attached when submitted for payment. Without the federally required form, the hysterectomy claim will only be paid if the provider certifies that the procedure was done due to a life-threatening emergency (and a description of the emergency) or that the woman was already sterile and the cause of the sterility is stated (See Chapter 23: Forms). These claims must be sent by paper and not electronically.

Sterilization

Both male and female sterilization procedures require completion of a Consent for Sterilization form (7473 M ED) at least 30 days prior to the procedure. The member must be at least 21 years of age and may not be mentally incompetent. A copy of the signed consent must be attached when the claim is submitted for payment (See Chapter 23: Forms). These claims must be sent by paper and not electronically.

Dental Services – Information for Non Dentists

Dental services are comprehensive and are provided through LIBERTY Dental Plan. LIBERTY Dental Plan is responsible for covering routine and specialty dental services, the administration of the dental network and claim payment for dental services. Any procedures that require preauthorization can be submitted on the provider claim section of the LIBERTY Dental Plan's website or by mailing a completed claim form to LIBERTY Dental Plan. LIBERTY Dental Plan website: www.libertydentalplan.com , mailing address: LIBERTY Dental Plan, 340 Commerce, Suite 100, Irvine, CA 92602

Please refer to Chapter 11 for more details about Dental Services, including specific information for dentists.

Each member aged 20 or younger will be assigned to a Dental Home Primary Care Dentist (PCD) who will be the provider of all dental care not requiring a specialist. The PCD can be either a general dentist who treats children or a pedodontist. PCD assignments will consider existing dental relationships for the member and sibling; if there is no prior relationship, proximity to the member's home will be used. Members' guardians can ask not to be in the program.

Our dental benefit is comprehensive and includes:

- Two annual preventive dental visits for all Members of any age that include an oral evaluation, necessary x-rays, prophylaxis and fluoride application
- All necessary dental services
- Access without a referral for a Member to see a participating general dentist or dental specialist
- Members with special health care needs may receive four preventive visits in a 12 month period

Primary care providers should perform basic oral screening for all members, remind them of the need for annual dental visits and perform yearly caries assessments on all pediatric patients through age 6. The PCP must verify dental visits by asking these members' parents or caregivers. The PCP must refer members to a dentist by age one. Preventive dental visits should be recommended twice yearly for members of all ages and all recommended treatment should be completed.

Through the NJ Smiles Program, primary care providers who access the appropriate training can provide fluoride varnish to the teeth of children as a preventive measure against caries. Details are available on our website at:

https://www.aetnabetterhealth.com/newjersey/providers/notices

Non-dental providers can provide caries risk assessment, fluoride varnish application and dental referral for children through the age of six (6). Fluoride varnish may be applied by non-dental providers who have proof of training for this service. Primary care physicians (pediatricians or physicians seeing pediatric enrollees), physician assistants and nurse practitioners can receive this training. Fluoride varnish application should be combined with caries risk assessment and referral to a dentist that treats children under the age of six during regular well child visits for all children younger than or equal to 72 months. These three services are reimbursed as an all- inclusive ("bundled") service billed using a CPT code. The combined service including caries risk assessment and fluoride varnish application can be provided up to four (4) times a year. This frequency is separate from services by a dentist.

A referral to a dentist for a dental visit by twelve (12) months of age is required by the state periodicity schedule under the benefit for EPSDT. All primary care dentists and primary care physicians should be aware of the fluoride levels in the community's public water and prescribe fluoride supplements as appropriate (based on the member's access to and use of fluoridated public water). Both dentists and primary care providers should be aware of their responsibility to counsel parents and guardians of young children on oral health and age appropriate oral habits and safety; topics of counseling should include an understanding of what constitutes a dental emergency and when use of the emergency room for dental services is appropriate.

Caries risk assessment service are also covered for the primary care dentist and is billed using a CDT procedure code. The reimbursement is the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a primary care dentist; this service is linked to the provider, not the member (i.e., a member could have the service done more than once in a year if a different dentist starts care). It may be provided a second time by the same primary dentist with prior authorization and documentation of medical necessity.

Some services and procedures for oral/facial structures can be provided by either dental specialists or medical/surgical specialists. Examples include management of fractures, injuries, congenital abnormalities, maxillofacial prosthetics and tumors involving the upper and lower jaw but are not limited to these. Medically necessary services are covered whether they are provided by a dental provider or a medical/surgical provider. Please see Chapter 11 for more details about Dental Services.

Orthodontia

Limited, interceptive and comprehensive orthodontia are covered for children in the Medicaid/NJ FamilyCare programs in cases of medical necessity, which include:

- Severe functional difficulties
- Developmental anomalies of facial bones and/or oral structures
- Facial trauma resulting in severe functional difficulties
- Documentation that long-term psychological health requires orthodontic correction
- Habit appliances

A consultation to visually assess a member's needs is recommended and does not require precertification. A pre-orthodontic treatment visit to complete the Handicapped Labiolingual Deviation (HLD) assessment is required for consideration of interceptive and comprehensive treatment and does not require precertification. The HLD assessment form can be found at https://www.njmmis.com/downloadDocuments/22-14.pdf. All orthodontic treatment requires precertification. Please see Chapter 11 for more details about Orthodontic Services.

Emergency Dental Services

Dental providers are required to follow the dental appointment standards established by DMAHS. The standards are as follows: Emergency dental treatment to members no later than forty-eight (48) hours or earlier as the condition warrants, urgent dental care appointments within three days of referral, and routine nonsymptomatic dental care appointments within thirty (30) days of referral.

If a member calls with an urgent need when the dentist's office is closed, the member should be given information for a covering emergency provider by an answering service or telephone message. If the dentist is not able to see the member or is unavailable the member can also call LIBERTY Dental Plan at 1-855-225-1727for help in scheduling an appointment or finding another dentist or visit the member portal at LIBERTY Dental Plan's website. Members always have the option to call Aetna Better Health of New Jersey Member Services at 1-855-232-3596, which is available 24 hours a day. If the member is out of town and in need of emergency dental care, he/she can go to any dentist for care or call LIBERTY Dental Plan for help to find a dentist. Members do not need a referral or Aetna Better Health of New Jersey's prior approval before receiving emergency dental care.

Dental emergencies include:

- Tooth fracture
- Loss of a permanent tooth
- Severe gingival, jaw or mouth pain and fever

Vision Services – March Vision

Routine vision services are provided through March Vision. March Vision covers routine eye exams, prescription frames, and lenses, administers the vision network, and processes vision claim payment. Medical and surgical care of the eye (including any medical care provided by an optometrist) is covered directly by Aetna Better Health of New Jersey. Claims for routine vision care should be billed to March Vision. Claims for medical or surgical care of the eye should be billed to Aetna Better Health of New Jersey. Optometrists or ophthalmologists that plan to provide both routine care and medical care of the eye should be contracted both with March Vision and directly with Aetna Better Health of New Jersey.

Under Medicaid and NJ FamilyCare A, B and C, the following services are covered under the routine vision benefit:

- One exam is covered once every twelve (12) months for members up to age 18. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every twelve (12) months or more frequently as medically necessary.
- One exam is covered once every twelve (12) months for members ages 19 through 59. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every twenty-four (24) months or more frequently as medically necessary.
- One exam is covered once every twelve (12) months for members age 60 or older. One pair of eyeglasses, including frame and lenses selected from Medicaid-allowable materials, is covered once every twelve (12) months or more frequently as medically necessary.

Under NJ FamilyCare C and D, the vision exam requires a $5 copayment. No copayment is required for Native Americans and Eskimos under age 19 enrolled in NJ FamilyCare C and D.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health of New Jersey's Member Services Department at 1-855-232-3596.

CHAPTER 6: BEHAVIORAL HEALTH

Back to Table of Contents

Mental Health/Substance Abuse Services

Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Mental Health/substance abuse (BH/SA) services are collectively referred to as Behavioral Health in Aetna Better Health of New Jersey. Substance use disorders include abuse of alcohol and other drugs. In order to meet the behavioral health needs of our members, Aetna Better Health of New Jersey will provide a continuum of services to members at risk of or

suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with behavioral health providers who are experienced in providing behavioral health services to the NJ population.

A comprehensive package of inpatient and outpatient behavioral health services are covered for members who are clients of the Division of Developmental Disabilities (DDD) and members who are in the Managed Long Term Services and Supports (MLTSS) Program. (See Chapter 5 of this Manual for a complete description of benefits.) Inpatient admission for mental health and substance use disorders, whether to an acute care general hospital or to an institute for mental disease (acute psychiatric hospital) are covered for all members. Members in Medicaid and FamilyCare are covered for inpatient behavioral health care at non-acute care facilities and for outpatient behavioral health services under the Medicaid Fee-for-Service (FFS) program. Acute inpatient admissions and some outpatient services covered under Aetna Better Health require authorization. Providers can call the toll-free number located on the back of the member's identification card to access information about services, participating behavioral health providers and authorization information for members who request services from a behavioral health provider directly.

In addition, for all categories of members, Aetna Better Health of New Jersey will cover services related to diseases of organic origin categorized as altering the mental status of a member.

Referral Process for Members Needing Mental Health/Substance Abuse Assistance

Mental Health/substance abuse (MH/SA) services are collectively referred to as Behavioral Health in Aetna Better Health of New Jersey. Inpatient and outpatient behavioral health services are covered within the plan for members in Managed Long Term Services and Supports (MLTSS) and members registered with the Division of Developmental Disabilities (DDD). For non-emergent behavioral health services members may self-refer to any outpatient behavioral health provider within our network without a referral from their PCP. Some services require authorization. Acute care hospital admissions for Behavioral Health are also covered for members in Medicaid and FamilyCare.

Medicaid fee for service covers outpatient behavioral health services for Medicaid and Family Care members (members not in MLTSS or DDD). When Aetna Better Health does not cover the behavioral health benefit, members in need of non emergency behavioral health services can self refer to any provider within the Medicaid network. Aetna Better Health will assist with coordination of these services whether the service is or is not covered by the health plan.

To assure coordination of care and when medically necessary , Providers are responsible for notifying a member's MH/SA provider of the findings of his/her physical examination and laboratory/ radiological tests within twenty-four (24) hours of receipt for urgent cases and within five (5) business days in non-urgent cases. Provider must send the mental health/substance abuse provider a copy of the member's consultation and diagnostic results.

Primary Care Provider Referral

We promote early intervention and health screening for identification of behavioral health problems and patient education. To that end, Aetna Better Health of New Jersey providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and/or substance abuse disorders within the scope of their practice
- Inform Members how and where to obtain behavioral health services
- Understand that members may self-refer to an Aetna Better Health of New Jersey behavioral health care provider without a referral from the member's Primary Care Provider (PCP)

Availability

Mental Health/Substance Abuse (MH/SA) providers must be accessible to members, including telephone access, 24-hours-a-day, 7 days per week, in order to advise members requiring urgent or emergency services. If the MH/SA provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. Mental Health/Substance Abuse (MH/SA) providers are required to meet our contractual standards for urgent and routine behavioral health appointments. For a complete list, please see Chapter 4 of this Manual.

Behavioral Health for Members with Special Needs

Adults with special needs include our members with complex and or chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders and/or developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Providers can refer special needs members to any outpatient behavioral health provider within our network without a referral. If the member requires specialized care from a provider outside of our network, a prior authorization is required. If assistance is needed finding a behavioral health specialist in our network, you may call our toll-free number at 1-855-232-3596.

How to Request Prior Authorizations

Prior authorizations for services covered by the health plan are managed by the Utilization Management Department. Providers should submit requests by the same process for all requests, as described below. (see chapter 5 for a list of covered behavioral health services)

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of New Jersey's website at www.aetnabetterhealth.com/newjersey, or
- Fax the request form to 1-844-797-7601 (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing; or
- Through our toll-free number 1-855-232-3596

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal at www.aetnabetterhealth.com/newjersey, or call us at 1-855-232-3596. The portal will allow you to check status, view history, and/or email a Case Manager for further clarification if needed. (please see chapter 14 for additional prior authorization information)

Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health of New Jersey uses nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members, characteristics of the local delivery system and requirements of the Medicaid program. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria are established and reviewed according to Aetna Better Health of New Jersey policies and procedures.

Concurrent Review

Aetna Better Health of New Jersey conducts concurrent utilization review on each member admitted to an inpatient facility. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines®. Admission certification is conducted within one business day of receiving timely notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses and behavioral health clinicians conduct these reviews. The professional staff work with the medical directors in reviewing medical record documentation for hospitalized members. Our medical directors conduct rounds as necessary. (please see chapter 13 for additional concurrent review information)

MCG Guidelines

Aetna Better Health of New Jersey uses the MCG Guidelines® to ensure consistency in hospital–based utilization practices for both physical health and behavioral health (see exception below). The guidelines span the continuum of member care and describe best practices for treating common conditions. The MCG Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Behavioral Health Guidelines

In accordance with DMAHS requirements, the American Society of Addiction Medicine (ASAM) guidelines are applied to requests for substance use disorder services covered by Aetna Better Health of New Jersey, for both inpatient and outpatient services.

Coordination Between Behavioral Health and Physical Health Services

We are committed to coordinating medical and behavioral care for members. Members should be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use disorder, dual or multiple diagnoses and/or intellectual or developmental disabilities. With the member's permission, our case management staff can facilitate coordination of case management related to substance abuse screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers should be screened for co-existing medical issues. Behavioral health providers should refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. Mental Health/Substance Abuse (MH/SA) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the member's consent if required, and work collaboratively on a plan of care.

Information is shared between Aetna Better Health of New Jersey and participating behavioral health and medical providers to ensure that interactions with the member result in appropriate coordination between medical and behavioral health care.

The Primary Care Provider and behavioral health provider are asked to share pertinent history including his/her physical examination and test results within twenty-four (24) hours of receipt of results in urgent or emergent cases, and provide notification within five (5) business days of receipt of results for non-urgent or non-emergent test results for services that are managed by the MCO as well as services that remain FFS. Members are able to self-refer to any participating MH/SA provider within our network without a prior authorization or a referral from their PCP.

Office Based Addiction Treatment (OBAT) Services

OBAT is a program to support non-methadone Medication Assisted Treatment (MAT) for members with substance use including opioid, alcohol and poly-substance abuse. Physicians who are DATA 2000 waivered including physician assistants and APN's can participate in the OBAT program. The OBAT program supports providers by an increased reimbursement rate for OBAT services. OBAT providers must designate a Navigator who works within their practice. The Navigator is an essential component to ensure the member's psychosocial needs are addressed and assist with coordination of care with counseling, resources for recovery supports and family education. Physicians, physician assistants and APN's who are not DATA 2000 Waivered can participate in training to obtain their certification. Please call member services at 1-855-232-3596 for more information.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 4 of this Manual.

When a provider receives a request from Aetna Better Health of New Jersey to supply medical records, these records must be sent to us within 14 days of our request. If the request comes from the state of New Jersey or other government entity, records must be sent within the time frame specified, even if sooner than 14 days. Aetna Better Health of New Jersey does not reimburse health care providers for expenses related to providing copies of patient records or documents, unless required by state or federal law.

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES

Back to Table of Contents

Aetna Better Health of New Jersey is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers and members each year.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of New Jersey requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health of New Jersey's policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation or any other basis that is prohibited by law. Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of New Jersey is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of New Jersey will initiate an investigation into the matter and report the findings to the Quality Management Oversight Committee, after which further action may be necessary.

In the event Aetna Better Health of New Jersey is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of New Jersey will make good faith efforts to address the issue with the member and educate the member on their responsibilities.

Members have the following rights and responsibilities:

Member Rights

Aetna Better Health of New Jersey members, their families and or guardians have the right to information related to their treatment or treatment options in a manner and language appropriate to the member's condition and ability to understand. This includes, but is not limited to:

- Names of participating providers and, if appropriate, the member's case managers
- Copies of medical records as allowed by law and the right to request that they be amended or corrected
- A description of the Aetna Better Health of New Jersey services or covered benefits
- A description of their rights and responsibilities as members, including the right to be free from any form of restraint, interference or seclusion used as a means of coercion, discrimination, reprisal, discipline, convenience, or retaliation by Aetna Better Health of New Jersey or its providers
- How Aetna Better Health of New Jersey provides for after-hours and emergency health care services. This includes members' right to available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions; the 911 emergency response systems should be called whenever a member has a potentially life-threatening condition
- Information about how Aetna Better Health of New Jersey pays providers, controls costs and manages the use of services
- Summary results of member surveys and grievances
- Information about the cost to a member if the member chooses to pay for a service that is not covered
- Procedures for obtaining services, including authorization requirements
- A description of how Aetna Better Health of New Jersey evaluates new medical procedures for inclusion as a covered benefit
- Advance Directives where the member or his/her representative make legal decisions to withhold resuscitative services, to forgo or withdraw life-sustaining treatment or to obtain or forego mental health services
- Receipt of a provider directory in the welcome packet and upon request; the directory includes the address and phone numbers of participating providers as well as an indicator for non-English languages spoken by the provider or staff
- Having a candid discussion of appropriate or medically necessary treatment options and alternative choices of care for their conditions, regardless of cost or benefit coverage
- Information on Aetna Better Health of New Jersey's benefits and provider network changes

Members have a right to respect, fairness, dignity and the need for privacy. This includes, but is not limited to:

- An ability to receive covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or ability to speak English
- Quality medical services that support personal beliefs, medical condition and background in a language the member can understand
- Interpreter services for members who do not speak English or who have hearing impairment, or written information in an alternative format
- The right to be free from any form of harm, including unnecessary physical restraint or isolation, excessive medication, physical or mental abuse or neglect
- The right to be free of hazardous procedures
- To have services provided that promote a meaningful quality of life and autonomy for members, independent living in members' homes and other community settings as long as medically and socially feasible, and preservation and support of members' natural support systems.

Members have a right to confidentiality and privacy. This includes, but is not limited to:

- The right to privacy and confidentiality of health care information; information will be distributed only if allowed by law
- The right to ask how their health care information has been given out and used for non-routine purposes
- The right to talk to health care professionals and case managers privately

Members have a right to participate in decision making about their health care, and/or have a representative facilitate care or treatment decisions when necessary. This includes, but is not limited to:

- Choice of a Primary Care Provider (PCP), within the provider network, to help with planning and coordinating care
- Timely access to providers and care from a specialist when it is needed; timely access to prescriptions from a network pharmacy
- Being informed about any risks involved in care
- The right to be fully informed by the PCP, other health care provider or case manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence
- Seeing a women's health specialist without a referral
- The right to be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments
- The right to change PCP if necessary
- The right to request specific, condition-related information from a PCP
- The right to request information about procedures and who will perform them
- Decision as to who should be in attendance at treatments and examinations
- Choice to have a female in the room for breast and pelvic exams
- The right to refuse a treatment, services, or PCPs, including a right to leave the hospital even though a doctor advises against it, and to request an explanation of consequences; eligibility or medical care does not depend on a member's agreement to follow a treatment plan
- The right to stop taking medications when the medication is needed to protect the member or others from harm
- Written notification when health care services are reduced, suspended, terminated, or denied; notification is accompanied by instructions

Members have a right to seek emergency care and specialty services. These rights include:

- Obtaining emergency services without prior approval from the PCP or Aetna Better Health of New Jersey when they have an emergency
- Obtaining services from a specialist including those with experience in the treatment of chronic disabilities, with prior authorization
- Refusing care from a specialist the member was referred to and requesting another referral
- Requesting a second opinion from another Aetna Better Health of New Jersey provider

Members have a right to report concerns to Aetna Better Health of New Jersey. This includes, but is not limited to:

- Reporting complaints and grievances about the organization or quality of care or services, interpersonal relationships, failures to respect rights, or any other issues concerning the member's health care services to Aetna Better Health of New Jersey or the New Jersey Department of Banking and Insurance; members have the right to an answer to these complaints within a reasonable period of time
- Filing appeals after an Aetna Better Health of New Jersey determination and then receiving a decision in a reasonable amount of time
- Giving suggestions for changes to policies and services
- Receiving a detailed explanation if a member believes that an Aetna Better Health of New Jersey provider has denied care the member believes they are entitled to receive

Members have the right to be free from liability under certain circumstances. This includes:

- Aetna Better Health of New Jersey's debts in the event of insolvency
- Any covered services or services approved by Aetna Better Health of New Jersey with the exception of the member's cost sharing responsibility as determined by the Division of Medical Assistance and Health Services (DMAHS); this also applies to services provided by Aetna Better Health of New Jersey's subcontractors and vendors

Members in MLTSS also have certain rights. These include:

- To request and receive information on choice of services available;
- Have access to and choice of qualified service providers;
- Be informed of their rights prior to receiving chosen and approved services;
- Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability;
- Have access to appropriate services that support their health and welfare;
- Choose between nursing facility and Home and Community Based Services if the member qualifies for nursing facility care and if the member's needs can be safely and cost effectively met in the community
- To assume risk after being fully informed and able to understand the risks and consequences of the decisions made;
- To make decisions concerning their care needs;
- Participate in the development of and changes to the Plan of Care;
- Request changes in services at any time, including to add, increase, decrease or discontinue;
- Request and receive from their Care Manager a list of names and duties of any person(s) assigned to provide services to them under the Plan of Care;
- Receive support and direction from their Care Manager to resolve concerns about their care needs and/or grievances about services or providers;
- Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings;
- Be informed of all the covered/required services they are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility;
- Not to be transferred or discharged out of a facility except for medical necessity; to protect their physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non payment to the facility from available income as reported on the statement of available income for Medicaid payment.
- Have their health plan protect and promote their ability to exercise all rights identified in this document. Have all rights and responsibilities outlined here forwarded to their authorized representative or court appointed legal guardian
- Appeal or request Medicaid Fair Hearing through DMAHS regarding eligibility for MLTSS or participation in the participant direction program

Member Responsibilities

Aetna Better Health of New Jersey members, their families, or guardians are responsible for:

- Knowing the name of the assigned PCP and/or Case Manager
- Familiarizing themselves about their coverage and the rules they must follow to get care
- Respecting the health care professionals providing service

[1] NJ DMAHS Contract 5.8.2.K.6; 9.4.1.A.7

- Sharing any concerns, questions or problems with Aetna Better Health of New Jersey
- Providing all necessary health related information needed by the professional staff providing care, and requesting more explanation if a treatment plan or health condition is not understood
- Following instructions and guidelines agreed upon with the health professionals giving care
- Protecting their member identification card and providing it each time they receive services
- Scheduling appointments during office hours, when possible
- Arriving for appointments on time
- Notifying the health care professionals if it is necessary to cancel an appointment
- Disclosing other insurance, they may have and/or applying for other benefits they may be eligible for
- Bringing immunization records to all appointments for children less than eighteen (18) years of age.
- Understanding their health problems and participating in developing mutually agreed upon treatment goals, to the degree possible
- Reporting changes like address, telephone number and/or assets, and other matters that could affect the member's eligibility to the office where the member applied for Medicaid services

Members covered under MLTSS have the following responsibilities associated with their benefits:

- Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care
- Understand their health care needs and work with their Care Manager to develop or change goals and services
- Work with their Care Manager to develop and/or revise their Plan of Care to facilitate timely authorization and implementation of services
- Ask questions when additional understanding is needed
- Understand the risks associated with their decisions about care
- Report any significant changes on their health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager
- Notify their Care Manager should any problem occur or if they are dissatisfied with the services being provided; and
- Follow their health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share)

For questions or concerns, please contact our Provider Relations Department at 1-855-232-3596.

Member Rights Under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers and human service programs such as Medicaid.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits

- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

CHAPTER 8: ELIGIBILITY AND ENROLLMENT

Back to Table of Contents

Aetna Better Health of New Jersey arranges medically necessary covered services for individuals who are enrolled in the NJ Medicaid and NJ FamilyCare Programs. This chapter describes eligibility categories, the role of the health benefits coordinator and the enrollment and disenrollment processes.

Eligibility

To become a member with Aetna Better Health of New Jersey, a member must first be eligible for the NJ Medicaid and or Medicaid Programs. Benefits are predetermined by the State of New Jersey and not Aetna Better Health of New Jersey. The Division of Medical Assistance and Health Services (DMAHS) must approve a member's enrollment with Aetna Better Health of New Jersey. It takes between 30 and 45 days after a member applies in order for their membership to start. A member's coverage with us starts on the first day of the month after the member receives approval from DMAHS that their enrollment was accepted.

To be eligible for New Jersey Medicaid, a person must:

- Be a resident of New Jersey be a U.S. Citizen or qualified alien (most immigrants who arrive after August 22, 1996 are barred from Medicaid for five years, but could be eligible for NJ FamilyCare and certain programs for pregnant women)
- Meet specific standards for financial income and resources

In addition, a person must fall into one of the following categories:

- FamilyCare A:
    - Uninsured children below the age of 19 with family incomes up to and including 133 percent of the federal poverty level
    - Pregnant women up to 200 percent of the federal poverty level
    - Beneficiaries eligible for MLTSS services
- FamilyCare B:
    - Uninsured children below the age of 19 with family incomes above 142 percent and up to and including 150 percent of the federal poverty level.
- FamilyCare C:
    - Uninsured children below the age of 19 with family incomes above 150 percent and up to and including 200 percent of the federal poverty level.
- FamilyCare D:
    - Parents/caretakers with children below the age of 19 who do not qualify for AFDC/TANF – related Medicaid with family incomes up to and including 200 percent of the federal poverty level
    - Parents/caretakers with children below the age of 23 years and children from the age of 10 through 22 years who are full time students who do not qualify for AFDC/TANF Medicaid and family incomes up to and including 250 percent of the federal poverty level who were transferred to the NJ FamilyCare program effective November 1, 2001
    - Children below the age of 19 with family income between 201 percent and up to and including 350 percent of the federal poverty level.
    - Adult and couples without dependent children under the age of 19 with family incomes up to and including 100 percent of the federal poverty level who applied as such for NJ FamilyCare benefits prior to September 1, 2001, and continuously have received those benefits

Adults and couples without dependent children under the age of 23 years, who do not qualify for AFDC/TANF Medicaid, with family incomes up to and including 250 percent of the federal poverty level who were transferred to the NJ FamilyCare program effective November 1, 2001:

- FamilyCare ABP:
    - Parents between 19-64 with income with two and including 133% of the federal poverty level, and childless adults between 19-64 with income up to and including 133% of the federal poverty level

Individuals meeting nursing home level of care, based on meeting program requirements:

- NJ MLTSS

Our Members

Our members include the following groups:

- Non-institutionalized Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF) and related New Jersey Care members
- Supplemental Security Income (SSI) — Aged, Blind and Disabled (ABD) and related groups
- Clients of the Division of Developmental Disabilities (DDD) and Community Care Waiver (CCW)
- New Jersey Care — Aged, Blind and Disabled (ABD)
- NJ FamilyCare members
- Eligible Division of Child Protection and Permanency covered members
- Individuals meeting nursing home level of care and living in nursing facilities or special care nursing facilities
- Individuals meeting nursing home level of care and living in the community (Home and Community Based Services–HCBS)

Health Benefits Coordinator (HCB)

The Health Benefits Coordinator (HCB) is responsible for assisting members with the selection and disenrollment of health plans; determining premiums and assisting members with questions. You can help identify members who may qualify for coverage. If you know of or identify potential eligibles that may be entitled NJ Medicaid or NJ Family Care coverage, please ask them to call the HCB at 1-800-701-0720, or Aetna Better Health of New Jersey at 1-855-232-3596.

Open Enrollment

Members have the option to change health plans during the initial 90 days after the effective date of enrollment (the member's anniversary date). Thereafter, members can change health plans annually upon open enrollment, in which they will have a 60-day period to change health plans. The HCB will send members a notice of their option to change health plans and the associated deadline. Enrollment in a new health plan will be effective on the member's anniversary date.

Disenrollment

Member may disenroll from Aetna Better Health of New Jersey at any time during the first ninety (90) days of enrollment. After the first ninety (90) days, the member is "locked in" as an Aetna Better Health of New Jersey member unless there is good cause to disenroll. DMAHS will decide if the member has good cause. It can take up to 30–45 days to process a member disenrollment request.

Re-Enrollment

Member who lose their Medicaid eligibility and whose coverage is reinstated within the last two months will be re-enrolled with the health plan with which they were previously enrolled. Aetna Better Health of New Jersey will assign the member to their previous Primary Care Provider (PCP) if the PCP is still accepting new patients.

ID Card

Members should present their Aetna Better Health of New Jersey ID card at the time of service. The Aetna Better Health of New Jersey ID card will note whether or not the member has a copay. Some NJ FamilyCare C and D members must pay copayments for certain services.

Please note that some members may still carry a Medicaid card for those services not covered under Aetna Better Health of New Jersey. NJ FamilyCare members will receive an ID card directly from DMAHS. The card issued by DMAHS is only for those services covered under DMAHS, which are not covered by Aetna Better Health of New Jersey. In addition, some members may have Medicare coverage and will receive a separate Medicare ID card from the Centers of Medicare and Medicaid (CMS). This is often referred to as a red, white and blue card. If the member has Original Medicare, they will use the Medicare card first for those services covered by Medicare. They should also show the Aetna Better Health of New Jersey ID card for services which are not covered by Medicare and forcovered copayments.

The member ID card contains the following information:

- Member Name
- Member ID Number
- Date of Birth of Member
- Member's Gender
- Copay Amounts (if applicable)
- PCP Name
- PCP Phone Number
- Effective Date of Eligibility
- Claims address
- Emergency Contact Information for Member
- Health Plan Name - Aetna Better Health of New Jersey
- Aetna Better Health of New Jersey Logo
- Aetna Better Health of New Jersey's Website
- Carrier Group Number
- RX Bin Number
- RX PCN Number
- RX Group Number
- CVS Caremark Number (For Pharmacists use only)

Sample ID Card

Front:

Back:

Verifying Eligibility

Presentation of an Aetna Better Health of New Jersey ID card is not a guarantee of eligibility. The provider is responsible for verifying a member's current enrollment status before providing care. Aetna Better Health of New Jersey will not reimburse for services provided to patients who are not enrolled with Aetna Better Health of New Jersey. Providers can verify member eligibility by calling the Member Services Department at 1-855-232-3596, or online through the Secure Web Portal at www.aetnabetterhealth.com/newjersey.

CHAPTER 9: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

Back to Table of Contents

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are Medicaid's comprehensive and preventive health program for individuals under the age of 21. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT Program consists of two mutually supportive, operational components: **(1) assuring the availability and accessibility of required health care resources;** and **(2) helping members and their guardians effectively use these resources.** These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available, and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations, and to see that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. (Adapted from CMS website at https://www.cms.gov/MedicaidEarlyPeriodicScrn/.)

New Jersey Specific Requirements for Vaccines under EPSDT

The New Jersey Immunization Information System

The New Jersey Immunization Information System (NJIIS), operated under the New Jersey Department of Health, has established a statewide immunization information system serving as the official repository of immunizations administered to children in New Jersey. The Division of Medical Assistance and Health Services (DMAHS) and Aetna Better Health of New Jersey require that PCPs caring for individuals younger than 21 participate and enroll in their registry database.

By participating, providers are able to:

- Obtain a complete and accurate immunization history for a new or continuing patient;
- Produce immunization records;
- Manage vaccine inventories;
- Introduce new vaccines or change in the vaccine schedule;
- Help interpret the complex immunization schedule; and
- Provide immunization coverage data for the office, health plans and other national organizations.

For more information, please visit https://njiis.nj.gov/njiis.

Department of Health (DOH) Vaccines for Children (VFC) Program

Providers who see Medicaid members and administer vaccines to children enrolled in FamilyCare Plan A are required to enroll with the Department of Health (DOH) Vaccines for Children (VFC) Program. Additionally, providers must use the free vaccines for Plan A Medicaid patients if the vaccine is covered by the VFC Program. The Department of Health does not reimburse providers for the cost of VFC covered vaccines; however, Aetna Better Health of New Jersey reimburses providers for the administration and the cost of non-VFC vaccines and vaccines for children enrolled in other FamilyCare benefit plans.

For more information about enrollment, please visit https://njiis.nj.gov/docs/VFC_enrollment_forms_for_children.pdf.

Periodicity Schedule

The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at http://brightfutures.aap.org/clinical_practice.html .

Identifying Barriers to Care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and/or caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, Aetna Better Health of New Jersey trains its Member Services and Care Management Staff to identify potential obstacles to care during communications with members, their family/caregivers, Primary Care Providers (PCPs) and other relevant entities and works to maintain access to services.

Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health of New Jersey closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. Aetna Better Health of New Jersey also notifies members annually of their eligibility for EPSDT services and encourages the use of the services.

Educating Members about EPSDT Services

Aetna Better Health of New Jersey informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that Aetna Better Health of New Jersey offers. The information process includes:

- Member Handbook & Evidence of Coverage documentation
- Member newsletters and bulletins
- Aetna Better Health of New Jersey's website
- Educational flyers
- Reminder postcards
- Care plan interventions for high risk members enrolled in care management

Provider Responsibilities in Providing EPSDT Services

Participating providers are contractually required to do the following in providing EPSDT services:

- Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with New Jersey's periodicity schedule, including federal and State laws standards and national guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care: http://brightfutures.aap.org/clinical_practice.html) and as federally mandated
- Address issues identified in screenings by appropriate testing, referrals and follow-up visits to assure compliance
- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling's visit)

- Assure that members access recommended dental care, including a first dental visit by age one(1)
- Assure that members aged 9 months to 6 years receive appropriate lead verbal risk screening and lead testing
- Participate in the Department of Health and Senior Services (DHSS) Vaccines for Children (VFC aka NJVFC) Program, the federally funded, state-operated vaccine supply program that provides pediatric vaccines at no cost to doctors who serve children who might not otherwise be vaccinated because of inability to pay
- Participate in the statewide immunization registry database, the New Jersey Immunization Information System (NJIIS)
- Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities, on the state-required standard encounter documentation form and ensure that the record is completed andreadable
- Comply with Aetna Better Health of New Jersey's Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law
- Cooperate with Aetna Better Health of New Jersey's periodic reviews of EPSDT services, which will include chart reviews to assess compliance with standards
- Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form with the appropriate -EP suffix
- Contact members or their parents/guardians after a missed EPSDT appointment so that it can be rescheduled
- Have systems in place to document and track referrals including those resulting from an EPSDT visit; the system should document the date of the referral; date of the appointment and the date information is received documenting that the appointment occurred

Aetna Better Health of New Jersey requires participating providers to make the following recommended and covered services available to EPSDT-eligible children at the ages recommended on the state Medicaid regulators' periodicity schedule:

- Immunizations, education, and screening services, provided at recommended ages in the child's development, including all of the following:
  - Comprehensive health and developmental history (including assessment of both physical and mental health development)
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines)
  - Laboratory tests
  - Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental exams provide the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in their understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and diseaseprevention
  - Vision services, including periodic screening and referral or direction to treatment for defects in vision, including eyeglasses
  - Dental services, including oral screening, periodic direct referrals for dental examinations (according to the state periodicity schedule), relief of pain and infections, restoration of teeth, and maintenance of dentalhealth
  - Hearing services, including, at a minimum, referral to diagnosis and treatment for defects in hearing, including hearing aids
  - Lead toxicity screening, consists of two components, verbal risk assessment and blood lead testing in accordance with CMS and New Jersey state requirements
  - Developmental screening using a validated screening tool, at ages according to the American Academy of Pediatric periodicity schedule
  - Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services

For questions or concerns, please contact our Relations Department at 1-855-232-3596.

PCP Notification

On at least a quarterly basis Aetna Better Health of New Jersey will provide all PCPs with a list of members who have not had an encounter and/or who have not complied with the EPSDT periodicity and immunization schedules for children.

Provider Incentives

In order to promote provider compliance with our EPSDT plan, Aetna Better Health of New Jersey will pay $10 for every documented encounter record for an Aetna Better Health of New Jersey-approved EPSDT screening examination in accordance with New Jersey's contractual requirements. This incentive payment will be reimbursed for EPSDT encounter records submitted in accordance with 1) procedure codes specified by DMAHS, and 2) the EPSDT periodicity schedule. Additional incentives are provided for proof of appropriate lead testing.

Direct-Access Immunizations

Members may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the member if it is the only service provided at that visit. A PCP copayment (when applicable according to benefit plan) will apply for all other immunizations that are medically necessary.

EPSDT Service Details

EPSDT services include:

- A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit; developmental screening should use a validated formal tool and be provided at the following ages:
  - 9 months
  - 18 months
  - 30 months
- A comprehensive unclothed physical examination including vision and hearing screening; dental inspection; and nutritional assessment
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. Providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits and necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.
- Appropriate laboratory tests: A recommended sequence of screening laboratory examinations as provided by Aetna Better Health of New Jersey. The following list of screening tests is not all inclusive:
  - Hemoglobin/hematocrit/EP
  - Urinalysis
  - Tuberculin test – intradermal, administered annually and when medically indicated
  - Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child:
    - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age
    - at 18-26 months, preferably at twenty-four (24) months of age
    - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested
  - Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and should be obtained as necessary
- Health education/anticipatory guidance
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate)
- EPSDT screening services should reflect the age of the child and be provided periodically according to the following schedule:
  - Neonatal exam
  - Under six (6) weeks
  - Two (2) months
  - Four (4) months
  - Six (6) months

- Nine (9) months
- Twelve (12) months
- Fifteen (15) months
- Eighteen (18) months
- Twenty-four (24) months
- Annually through age twenty (20)

Vision Services

At a minimum, include referral for diagnosis and treatment for defects in vision, including eyeglasses. The vision screening of an infant means, at a minimum, eye examination, and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment should be done for each child beginning at age three.

Dental Services

Dental services are not limited to emergency services. Dental exams in this context means, at a minimum, observation of tooth eruption, occlusion pattern and presence of caries or oral infection. A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory. Thereafter there must be, at a minimum, a dental visit twice a year with confirmation by the PCP during well child visits to ensure that all needed dental preventative and treatment services are provided, through the age of twenty (20) years. Communication between the dentist and the primary care provider should occur.

Hearing Services

At a minimum, include referral for diagnosis and treatment for defects in hearing, including hearing aids. For infants identified as at risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to three months of age using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant's response to auditory stimuli and audiogram for a child three (3) years of age and older. Speech and hearing assessment are a part of each preventive visit for an older child.

Mental Health/Substance Abuse

Include a mental health/substance abuse assessment documenting pertinent findings. When there is an indication of possible MH/SA issues, a mental health/substance abuse-screening tool should be used to evaluate the member.

Additional Diagnostic and Treatment Services

Include such other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental/substance abuse illnesses and conditions discovered by the screening services.

Lead Screening

Verbal Risk Assessment – The provider is expected to perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of six (6) and seventy-two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions:

1. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint?
2. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint?
3. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling?
4. Have any of your children or their playmates had lead poisoning?
5. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community.
6. Do you give your child home or folk remedies that may contain lead?

Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or “I don’t know”, a child is considered to be at high risk for high doses of lead exposure. Regardless of risk, each child must be tested. A child's risk category can change with each administration of the verbal risk assessment.

Blood Lead Testing

All children between ages 9 months and 6 years must have lead screening through a blood lead level determination. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia.

Screening blood lead testing may be performed by either a capillary sample (finger stick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. The blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, once between 18 and 26 months, preferably at twenty-four (24) months, and for any child between twenty-seven (27) and seventy-two (72) months not previously tested. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high-risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages.

- If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed.
- If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood test.
- If a child between the ages of twenty-four (24) months and seventy-two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above listed questions.
- When a child is found to have a blood lead level equal to or greater than ten (10) µg/dl, or two (2) consecutive tests one to four months apart with results between 5 and 9 µg/dl, PCPs should cooperate with the local health department in whose jurisdiction the child resides to facilitate the environmental investigation to determine and remediate the source of lead. This cooperation must include sharing of information regarding the child's care, including the scheduling and results of follow-up blood lead tests.
- When laboratory results are received, the PCPs should report to Aetna Better Health of New Jersey all children with blood lead levels > 5 µg/dl.

Provider Monitoring

The methods we utilize to monitor our providers' and members' compliance/success in obtaining the appropriate care associated with EPSDT include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

1. Analysis and evaluation of provider utilization
   - EPSDT Audit and other provider office visits
   - EPSDT Compliance Report
2. Tracking and trending provider data
   - Evaluation of performance measures and outcome data including Healthcare Effectiveness Data and Information Set (HEDIS®) and Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) results (monitoring results on a monthly basis).
3. Review and tracking of member grievances and appeals and provider complaints to identify trends
   - Peer review of quality, safety, utilization and risk management referrals
   - Recredentialing review activities
   - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
   - Review of sentinel events
4. Review of lead testing results to assess provider compliance with lead testing requirements
5. Monitoring network capacity and availability and accessibility to care delivery systems, recredentialing review activities
6. Review of individual cases through care management of members covered by EPSDT who have special needs

Our Provider Relations Department educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Relations Staff may take referrals from a provider to have a member outreached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Provider Relations Staff may also take referrals from providers who identify problems through EPSDT exams.

CHAPTER 10: MEMBERS WITH BEHAVIORAL HEALTH AND SPECIAL NEEDS

Members with Behavioral Health and Special Needs

Back to Table of Contents

Members with special needs include our members with complex and or chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, **behavioral health conditions**, substance use disorders and/or developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Aetna Better Health of New Jersey has developed methods for:

- Promoting well-childcare to children with special needs, who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of these members
- Coordination and approval of home therapies and home care services when indicated
- Care management for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so that long-term complications may be treated as necessary
- Care management systems to assure that children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of New Jersey for diagnosis and treatment of rare disorders

The Initial Health Screen (IHS) for new members will assist us in identifying those with special needs. We also review hospital and pharmacy utilization data. Additionally, we rely on you, our network providers, to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we follow up with a Comprehensive Needs Assessment for each of these members.

Aetna Better Health of New Jersey has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. For members with a chronic, complex condition needing care outside of the network over a prolonged period of time, referrals covering multiple visits (“standing referral”) may be provided, subject to the approval of the Chief Medical Officer (CMO).

Aetna Better Health of New Jersey will develop care plans that address the member’s service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. Our care management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

For children with special healthcare needs, care managers review their utilization of well childcare and access to specialty care and address health promotion and disease prevention activities relevant to their clinical need. Families who experience barriers to completing evaluations and tests for problems identified in EPSDT exams are assisted in addressing the barriers.

Aetna Better Health of New Jersey works to provide immediate transition planning for a new member with complex and or chronic conditions or any special needs. The planning will be completed within a time frame appropriate to the member’s condition, but in no case later than ten (10) business days from the effective date of enrollment when indicated on the Plan Selection form or within thirty (30) days after special conditions are identified by a provider. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan to maintain continual care during the transfer to the plan
- Coordination and follow-through to approve and provide any necessary DME if it was ordered prior to the member’s enrollment with us and it was not received by the date of enrollment with us

Outreach and enrollment staff are trained to work with members with special needs and to be knowledgeable about their care needs and concerns. Our staff use interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and use the NJ Relay system and American Sign Language interpreters, if necessary.

If a new member upon enrollment including DDD, MLTSS or upon diagnosis requires very complex, highly specialized health care services including behavioral health the member may receive care from a contracted specialist or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. If requested, the specialist or specialty care center may also be authorized to be responsible for providing and coordinating the member’s primary and specialty care. The specialist or

specialty care center, acting as both primary and specialty care provider, will then be permitted to treat the member without a referral from the member's Primary Care Provider (PCP) and may authorize such referrals, procedures, tests and other medical services as are needed. When the specialty care provider or center does not elect to take on both roles, the PCP will continue to coordinate care with the specialists.

Whenever approval is obtained to receive specialized services from a non-network provider, the care will be provided at no additional cost to the member. If our network does not have a provider or center with the expertise the member requires, we will authorize care out of network.

Aetna Better Health of New Jersey will arrange for the provision of dental services to members with developmental disabilities as well members Behavioral Health needs. At a minimum, dental services coverage will provide:

- Consultations and assistance to the member's caregivers
- Adequate time for members with developmental disabilities, knowing that initial and follow-up comprehensive dental visits may require up to sixty (60) minutes on average. Our standards allow for up to four visits annually without prior authorization for these members
- Home visits when medically necessary and where available
- Adequate support staff to meet the needs of the members
- Use and replacement of fixed as well as removable dental prosthetic devices as medically necessary and appropriate
- Reimbursement for preoperative and postoperative evaluations associated with dental surgery
- A dental management plan
- Processing of authorizations for dental required hospitalizations by consulting with our dental and medical consultants in an efficient and time-sensitive manner

After-hours protocol for members with special needs is addressed during initial provider trainings and in our Provider Manual. Providers must be aware that non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health of New Jersey Nurse Line is available 24 hours a day 7 days a week for members with an urgent or crisis situation.

For urgent issues or crises for dental services, the member must contact their dentist right away. If a member calls when the dentist's office is closed, the member should be given information for a covering emergency provider by an answering service or telephone message. If the dentist is not able to see the member or is unavailable the member can also call LIBERTY Dental Plan at 1-855-225-1727 for help in scheduling an appointment or finding another dentist or visit the member portal at Liberty Dental Plan's website. Members always have the option to call Aetna Better Health of New Jersey Member Services at 1-855-232-3596, which is available 24 hours a day. If the member is out of town and in need of emergency dental care, he/she can go to any dentist for care or call LIBERTY Dental Plan for help to find a dentist. Members do not need a referral or Aetna Better Health of New Jersey's prior approval before receiving emergency dental care.

Aetna Better Health of New Jersey requires our contracted providers to use the most current diagnosis and treatment protocols and standards established by the Department of Health and Senior Services (DHSS) and medical community. During initial provider orientations, we highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

CHAPTER 11: DENTAL SERVICES

Back to Table of Contents

Aetna Better Health of New Jersey has a comprehensive dental benefit that covers all medically necessary dental treatment. All NJFC Members: plans A, B, C, D, ABP and MLTSS and FIDE SNP (dual eligible Medicare/Medicaid) have the same comprehensive dental benefits which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral surgical and other adjunctive general services. Some procedures may require prior authorization with documentation of medical services. Orthodontic services are age restricted and only approved with adequate documentation of handicapping malocclusion or medical necessity.

Dental Services Covered under the Medical Benefit

Dental services provided to Aetna Better Health of New Jersey members are comprehensive and include reparative, restorative and reconstructive procedures involving the upper or lower jaws and dental structures as appropriate to provider specialty.

Medical and surgical services that are performed by either dentists or physicians are covered, regardless of whether the provider is a medical or a dental specialist. Examples of such services include management of facial trauma, maxillofacial prosthetics, management of tumors or cysts of the oral/facial structures and craniofacial reconstruction, which might be treated by otolaryngologists, oral surgeons, other dental providers or plastic surgeons. Whether the service is covered under the dental benefit or under the medical benefit will depend upon multiple factors, including the need for additional service providers, such as anesthesia, or for specific places of service, such as a hospital. Both dental and medical providers will be covered according to the circumstances.

Services that need prior authorization under the medical benefit should be requested through the UM process. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are age restricted and only approved with adequate documentation of handicapping malocclusion or medical necessity. When services are covered under the dental benefit, they should be requested through the dental vendor (see below). If there is a question about which benefit applies, please call Provider Relations at 855-232-3596.

In addition, medically necessary dental services which are performed at a facility-based setting, such as dental care under general anesthesia, are covered under the medical benefit. Providers who perform these procedures at hospitals must have admitting privileges at a participating NJ hospital. They should submit requests for the dental service to LIBERTY Dental Plan for authorization. Upon receiving authorization from LIBERTY Dental Plan, the provider should contact Aetna Better Health of New Jersey's Prior Authorization Department for the facility authorization.

A prior authorization request may be submitted to the Aetna Better Health of New Jersey Utilization Management Department by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of New Jersey's website at www.aetnabetterhealth.com/newjersey, or
- Fax the request form to 1-844-797-7601 (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing; or
- Through our toll-free 855-232-3596 number

Please refer to Chapter 14 for additional information about prior authorization.

DEFINITIONS

Consultation--A referral between different provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or, when needed, to medically necessary services provided by that specialty provider.

Dental records – the complete, comprehensive records of dental services, to include chief complaint, treatment needed and treatment planned, to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on site of the enrollee's participating dentist and in the records of a facility for enrollees in a facility.

Primary Care Dentist (PCD)--a licensed dentist who is the health care provider responsible for supervising, coordinating, and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

Children with Special Health Care Needs--those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Enrollee with Special Needs--for adults, special needs include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, including persons who are eligible for the MLTSS program. See also "Children with Special Health Care Needs"

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)--a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to

correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

Dental Vendor

Dental benefits are administered by LIBERTY Dental Plan, which manages the dental network and does utilization management for all services covered under the dental benefit. LIBERTY Dental Plan has an Office Reference Manual that describes expectations and requirements for dental providers in their network. This is available on their website below. Any procedures that require preauthorization can be submitted on the provider claim section of the LIBERTY Dental Plan's website or by mailing a completed claim form to the address below.

LIBERTY Dental Plan can be reached as follows:

LIBERTY Dental Plan
340 Commerce, Suite 100, Irvine, CA 92602
Telephone: 1-855-225-1727

Website: www.libertydentalplan.com

Credentialing of Dentists

Aetna and our dental vendor LIBERTY Dental Plan have a vigorous credentialing process to assure that providers participating in the dental network meet our requirements and are quality providers. Information from the LIBERTY Dental Plan Credentialing Committee is reviewed by Aetna Better Health's plan Credentialing Committee. All dental specialists are credentialed by this process, including the following dental specialties (as defined by Board Certifications): General Dentists, Oral Surgeons, Endodontists, Orthodontists, Periodontists, Pediatric Dentists and Prosthodontists. Dental specialists must meet the NJ Board requirements for that specialty and have a current "specialty permit". A dentist with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics and Prosthodontics must have, or have confirmation of application submission of, valid DEA and CDS certificates. Dentists who regularly provide services covered under the medical benefit may submit credentials to both LIBERTY Dental Plan and Aetna Better Health.

Dental Specialists and Specialty Care

The comprehensive dental benefit covers all dental specialty care. Any primary care provider or primary care dentist may refer all members including DDD or MLTSS to a participating dental specialist for non- emergency including behavioral health services managed by the MCO by written referral for initial evaluation which must be recorded in the member's medical record. There are no arbitrary number of attempted dental treatment visits by a primary care dentist as a condition prior to the primary care dentist initiating any specialty referral requests. The referring dentist is not obligated to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. The dentist receiving the referral is not obligated to prepare and submit diagnostic materials in order to be approved or reimbursed for a referral. Specialty providers are listed on Aetna's or LIBERTY Dental Plan's website. Dental specialists are either board eligible or board certified. The listing of all dental providers and dental specialists can be found on our website at www.aetnabetterhealth.com/newjersey.

Requirements for Dental Providers using Mobile Dental Services

Some dentists provide services by traveling to the location where members reside, such as in nursing homes, or at schools. There are special state requirements to assure that members treated at such locations have access to continuity of care and comprehensive treatment.

Definitions

Mobile Dental Practice--provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. Aetna Better Health must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.

Mobile Dental Van-- a vehicle specifically equipped with stationary dental equipment and used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). Patient records are to be maintained in the brick and mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements. When a mobile dental van's use is associated with health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. Aetna Better Health must maintain documentation for all locations served to include schedule of time and days.

EPSDT Dental Services and Fluoride Varnish Program

The EPSDT benefit for children ages 0-20 includes oral health screenings provided by the primary care provider as well as comprehensive dental services provided by dentists. Dental screenings include, at a minimum, observation of tooth eruption and occlusion pattern as well as examination for the presence of caries or oral infection. All children should be referred to a dentist before they reach one year of age and at least twice annually thereafter for oral evaluation and preventive services. All needed dental preventive and treatment services are covered. Dental Services may not be restricted to emergency services. There should be bidirectional communication between the dentist and the member's primary care provider.

Aetna Better Health participates in the NJ Smiles Program. The program allows non-dental providers to provide dental risk assessment, fluoride varnish and dental referral for children through age three Fluoride varnish to prevent caries can be applied up to four times a year by a PCP in addition to fluoride application performed by the primary care dentist (PCD). PCDs and PCPs should provide caries risk assessment at least once annually. Information about training for primary care providers in application of fluoride varnish can be found on our website at www.aetnabetterhealth.com/newjersey. EPSDT services and requirements are also described in Chapter 9.

Through the NJ Smiles Program, primary care providers who access the appropriate training can provide fluoride varnish to the teeth of children as a preventive measure against caries. Details are available on our website at:

https://www.aetnabetterhealth.com/newjersey/providers/notices

Fluoride varnish may be applied by non-dental providers who have proof of training for this service. Primary care providers (pediatricians or physicians seeing pediatric members), physician assistants, nurse practitioners and other trained medical office staff can receive this training. Fluoride varnish application should be combined with risk assessment and referral to a dentist that treats children under the age of three (3) during regular well child visits for children younger than or equal to 72 months. These three services are reimbursed as an all-inclusive ("bundled") service using a CPT code. The combined service including caries risk assessment and fluoride varnish application can be provided up to four (4) times a year. This frequency is separate from services by a dentist.

A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory under the benefit for EPSDT. The listing of general dentists and pedeodontists treating children under six is located at our website https://www.aetnabetterhealth.com. All primary care dentists and primary care providers should be aware of the fluoride levels in the community's public water and prescribe fluoride supplements as appropriate (based on the member's access to and use of fluoridated public water). Both dentists and primary care providers should be aware of their responsibility to counsel parents and guardians of young children on oral health and age appropriate oral habits and safety; topics of counseling should include an understanding of what constitutes a dental emergency and when use of the emergency room for dental services is strongly recommended.

The caries risk assessment service is also covered for the primary care dentist and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year

in conjunction with an oral evaluation service by a primary care dentist; this service is linked to the provider not the member (i.e., a member could have the service done more than once in a year if a different dentist starts care). Primary care providers should provide caries risk assessment at least once annually. It may be provided a second time by the same primary dentist with prior authorization and documentation of medical necessity.

Utilization Management for Dental Care

Dental services provided through the dental benefit are managed by Aetna Better Health's dental vendor, LIBERTY Dental Plan. Utilization management is among the services they provide. Criteria established for dental benefits are described in their Office Reference Manual and available on their website at: www.libertydentalplan.com.

Consideration for prior authorization of services considers the overall general health, patient compliance and dental history, condition of the oral cavity and a complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

Proposed treatment plans are reviewed through the prior authorization process to assure that all services are medically necessary and within the benefit, with the considerations above. If documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the documentation. All final decisions regarding denials of referrals, PA's, treatment and treatment plans for non-emergency services shall be made by a licensed New Jersey dentist/dental specialist.

Outcomes of dental treatment plans are affected by multiple factors, including member adherence to instructions, noncompliance with appointments and other factors causing delays in treatment. When dental services are authorized, the approval is in force for 183 calendar days, with the exception of orthodontics, where approved treatment duration may be longer. The dentist or dental specialist must resubmit a request for authorization when the authorization has expired. In special clinical situations, such as, but not limited to member's illness or hospitalization, an extension may be granted with provider request.

Second Dental Opinion

Any member may request and receive a second opinion from a different dentist or dental specialist within the network. With prior authorization and when medically necessary, requests may also be approved to obtain a second opinion outside the network.

Continuity of Care for Dental Services

Treatment plans established in another plan before a member joins Aetna Better Health of New Jersey are honored for up to 183 days or as long as the member is in active treatment, whichever is longer. The time frame begins on the first day of their active eligibility in Aetna Better Health.

The same time frame of 183 days or as long as the member is in active treatment, whichever is longer, also applies if the dentist treating the member started care as a participating provider but subsequently leaves the network, either voluntarily or involuntarily.

Dental Care for Members with Special Needs

Aetna Better Health of New Jersey has enhanced dental benefits for child and adult members with special needs, including intellectual/developmental disabilities, chronic medical conditions and behavioral health conditions. These members may need longer appointments, more frequents appointments or have other needs for modification of dental services. For members with special needs, preventive and other dental services are covered every three months or more often as needed to address their dental needs. There is no restriction in referral of these members to a dental specialist or provider who has special skills in treating individuals with special needs Additional diagnostic, preventative and periodontal services shall be available beyond the frequency limitations of every

six months and be allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

Some members with special needs may require a prescribed nonstandard, specialized toothbrush to improve the member's oral hygiene. In addition, oral hygiene instructions may be necessary for the caregivers responsible for the oral care of the member. Specialized toothbrushes and oral hygiene instruction are a covered benefit including designing and implementing a dental management plan, coordinated by the Care Manager overseeing a patient's oral care.

Members who exhibit severe situational anxiety in the dental office setting can be treated under sedation at a hospital. Providers who treat members with special health care needs are identified as such in the dental provider network through the LIBERTY Dental Plan provider directory.

Medically necessary dental services which are performed at a facility-based setting, such as dental care under general anesthesia, are covered under the medical benefit. Providers who perform these procedures at hospitals or surgi-centers must have admitting privileges at a participating NJ facility. They should submit requests for the dental service to LIBERTY Dental Plan for authorization. The information submitted should include a narrative describing the medical necessity that includes the following information:

- Report CDT procedure code D9999 to request prior authorization;
- Report the member's medical condition and related diagnosis codes on office letterhead;
- Report on office letterhead how the clinical presentation of the beneficiary prevents the beneficiary from receiving dental treatment in an office or clinic setting, including reason(s) why other levels of sedation are not an option; and,
- Report the planned or expected treatment (e.g. oral examination, cleaning, restorative dental treatment, extractions) to be provided during the hospital visit and a summary of the member's most recent dental history, including dental treatment provided in the last twelve (12) calendar months.

Providers shall be reimbursed for costs of pre-op and post-op costs related to OR services. Preauthorization is not required for the dentist for dental procedures performed for these members for dentally appropriate restorative, endodontic, periodontal or oral surgical care provided under general anesthesia. Upon receiving authorization from LIBERTY Dental Plan, the provider should contact Aetna Better Health of New Jersey's Prior Authorization Department at 1-855-232-3596 for the facility authorization. Informed consent, signed by the member or authorized person, must be obtained prior to the operating room visit. In the event that normally preauthorized procedures are completed in the operating room, x-rays should be submitted with the claim supporting the procedures completed.

A medical exception process allows the processing of a claim for dental treatment provided in an operating room and the outpatient hospital charges related to the dental visit. Approval of the dental visit requires that a diagnosis meet certain medical exception criteria including, but not limited to, one or more ICD-10-CM diagnosis codes for claims, shown below:

ICD-10-CM DIAGNOSIS CODES FOR MEDICAL EXCEPTION REQUIREMENT

The ICD-10-CM diagnosis codes listed below meet the medical exception requirement for an operating room visit by a dentist to provide dental services. The medical exception diagnosis codes must be reported on outpatient hospital claims. A valid ICD-10-CM diagnosis code is composed of 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided.

E75 – E756 Disorders of Sphingolipid Metabolism and Other Lipid Storage Disorders
F03 – F0391 Unspecified Dementia
F06 – F068 Other Mental Disorders Due to Known Physiological Condition
F07 – F079 Personality and Behavioral Disorders Due to Known Physiological Condition
F09 Unspecified Mental Disorder Due to Known Physiological Condition
F48 – F489 Nonpsychotic Mental Disorders
F53 Puerperal Psychosis
F60 – F609 Specific Personality Disorders

F70 Mild Intellectual Disabilities (IQ 50-55 to ~70))
F71 Moderate Intellectual Disabilities (IQ 35-40 to 50-55)
F72 Severe Intellectual Disabilities (IQ 20-25 to 35-40)
F73 Profound Intellectual Disabilities (IQ level below 20-25)
F78 Other Intellectual Disabilities
F79 Unspecified Intellectual Disabilities
F84 – F849 Pervasive Developmental Disorders
F88 Other Disorders of Psychological Development
F89 Unspecified Disorder of Psychological Development
F90 - F909 Attention-Deficit Hyperactivity Disorder
F91 - F919 Conduct Disorders
G10 Huntington's Disease
G25 – G259 Other Extrapyramidal and Movement Disorders
G31 – G319 Other Degenerative Diseases of Nervous System, Not Otherwise Classified
G40 – G409 Epilepsy and Recurrent Seizures
G71 – G719 Primary Disorders of Muscles
G72 – G729 Other and Unspecified Myopathies
G73 – G737 Disorders of Myoneural Junction and Muscle in Diseases Classified Elsewhere
G80 – G809 Cerebral Palsy
G93 – G939 Other Disorders of Brain
P04 – P049 Newborn (Suspected to be) Affected by Noxious Substances Transmitted via Placenta or Breast Milk (Does Not Include P042 (Maternal Use of Tobacco))
Q86 Congenital Malformation Syndromes Due to Known Exogenous Causes, Not Elsewhere Classified
Q90 – Q99 Down Syndrome
R56 – R569 Convulsions, Not Otherwise Classified
S06 – S069X9 Intracranial Injury
F819 Developmental Disorder of Scholastic Skills, Unspecified
I6783 Posterior Reversible Encephalopathy Syndrome (PRES)
P154 Birth Injury to Face (Facial Congestion Due to Birth Injury)
P158 Other Specified Birth Injuries
P159 Birth Injury, Unspecified

Additional information can be found in the Dental Provider Manual at www.libertydentalplan.com
or www.aetnabetterhealth.com/newjersey

Special Considerations for Orthodontia

Orthodontics are covered up to age 21 or until the time when NJFamilyCare eligibility is lost. This includes limited, interceptive and comprehensive orthodontic treatment. There are special criteria for medical necessity for all orthodontic treatment as indicated in the form *NJ Orthodontic Assessment Tool HLD (NJ Mod 3).* All orthodontic treatment requires prior authorization. Initial visits to evaluate (consultation and pre-orthodontic treatment visits) do not require authorization.

Limited and interceptive orthodontic treatment can be authorized for primary, mixed or permanent dentition. Comprehensive orthodontic treatment can be authorized for the permanent teeth. Response to a request for authorization will be provided within 10 days of receipt of all the required information.

In the event that a request for authorization is not approved, the response will contain a detailed explanation of the reason(s) for denial, explain whether additional information is needed and describe the process for reconsideration. The dental consultant who denied the treatment request will be identified to allow the provider an opportunity to discuss the case. An approved case must be started within six (6) months of receiving the approval.

An **orthodontic consultation (D9310)** is a visual examination and may also include a completed HLD (NJ-Mod3) assessment tool by the attending provider or a provider in the same group who will be providing the service, and which does not require prior authorization. The consultation can be provided once a year; the member can have a second opinion with a different provider

A **pre-orthodontic treatment visit (D8660) –** includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool.
The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ-Mod3) is completed by the dentist that will be rendering the orthodontic treatment.

The new HLD (NJ-Mod3) Assessment Tool
If the HLD (NJ-Mod3) Assessment Tool has an "X" and correctly documented clinical criteria found in sections1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool requires documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor Treatment to Control Harmful Habits
Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited, interceptive or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity.

For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records. Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Orthodontic Treatment Services
Limited, interceptive and comprehensive orthodontic services **must be prior authorized** and will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition for treatment of the permanent teeth.
Prior authorization determinations shall be made, and notice sent to the provider within ten (10) days of receipt of necessary information sufficient for a dental consultant to make an informed decision.

In cases where prior authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment
Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition.
For prior authorization, the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films;
- Diagnostic study models or diagnostic digital study cast images; and,
- The referring primary care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy **must** be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered with documentation of medical necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment
For prior authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction and dental diagnosis;
- The interceptive or comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring primary care dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models;
- Diagnostic photographs (which may suffice in place of models;
- Diagnostic x-rays, digital x-rays or cephalometric film with tracing (when applicable); and, when applicable:
    - Medical diagnosis and surgical treatment plan
    - Detailed documentation of extenuating circumstances
    - Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

Interceptive Orthodontics
Interceptive treatment can be considered for localized tooth movement and may be for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary or transitional dentition. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers to the provider of placement. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and documentation of medical necessity.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase, including the expected time frame and expected initiation (month/year) of comprehensive treatment.
Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

The NJFC Medicaid program reimburses for periodic treatment visits (D8670) which are billed for the date of service. A maximum of 24 units of D8670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is requested using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) **is billed separately** on the date of service. Services reimbursed through these codes will include all appliances, **their** insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the service; however, replacement of retainers or removable appliances due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires prior authorization and can be considered with documentation of the incident and medical necessity. Reimbursement for orthodontic services includes the placement **and removal** of all appliances and brackets; therefore should it become necessary to remove the bands following or due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the **appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service.** In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting Prior Authorization
Prior authorization for comprehensive orthodontic treatment will only be considered for the **late mixed and permanent dentitions**. Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning Treatment

- In addition to submission requirements already noted, the prior authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with a maximum number of units for treatment visits to be considered on any one prior authorization being twelve (12);
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- If the prior authorization expires before all approved units are used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.

Continuing treatment

- Prior authorization for the continuation of treatment visits for the continuation of the case shall be submitted after completing the first twelve (12) units of treatment visits or at the mid-point of treatment.
- The maximum number of additional treatment visits allowed to continue the case is twelve (12).
- If the prior authorization expires before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation
- that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.
- The following shall be included with the prior authorization to continue treatment:
- A copy of the treatment notes;
- Documentation of any problems with compliance;
- Attestation from the current primary care dentist that recall visits occurred and that all needed
- preventive and dental treatment services have been completed;
- Pre treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
- A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC Medicaid Program
For continuation of care for transfer cases whether they were or were not started by another NJFC Medicaid provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval (if applicable);
- Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes from provider that started the case (if available);
- Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment images;
- The date when active treatment was started;
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed; and,
- If applicable a new treatment plan and documentation to support the treatment change if re-banding is planned.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC Medicaid program.

Conclusion of Active Treatment

- Attestation of case completion must be submitted to document that active treatment had a favorable outcome and that the case is ready for retention.
- Procedure code D8680, orthodontic retention, shall be submitted for prior authorization along with recent panorex and photographs when the active phase of orthodontic treatment is completed.
- Once approved, the bands can be removed, and the case placed in retention.

Documentation for Completion of Comprehensive Cases – Final Records
The following **must** be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph;
- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes
It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen; and,
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that treatment is not progressing because the patient is exhibiting non-compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered. A letter must be sent to the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the discontinuation of treatment with de-banding.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. A copy of the signed form and the patient treatment records must be sent to the NJFC MCO of enrollment. **The reimbursement for appliance placement includes their removal**, however, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

Questions regarding the requirements for orthodontic treatment can be submitted to LIBERTY Dental Plan Provider Services at 1-855-225-1727.

Grievances and Appeals for Dental Services or Issues

Member complaints, grievances and appeals regarding dental care, dental services and dental providers should be submitted to the Aetna Better Health Grievance and Appeals process (see Chapter 20: Grievance System), orally or in writing, similarly to all other types of complaints, grievances and appeals.

Aetna Better Health of New Jersey reviews every complaint and grievance to assure that each is handled within the required timeframes and is handled as is appropriate to our members. If a member is not satisfied with the outcome of a first level appeal, all other levels of appeal are managed the same way as for other types of services.

Member complaints, grievances and appeals can be submitted to Aetna Better Health of New Jersey at:

Aetna Better Health of New Jersey
PO Box 81139
5801 Postal Road
Cleveland, OH 4418

Fax: 1-844-321-9566

Provider claim appeals and other non-utilization management appeals should be submitted to LIBERTY Dental Plan:

LIBERTY Dental Plan
Grievance and Appeals Department
P.O. Box 26110
Santa Ana, CA 92799-6110
Phone: 888-703-6999

Providers may contact the Dental Director for any concerns.

Joseph Maggio, DMD Dental Director Medicaid Health Plan

Aetna Better Health of New Jersey
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

609-282-8192 Telephone
609-282-8245 Fax

Dental Forms

The following forms referenced in this Chapter are available on our Website at www.aetnabetterhealth.com/newjersey and are also attached below:

American Academy of Pediatrics Oral Health Risk Assessment Tool For PCPs, American Dental Association Caries Risk Assessment Form (Age 0<6) For Dentists, American Dental Association Caries Risk Assessment Form (Age 0>6) For Dentists, NJ Orthodontic Assessment Tool HLD (NJ-Mod2), and Updated Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod3) Index Form:

NJ-ORTHOEVAL_HLD_NJ-Mod3.pdf

Updated Instructions for Com

ADA Caries Risk Over Six.pdf

ADA Caries Risk Under Six.pdf

Oral Health Risk Assessment Tool.pdf

CHAPTER 12: MEDICAL MANAGEMENT

Back to Table of Contents

Tools to Identify and Track At-Risk Members

Aetna Better Health of New Jersey uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and/or who may benefit from Care Management. These tools have two main components. The first is our predictive modeling tool known as the CORE model, or Consolidated Outreach and Risk Evaluation, which uses predictive modeling based on claims data, pharmacy data, and diagnoses along with predictive modeling that indicates each member's risk of ED utilization and inpatient admission over the next twelve (12) months. We supplement this information with data collected from Health Risk Assessments. We track member information in a web-based care management tracking application.

These tools, described below, enable us to work closely with providers, members and their families or caregivers to help improve clinical outcomes and enhance the quality of members' lives.

Predictive Modeling

Aetna Better Health of New Jersey's predictive modeling software identifies and stratifies members who should be targeted for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each member. The application funnels information from these various sources into a member profile that allows our Case Managers to access a concise twelve (12) month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks members and prepares a monthly "target" report of the members most likely to benefit from care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- Call tracking from Aetna Better Health of New Jersey's Member Services Department

Initial Health Screen (IHS)

Aetna Better Health of New Jersey also assesses members through the Initial Health Screen (IHS) tool. The IHS is administered during a telephone call made to each member to welcome them to the health plan. The IHS gathers:

- Member contact information
- Primary Care Provider (PCP) or medical home information
- Member's health history and self-rated assessment of health
- Frequency of ER use
- Medication usage

Care Management Business Application Systems

Our care management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires and care plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the information in future cases. The system interfaces with our predictive modeling software and the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

Medical Necessity

Medical necessity applies to a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider and in accordance with Aetna Better Health of New Jersey's guidelines for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, investigational, or cosmetic (and not reconstructive) are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers. Only a physician can make a determination that a service is not medically necessary.

CHAPTER 13: CONCURRENT REVIEW

Back to Table of Contents

Concurrent Review Overview

Aetna Better Health of New Jersey conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities for subacute care and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG Guidelines®. Admission certification is conducted within one business day of receiving timely notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses and behavioral health clinicians conduct these reviews. The professional staff work with the medical directors in reviewing medical record documentation for hospitalized members. Our medical directors conduct rounds as necessary.

MCG Guidelines

Aetna Better Health of New Jersey uses the MCG Guidelines® to ensure consistency in hospital–based utilization practices for both physical health and behavioral health (see exception below). The guidelines span the continuum of member care and describe best practices for treating common conditions. The MCG Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Behavioral Health Guidelines

In accordance with DMAHS requirements, the American Society of Addiction Medicine (ASAM) guidelines are applied to requests for substance use disorder services covered by Aetna Better Health of New Jersey, for both inpatient and outpatient services.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse or Behavioral Health clinician works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, Durable Medical Equipment (DME)/medical supply companies or other outpatient providers)
- Informing hospital staff and attending physician of covered benefits as indicated

Discharge from a Skilled Nursing Facility or Nursing Home

All discharges from a Skilled Nursing Facility (SNF) must be coordinated with the member's Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the member, his or her representative, and the member's Case Manager must be involved in discharge planning.

CHAPTER 14: PRIOR AUTHORIZATION

Back to Table of Contents

Primary care providers (PCP) or treating providers (including MLTSS providers) are responsible for initiating and coordinating all member's request for authorization including BH services. However, specialists, PCPs and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of New Jersey's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of New Jersey will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of New Jersey about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency Services

Emergency medical services are permitted to be delivered in or out of network without obtaining prior authorization for all members including DDD and MLTSS, f the member was seen for the treatment of an emergency medical condition, which includes BH services based on the prudent layperson standard Aetna Better Health of New Jersey will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from providers in or out of network, subject to state requirements. However, notification is encouraged for appropriate coordination of care and discharge planning.

Post-stabilization Services

Aetna Better Health of New Jersey will cover post-stabilization services without a requirement for authorization under the following circumstances, whether or not the services are provided by an Aetna Better Health of New Jersey network provider:

- The post-stabilization services were prior approved by Aetna Better Health of New Jersey OR
- The provider requested prior approval for the post-stabilization services, but Aetna Better Health of New Jersey did not respond within one hour of the request OR
- The provider could not reach Aetna Better Health of New Jersey to request prior approval for the services

Services Requiring Prior Authorization

Our Secure Web Portal located on our website lists the services that require prior authorization, consistent with Aetna Better Health of New Jersey's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate.

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized.

Exceptions to Requirements for Prior Authorizations

- Prior authorization for emergency services or post-stabilization services whether provided by an in-network or out-of- network provider
- Access to family planning services
- Well-woman services by an in-network provider

Provider Requirements

Generally, a member's PCP or treating provider is responsible for initiating and coordinating a request for authorization. However, specialists and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization. The requesting provider is responsible for complying with Aetna Better Health of New Jersey's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current, applicable codes that may include:
    - Current Procedural Terminology (CPT),
    - International Classification of Diseases, 10th Edition (ICD-10),
    - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
    - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

How to Request Prior Authorizations

Prior authorizations for services covered under the core Medicaid/FamilyCare benefit are managed by the Utilization Management Department. Authorizations for Personal Care Assistance Services, Adult Medical Day services and MLTSS services are managed by the Utilization Management Department in collaboration with the MLTSS care management team. Providers should submit requests by the same process for all requests, as described below.

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of New Jersey's website at www.aetnabetterhealth.com/newjersey, or
- Fax the request form to 1-844-797-7601 (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing; or
- Through our toll-free number

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal at www.aetnabetterhealth.com/newjersey, or call us at 1-855-232-3596. The portal will allow you to check status, view history, and/or email a Case Manager for further clarification if needed.

For further information about the Secure Web Portal, please review Chapter 4 of this manual. If response for a non-emergency prior authorization is not received within 15 days, please contact us at 1-855-232-3596.

Medical Necessity Criteria

To support prior authorization decisions, Aetna Better Health of New Jersey uses nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members, characteristics of the local delivery system and requirements of the Medicaid program. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria are established and reviewed according to Aetna Better Health of New Jersey policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of New Jersey uses the medical review criteria listed below. Criteria sets are reviewed annually for appropriateness to Aetna Better Health of New Jersey's population needs and are updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting or reviewing criteria. The criteria are consistently applied, consider the needs of the members and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Applicable Milliman Care Guidelines (MCG) as the primary decision support for most medical diagnoses and conditions
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Policy Council Review

If MCG states "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna CPBs, are consulted and utilized.

For prior authorization of outpatient and inpatient behavioral health services, Aetna Better Health of New Jersey uses:

- Criteria required by applicable State or federal regulatory agency
- Applicable MCG Behavioral Health Guidelines
- LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM)
- Aetna Clinical Policy Bulletins (CPB's)
- Aetna Clinical Policy Council Review

Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Timeliness of Decisions and Notifications to Providers, and/or Members

Aetna Better Health of New Jersey makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the New Jersey Division of Medical Assistance and Health Services (DMAHS) or state law (e.g. HCAPPA), Aetna Better Health of New Jersey adheres to the following decision/notification time standards. Notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 14 calendar days following receipt of the request for service, in accordance with 42 C.F.R. 438.210.d.1. Aetna Better Health of New Jersey ensures the availability of appropriate staff between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the established time frames. Departments that handle prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within twenty-four (24) hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner/ Provider	Telephone and in writing
Urgent pre-service **denial**	Within twenty-four (24) hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner/ Provider and Member	Telephone and in writing
Non-urgent pre-service approval	Within fourteen (14) calendar days (or sooner as required by the needs of the member) of receiptof necessary information sufficient to make an informed decision	Practitioner/ Provider	Telephone or in writing
Non-urgent pre-service **denial**	Within fourteen (14) calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner/ Provider and Member	Telephone and in writing within 2 business days of decision

Decision	Decision/notification timeframe	Notification to	Notification method
Continued / extended services approval (non-ED/acute inpatient)	Within 1 business day of receipt of necessary information	Practitioner/ Provider and Member	Telephone and in writing
Continued / extended service **denial** (non-ED/acute inpatient)	Within 1 business day of receipt of necessary information	Practitioner/ Provider and Member	Telephone and in writing
Post-service approval of a service for which no pre-service request was received.	Within 30 calendar days from receipt of the necessary information	Practitioner/ Provider	Telephone or in writing
Post-service **denial** of a service for which no pre-service request was received.	Within 30 calendar days from receipt of the necessary information	Practitioner/ Provider and Member	In writing

Prior Authorization Period of Validation

Prior authorization numbers are valid for the date of service authorized. If a date is not specified, service must be initiated within sixty (60) days after the service was authorized. For services that require multiple visits, a series of tests, etc. to complete the services, the authorized time period is adequate to cover the anticipated span of time that best fits the service needs and circumstances of each individual member. The member must be enrolled and eligible on each date of service.

For information about how to verify member eligibility, please review Chapter 8 in this Manual.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health of New Jersey will assign a prior authorization number, which refers to and documents the determination. Aetna Better Health of New Jersey sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of New Jersey makes such decisions on a case-by-case basis in consultation with Aetna Better Health of New Jersey's medical director.

Notice of Action Requirements

Aetna Better Health of New Jersey provides the provider and the member with written notification (i.e., Notice of Action (NOA)) of any decision to deny, reduce, suspend, or terminate a prior authorization request, to impose limits, to authorize a service in the amount, duration or scope that is less than requested or to deny payment, in whole or part, for a service.

The notice will include:

- The action that Aetna Better Health of New Jersey has or intends to take
- The specific service denied, including the tooth, quadrant, or site if a dental denial
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based
- Notification that provider has the opportunity to discuss medical, dental or behavioral healthcare UM denial decision with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal

- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member's or provider's (with written permission of the member) right to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing if eligible through member's benefit
- A description of the expedited appeals process for urgent preservice or urgent concurrent denials
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing (if eligible), how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the member's rights

Continuation of Benefits

Aetna Better Health of New Jersey will continue member's benefits during the appeal process if all of the following occur:

- The member or the provider files the internal appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e. a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal and
- The member requested continuation of benefits within ten (10) days of the date of the denial letter, for those eligible who requested the Medicaid Fair Hearing Process, or the intended effective date of the HMO proposed action

Aetna Better Health of New Jersey will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A Medicaid Fair Hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health of New Jersey, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Self-Referrals

Aetna Better Health of New Jersey does not require referral forms from Primary Care Providers (PCP) or treating providers. Member may self-refer or access some services without an authorization from their PCP. These services include behavioral health care, vision care, Medicaid approved Alcohol and Drug Addiction facilities, dental care, family planning and women's health care services. The member must obtain these self-referred services from Aetna Better Health of New Jersey's provider network, except in the case of family planning.

Members may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Member have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health of New Jersey's network, and can obtain maternity and gynecological care without prior approval from a PCP.

CHAPTER 15: CARE MANAGEMENT

Back to Table of Contents

Overview

Aetna Better Health's Care Management (QM) Program is designed to identify the most bio-psycho-socially complex and vulnerable members among whom there is an opportunity to make a significant difference. The Care Management team staff engage these members in care management programs to remove or lessen barriers that limit their ability to manage their own health and well- being, to educate them about their chronic conditions and to help them remain in the least restrictive and most integrated environment, based on their preferences, needs, safety, burden of illness and availability of family or other supports. This is done in a manner that is consistent with each individual's personal and cultural values, beliefs and preferences and with the goal of helping individuals to develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

On an annual basis Aetna Better Health completes an assessment related to the needs and characteristics of the member population that includes their ages, gender, top diagnoses and re-admission rates, specific focus on the needs of children and adolescents, the elderly, individuals with disabilities, members meeting nursing home level of care and members identified with serious and persistent mental illness.

Aetna Medicaid's approach to care management is member-focused rather than disease-focused and incorporates members' values, needs and priorities using a culturally sensitive approach. The aim is to capitalize on each member's strengths and supports, using motivational interviewing techniques to enhance communication and member engagement. Integrated Care Management manages the continuum of member care needs by providing anywhere from acute and solution-focused interventions to complex care management, long term services and supports and end-of-life assistance, always aiming to keep members in the most integrated and least restrictive care environment possible.

Based on the member's needs, case managers use condition-specific assessments and care plan interventions to assist them with chronic condition management, thereby including traditional "disease management" within the ICM process rather than it being managed separately. Members with diabetes, COPD, heart failure, asthma, depression, hypertension and coronary artery disease are identified by our predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, concurrent review/prior authorization referral, as well as through member and provider referral.

Members are identified for entry into Care Management in a variety of ways. Any provider caring for a member can make a referral into Care Management if they believe it may of value to a member. This includes referrals of members who exhibit disruptive, inappropriate or other undesired behaviors. Examples of scenarios in which referral to Care Management is appropriate include the following (this is not a complete list):

- Members with chronic illnesses, such as diabetes, heart failure, hypertension, dementia, who may need help with compliance, medications, access to services, etc.
- Members with pregnancy, regardless of whether it is low risk or high risk
- Members meeting nursing home level of care
- Infants, children and youth with chronic, recurrent or disabling conditions such as type 1 diabetes, persistent asthma, cerebral palsy, intellectual disabilities, cancer or other conditions
- Individuals with intellectual disabilities and autism spectrum disorders
- Individuals in foster care
- Members with behavior or compliance issues
- Members with HIV/AIDS
- Members needing assistance with access to dental services
- Members with disabilities of any type, including members designated as having Special Needs

Within Care Management, there are a number of focused Programs for a variety of populations and types of members. For each of these we review data describing their characteristics and utilization of services in order to target interventions, which include educational materials, telephone contact and, for some, face-to-face visits. Some of these programs are described below.

Emergency Room Redirection

This program has two components. The medical Emergency Room Redirection Program identifies members who have had an excessive number of visits to emergency services and provides them with education regarding appropriate use of primary care services, availability of urgent care services for uncomplicated illness when the PCP is not available and what constitutes an emergency. In addition, the program enrolls members with multiple emergency room visits for non-emergency conditions in Care Management.

Similarly, the Dental Emergency Room Redirection Program identifies members who have visited an Emergency Room for a non-traumatic dental problem and provides them with education regarding the appropriate use of a primary care dentist. As in the medical program, the dental program seeks to identify social and other components for that member influencing their emergency service utilization and direct the member to assistance.

Face-to-Face Program

Care Managers visit members at the most intensive level of care management (also some members in less intensive levels of care management) face-to-face at their PCP offices, other health care sites or in their homes. Among the members who can benefit from this service are members who are medically and socially complex and members that have high ER and inpatient utilization. The program focuses on enhancing rapport between the member and the care manager, which improves the ability for behavior change in the member. By meeting members in the healthcare setting, the process also improves the relationship between our care managers and providers, making a partnership more effective for the benefit of members with complex issues. Among the benefits of this approach are the following:

- The plan of care is shared among the practitioner, the member and the care manager at the same time and in person
- Medication reconciliation is done at the point of care
- Visit in a medical setting frames the event as a component of the care plan, which may enhance the member commitment to follow-through
- Parameters for Emergency Room use can be mutually set
- Potential referral to other services can be discussed within the care plan

Pharmacy Lock-In Program

For members with a demonstrated pattern of going to multiple doctors and/or multiple pharmacies for controlled substances and other medications, Aetna Better Health has a Pharmacy Lock-In Program, as required by the state of New Jersey. Referral of a member for the program is prompted by a pattern of inappropriate usage over a period of time. Members are “locked-in” to get their medication at a single pharmacy and/or through prescriptions from a single provider who will accept this responsibility. Lock in is for a period of up to 1 year. Members who change their behavior can request removal from the program through the Appeals Process.
All members in this program are referred to a Care Manager to provide support and guidance through the process.

Lead Case Management

All children who are discovered to have a blood level above the state determined threshold (5 µg/dl) are followed by a Care Manager who coordinates with state and community efforts to assure that the member is in appropriate treatment and assure that any lead in the environment is avoided or abated as required. For members that require medical treatment for elevated lead level, such as chelation, the Care Manager works with the PCP, family, specialty providers (if involved) and the state coordination team.

Special Programs for the Elderly and Disabled, including members in MLTSS

Aetna Better Health has a special series of focused efforts to assure that our members who are elderly and/or have disabilities receive recommended anticipatory healthcare and monitoring and that certain indicators of quality of life are being addressed. Care Management can also assist members who have difficulties in accessing services due to being homebound, such as provider visits or access to appropriate vaccines.

For each of these categories of conditions among these populations we review data to assure that the recommended services are being provided or that the members are compliant with medication or that members' needs are being addressed to assure their maximal personal autonomy and functioning. Care Management assists in this process by reaching out to contact members (or providers, as applicable) to assure that the recommended courses of care are addressed or to assist in referrals where needed. For members in the MLTSS Program, Care Managers contact members at a high frequency. Specific reporting and monitoring applies to (but is not limited to) the following:

- Screening and management of depression
- Screening for and management of cognitive impairment
- Surveillance for abuse and neglect (both risk for abuse and suspected events of abuse, neglect or exploitation)
- Surveillance for risk of institutionalization
- Surveillance and prevention/treatment strategies for aspiration pneumonia, injuries, decubiti and seizures
- Access to immunizations for influenza and pneumococcal disease
- Cancer screenings for breast, colon and prostate cancer
- Medical care and medication use for congestive heart failure
- Medical care and medication use for chronic obstructive lung disease
- Appropriate management of diabetes
- Medication management and compliance for hypertension
- Screening and management of depression
- Screening for and management of cognitive impairment
- Surveillance for abuse and neglect (both risk for abuse and suspected events of abuse, neglect or exploitation)
- Surveillance for risk of institutionalization
- Surveillance and prevention/treatment strategies for aspiration pneumonia, injuries, decubiti and seizures

CHAPTER 16: QUALITY MANAGEMENT

Back to Table of Contents

Overview

Our Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness and effectiveness of care. Aetna Better Health of New Jersey uses this approach to measure conformity with desired medical standards and to develop activities designed to improve patient outcomes.

Aetna Better Health of New Jersey performs QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of members or maintain current health status when the member's condition is not amenable to improvement.

Aetna Better Health of New Jersey's QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of data in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of Aetna Better Health of New Jersey's quality improvement process.

Aetna Better Health of New Jersey's QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization and committees from the Board of Directors to the Member Advisory Committee. This structure allows members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. The Medical Director is supported in this effort by our QM Department and the Quality Management Oversight Committee (QMOC) and subcommittees.

The QMOC's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI program and make recommendations to the Board of Directors about Aetna Better Health of New Jersey's quality management and performance improvement activities and to work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers. Major functions of the QMOC Committee include:

- Confirm that quality activities are designed to improve the quality of care and services provided to members
- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys
- Advise and make recommendations to improve the health plan
- Review and evaluate company-wide performance monitoring activities, including care management, customer service, credentialing, claims, grievance and appeals, prevention and wellness, provider services and quality and utilization management

Additional committees such as Provider Advisory, Peer Review, Credentialing, Quality Assurance and Utilization Management further support our QAPI Program. Aetna Better Health of New Jersey encourages provider participation on key medical committees. We particularly seek providers who serve members with special healthcare needs or members who meet nursing home level of care to assure that these populations have their needs represented. Through committee participation providers have the opportunity to provide input to our Quality programs as well as our processes and policies.

For more information about joining a committee or to receive a copy of our Quality Assessment Performance Improvement Program, please call our Quality Management Department. In addition, interested providers may contact the Medical Director with any questions or inform their Provider Relations Representative if they wish to participate. Aetna Better Health of New Jersey can be reached by calling 1-855-232-3596. Please ask for the relevant department.

Aetna Better Health of New Jersey's QM staff develops and implements an annual work plan, which specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

Aetna Better Health of New Jersey's QM Department is an integral part of the health plan. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards, and to recommend and promote improvements in the delivery of care and service to our members. Our QM and Medical Management Departments maintain ongoing coordination and collaboration regarding quality initiatives, care management and disease management activities involving the care of our members.

Aetna Better Health of New Jersey's QM activities include, but are not limited to, medical record reviews, reviews of lead screening results, site reviews, peer reviews, satisfaction surveys, performance improvement projects and provider profiling. Utilizing these tools, Aetna Better Health of New Jersey, in collaboration with providers, is able to monitor and reassess the quality of services provided to our members. Providers are obligated to support and meet Aetna Better Health of New Jersey's QAPI and Utilization Management program standards.

Note: Providers must also participate in the CMS and DMAHS quality improvement initiatives. Any information provided must be reliable and complete.

Identifying Opportunities for Improvement

Aetna Better Health of New Jersey identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis and review of a broad range of external and internal data sources. The types of data Aetna Better Health of New Jersey monitors to identify opportunities for quality improvements include:

- Formal Feedback from External Stakeholder Groups: Aetna Better Health of New Jersey takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems (CAHPS)), or focus groups with individuals, such as members and families, providers and state and community agencies.
- Findings from External Program Monitoring and Formal Reviews*:* Externally initiated review activities, such as annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health of New Jersey in identifying specific program activities/processes needing improvement.
- Internal Review of Individual Member or Provider Issues: In addition to receiving grievances and appeals from members, providers and other external sources, Aetna Better Health of New Jersey proactively identifies potential quality of service issues for review through daily operations (e.g. member services, prior authorization, and care management). Through established formalized review processes (e.g., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services and quality of care), Aetna Better Health of New Jersey is able to identify specific opportunities for improving care delivered to individual members.
- Findings from Internal Program Assessments: Aetna Better Health of New Jersey conducts a number of formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes but is not limited to record reviews of contracted providers, credentialing/re-credentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment and assessment of provider accessibility and availability.
- Clinical and Non-Clinical Performance Measure Results: Aetna Better Health of New Jersey uses an array of clinical and non-clinical performance standards (e.g., call center response times and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, Aetna Better Health of New Jersey is able to identify opportunities for improvement in clinical and operational functions. These measures include:
    - Adherence to nationally recognized best practice guidelines and protocols
    - Prior authorization (e.g., timeliness of decisions, notices of action and service/care plan appeals)
    - Provider availability and accessibility, including:
        - Length of time to respond to requests for referrals
        - Timeliness of receipt of covered services
        - Timeliness of the implementation of members' care plans
        - Availability of 24/7 telephonic assistance to members and caregivers receiving home care services
- Data Trending and Pattern Analysis: With our innovative information management systems and data mining tools, Aetna Better Health of New Jersey makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- Other Service Performance Monitoring Strategies: Aetna Better Health of New Jersey uses a myriad of monitoring processes to confirm effective delivery of services to all of our members, such as provider and member profiles, service utilization reports and internal performance measures. Aspects of care that Aetna Better Health of New Jersey monitors include, but are not limited to:
    - High-cost, high-volume and problem prone aspects of the long-term care services our members receive
    - Effectiveness of the assessment and service planning process, including its effectiveness in assessing a member's informal supports and treatment goals, planned interventions and the adequacy and appropriateness of service utilization
    - Delivery of services enhancing member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) Concerns

Aetna Better Health of New Jersey has a process for identifying Potential Quality of Care (PQoC) concerns related to our provider network including Home and Community-Based Services (HCBS), researching and resolving these care concerns in an expeditious manner and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health of New Jersey tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified issues and closure levels. Aetna Better Health of New Jersey will use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Medicaid Credentialing and Performance Committee or identify the need for possible quality improvement initiatives.

Performance Improvement and Quality Improvement Projects (PIPs/QIPs)

Performance improvement and quality improvement projects (PIPs/QIPs), a key component of our QM Program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs/QIPs follow CMS protocols. Aetna Better Health of New Jersey participates in state-mandated PIPs/QIPs and selects PIP/QIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of members' care and services over time
- Address clinical or non-clinical topics as selected by DMAHS
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health of New Jersey enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM department prepares PIP/QIP proposals that are reviewed and approved by our Medical Director prior to submission to DMAHS for review and approval. Ongoing review by the Provider Advisory Committee and the QMOC occurs to improve PIPs/QIPs during their life cycle. PIP/QIP projects may require collaboration with providers to assure their success. Feedback from providers is invaluable in refining the projects as they are implemented.

The QM department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP/QIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, Aetna Better Health of New Jersey immediately conduct additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Peer Review

Peer review activities are evaluated by Peer Review Subcommittee of the Quality Management Oversight Committee. This subcommittee may make recommendations for action if a quality issue is identified. Such actions may include, but are not limited to, development of a Corrective Action Plan (CAP) with time frames for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, or referral to the Aetna Credentialing and Performance Committee, to consider limitations or discontinuation of the provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, and/or health provider credentials, as well as other quality issues.

Although peer review activities are coordinated by the Quality Management Department, they may require the participation of Utilization and Care Management, Provider Relations or other departments. Aetna Better Health of New Jersey may request external consultants with special expertise (e.g., in oral surgery, cardiology or oncology) to participate in peer review activities, if applicable.

The health plan's peer review process adheres to Aetna Better Health of New Jersey policies, is conducted under applicable State and federal laws and is protected by the immunity and confidentiality provisions of those laws.

The right of appeal is available to providers whose participation in the Aetna Better Health of New Jersey network has been limited or terminated for a reason based on the quality of the care or services provided. Appealable actions may include the restriction, reduction, suspension or termination of a contract under specific circumstances.

Performance Measures

Aetna Better Health of New Jersey collects and reports clinical and administrative performance measure data to DMAHS. The data enables Aetna Better Health of New Jersey and DMAHS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in member outcomes.

Satisfaction Survey

Aetna Better Health of New Jersey conducts member and provider satisfaction surveys to gain feedback regarding members and providers' experiences with quality of care, access to care, and service/operations. Aetna Better Health of New Jersey uses member and provider satisfaction survey results to help identify and implement opportunities for improvement. Each survey is described below.

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Children) are subsets of Healthcare Effectiveness Data and Information Set (HEDIS) reporting. Aetna Better Health of New Jersey contracts with a National Committee for Quality Assurance (NCQA)-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

Provider Satisfaction Surveys

Aetna Better Health of New Jersey conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and Aetna Better Health of New Jersey's response to inquiries.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. 1396u–2] for States to contract with an independent external review body to perform an annual review of the quality of services furnished under State contracts with managed care organizations, including the evaluation of quality outcomes, timeliness and access to services. External Quality Review (EQR) refers to the analysis and evaluation of aggregated information on timeliness, access and quality of health care services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health of New Jersey cooperates fully with external clinical record reviews assessing our network's quality of services, access to services and timeliness of services, as well as any other studies determined necessary by DMAHS. Aetna Better Health of New Jersey assists in the identification and collection of any data or records to be reviewed by the independent evaluation team. Aetna Better Health of New Jersey also provides complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health of New Jersey's contracted providers are required to provide any records that the EQRO may need for its review.

The results of the EQR are available to providers and incorporated into our overall QM and medical management programs as part of our continuous quality improvement process.

Provider Profiles

In an effort to promote the provision of quality care, Aetna Better Health of New Jersey profiles providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for management number of conditions. Provider profiling permits monitoring of whether PCP's are adhering to recommended guidelines for primary and preventive care, whether their members appear to overuse emergency services (which may reflect access issues) and whether there is overuse or underuse of services.

The Provider Profiling Program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Aetna Better Health of New Jersey's profiling program is intended to support clinical decision-making and patient engagement as providers often have little access to information about how they are managing their members or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider- patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

Aetna Better Health of New Jersey includes several measures in provider profiles, which may include but are not limited to:

- Percentage of members accessing primary care visits with their PCP
- Percentage of members using EPSDT services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications
- ER utilization and inpatient service utilization
- Referrals to specialists and out-of-network providers

Aetna Better Health of New Jersey makes profile reports available to providers so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information indicating performance for individual cases or specific disease conditions for their patient population
- A snapshot of their overall practice performance relative to evidence-based quality metrics

Gaps in Care Reports are available on the Provider Portal and can be used to identify members that should receive outreach by the office to bring them in for care.

Aetna Better Health of New Jersey's medical directors and/or quality staff may visit individual network providers to interpret profile results, review quality data and discuss any new medical guidelines. Our medical directors investigate potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health of New Jersey's medical leadership is committed to collaborating with providers to find ways to improve patient care.

Clinical Practice Guidelines

The evidenced-based clinical practice guidelines used by Aetna Better Health of New Jersey to inform our QM and UM programs represent best practices and are based on national (or international) standards, reasonable medical evidence and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the health plan chief medical officer, applicable medical committees and, if necessary, external consultants. Clinical practice guidelines are reviewed at least every two years, or as often as new information is available. Providers may request a copy of a guideline at any time by contacting their provider relations representative or the Aetna Better Health of New Jersey office of the chief medical officer.

Publicly available clinical practice guidelines from national groups such as the CDC, CMS and other entities are made available to providers on the Aetna Better Health of New Jersey website; providers should consult the website periodically for new guidelines and updates. Guidelines are selected to address a wide variety of commonly addressed clinical issues, including immunizations, management of common conditions and evidence-based recommendations.

CHAPTER 17: PHARMACY MANAGEMENT

Back to Table of Contents

Pharmacy Management Overview

Aetna Better Health of New Jersey covers prescription medications and certain over-the-counter medicines when you write a prescription for members enrolled in the New Jersey FamilyCare program. Pharmacy is administered through CVS Caremark. CVS Caremark is responsible for pharmacy network contracting, mail order delivery and network Point-of-Sale (POS) claim processing. Aetna Better Health of New Jersey is responsible for formulary development, drug utilization review, and prior authorization.

Prescriptions, Drug Formulary and Specialty Injectables

Check the current Aetna Better Health of New Jersey formulary before writing a prescription for either prescription or over-the-counter drugs. If the drug is not listed, a Pharmacy Prior Authorization Request form must be completed before the drug will be considered. Please also include any supporting medical records that will assist with the review of the prior authorization request. Pharmacy Prior Authorization forms are available on our website and requests may be made telephonically or via fax. Please use the most current forms posted. Aetna Better Health also provides access to electronic prior authorization through the website. Providers should go to the searchable formulary at the following link and select Electronic PA:

https://client.formularynavigator.com/Search.aspx?siteCode=8965797547

Aetna Better Health of New Jersey members must have their prescriptions filled at a network pharmacy to have their prescriptions covered at no cost to them.

Prior Authorization Process

Aetna Better Health of New Jersey's pharmacy Prior Authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health of New Jersey's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when an "A" rated generic equivalent is available

Pharmacy authorization guidelines and PA forms are available on our website at:
https://www.aetnabetterhealth.com/newjersey/providers/pharmacy

Providers should submit the following information when requesting a PA:

- The appropriate prior authorization form; if there is not a specific form for the drug the more general form for non-formulary, brand name request or other exception should be used; all relevant questions should be answered
- Specific medical documentation to address required information, such as documentation of diagnosis, prior medications tried and failed, and any other information required
- Medical records supporting the request if relevant
- Special circumstances relevant to the request
- Specific reasons for requesting a brand name exception when a generic equivalent is available

Aetna Better Health of New Jersey's Medical Director is in charge of generating adverse decisions, including a complete denial or approval of a different length of approval. Using specific, evidence-based PA pharmacy review guidelines Aetna Better Health of New Jersey's Medical Director may require additional information prior to making a determination as to the medical necessity of the drug requested. This information may include, but is not limited to, evidence indicating:

- Formulary alternatives have been tried and failed or cannot be tolerated (i.e., step therapy)
- There are no therapeutic alternatives listed in the formulary
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the Federal Drug Administration (FDA) or as accepted by established drug compendia)
- For brand name drug requests, a completed FDA MedWatch form documenting failure or intolerance to the generic equivalents

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board certified physician from an appropriate specialty area such as a psychiatrist.

Step Therapy and Quantity Limits

The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs. Drugs having step therapy are identified on the formulary with "STEP".

Certain drugs on the Aetna Better Health of New Jersey formulary have quantity limits and are identified on the formulary with "QLL" The QLLs are established based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat.

To request an override for the step therapy and/or quantity limit, please fax a Pharmacy Prior Authorization Request form and any supporting medical records that will assist with the review of the request to 1-855-232-3596.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Providers can call 1-855-232-3596 to request prior authorization or complete the applicable prior authorization form and fax to 1-855-296-0323.

Specialty medications can be delivered to the provider's office, member's home, or other location as requested.

Mail Order Prescriptions

Aetna Better Health of New Jersey offers mail order prescription services through CVS Caremark. Members can access this service in one of three ways.

- By calling CVS Caremark, toll free at 1-855-271-6603/ TTY 1-800-863-5488. Monday to Friday between 8 a.m. and 8 p.m., Eastern Time. They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By going to https://www.caremark.com/wps/portal/!ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP1An_z0zDz9gnRHRQDSauup/ The member can log in and sign up for Mail Service online. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the member calls CVS Caremark and asks CVS Caremark to mail them a Mail Service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:

  CVS CAREMARK
  PO BOX 94467
  PALATINE, IL 60094-4467

New Jersey Prescription Drug Monitoring Program

The NJ Prescription Drug Monitoring Program (NJPMP) is an important component of the New Jersey Division of Consumer Affairs' initiative to halt the abuse and diversion of prescription drugs. The NJPMP is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The NJPMP does not collect data on any other drugs.

Pharmacies must submit data to the NJPMP at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in New Jersey and by out-of-state pharmacies dispensing CDS or HGH into New Jersey. Patient information in the NJPMP is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations confirm patients' drug histories and document compliance with therapeutic regimens.

New registration access to the NJPMP database at www.NJRxReport.com is granted to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the NJPMP must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the NJPMP to any other individuals, including members of their staff. Providers should check the NJ PMP before prescribing opioid medications.

CHAPTER 18: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

Back to Table of Contents

Providers are required to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST) and, the New Jersey Advance Directive Health Care Act (NJSA 26:2H-53), including all other State and federal laws regarding advance directives for adult members.

Advance Directives

Aetna Better Health of New Jersey defines advance directives as a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under State law to make decisions regarding medical care and any provider's written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educating patients on Advance Directives (durable power of attorney and living wills).

For additional information about medical record requirements, please visit Chapter 4 of this Manual.

For advance directive forms and frequently asked questions, please visit http://nj.gov/health/advancedirective/forms_faqs.shtml.

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health of New Jersey as a grievance or complaint, or with the State of New Jersey Department of Health at 1-800-792-0367.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept, or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of New Jersey requires our providers to comply with this act.

For additional information about the PSDA, please visit https://www.gapna.org/patient-self-determination-act-psda

Physician Orders for Life Sustaining Treatment (POLST) Act

Aetna Better Health of New Jersey requires providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the Physician's Order for Life-Sustaining Treatment (POLST) program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member), and these preferences are then documented on a standardized medical form that the member keeps with them.

The form must be signed by a member's attending provider or advanced practice nurse. This form then must become part of a member's medical record, as this form will follow the member from one healthcare setting to another, including hospital, home, nursing home or hospice.

For additional information about the POLST Act, please visit http://nj.gov/health/advancedirective/polst.shtml

CHAPTER 19: ENCOUNTERS, BILLING AND CLAIMS

Back to Table of Contents

Aetna Better Health of New Jersey processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable State and federal laws, rules and regulations. Aetna Better Health of New Jersey will not pay claims submitted by a provider who is excluded from participation in NJ Medicaid or NJ FamilyCare Programs, or any program under federal law, or is not in good standing with the Division of Medical Assistance and Health Services (DMAHS).

Aetna Better Health of New Jersey uses our business application system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, Aetna Better Health of New Jersey encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of New Jersey has developed a business relationship with Emdeon. Aetna Better Health of New Jersey receives Electronic Data Interchange (EDI) claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance and member enrollment, and then uploads them into our business application each business day. Within twenty-hour (24) hours of file receipt, Aetna Better Health of New Jersey provides production reports and control totals to trading partners to validate successful transactions and to identify errors for correction and resubmission.

Encounters

Billing Encounters and Claims Overview

Our Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication, resubmissions and claims inquiry/research.

Aetna Better Health of New Jersey is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD-10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment. Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

The medical record entry associated with the claim should obviously indicate every diagnosis that was addressed in its documentation.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to ensure the integrity and accuracy of risk-adjusted payment to federally funded health plans, including Medicaid plans. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health of New Jersey by Medicaid based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

The Centers for Medicare and Medicaid Services (CMS) uses the Hierarchical Condition Category (HCC) payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health of New Jersey and payments made by Aetna Better Health of New Jersey to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- **Code all documented conditions** that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as “probable” “, suspected”, “questionable,” “rule out” or “working” diagnoses. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health of New Jersey. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at http://csscoperations.com/.

Billing and Claims

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing, if applicable.

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the NJ Medicaid and NJ FamilyCare Programs

- Provider MUST notify the member in advance that the charges will not be covered under theprogram.
- Provider MUST have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims and encounters must be reported to us, including prepaid services.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- Claims must be submitted within 180 calendar days from the date of services. The claim will be denied if not received within the required timeframes.
- Corrected claims must be submitted within 365 days from the date of service.
- Coordination of Benefits (COB) claims must be submitted within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the date of services, whichever islater.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Non-network providers rendering prior authorized services follow the same timely filing guidelines.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS 1450 Form**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Instructions on how to fill out the claim forms can be found on our website at www.aetnabetterhealth.com/newjersey .

2) Complete the claim form.

   a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimelyfiling.

3) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of New Jersey to the address below.
   a) Electronic Clearing House
      To submit a claim electronically, visit the Availity Provider Portal. See Secure Web Portal section on page 18 for more information.
      Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors.
      Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
      - Emdeon is the EDI vendor we use.
      - Contact your software vendor directly for further questions about your electronic billing.
      - Contact our Provider Relations Department for more information about electronic billing.

      All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of New Jersey policies and procedures.
   b) Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health of New Jersey P.O. Box 61925 Phoenix, AZ 85082-1925	Through Electronic Clearinghouse

Correct Coding Initiative
Aetna Better Health of New Jersey follows the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient and same date of service. For more information on this initiative, please feel free to visit **http://www.cms.hhs.gov/NationalCorrectCodInitEd/.**

Aetna Better Health of New Jersey utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies.

Correct Coding
Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:
- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect Coding
Examples of incorrect coding include:
- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service
- Billing separate codes for related services when one code includes all related services
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of New Jersey can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners indicate:

  > *"Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period."*

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department, to check the status of a disputed, resubmitted, and or reconsidered claim, please contact the CICR Department by calling 1-855-232-3536. Provider may also check the status of a claim by visiting the Availity Provider Portal. See Secure Web Portal section on page 18 for more information.

Online Status through Aetna Better Health of New Jersey's Secure Website

Aetna Better Health of New Jersey encourages providers to take advantage of using our online Provider Secure Web Portal at www.aetnabetterhealth.com/newjersey, as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. The provider must register to use our portal. Please see Chapter 4 for additional details surrounding the Provider Secure Web Portal.

Calling the Claims Inquiry Claims Research Department

The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims
- Assist in resolving problems or issues with a claim
- Provide an explanation of the claim adjudication process
- Help track the disposition of a particular claim
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly)
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections)

    Please be prepared to give the service representative the following information:
    - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
    - Member name, member identification number and date of birth
    - Date of service
    - Claim number from the remittance advice on which you have received payment or denial of the claim

Claim Resubmission

Providers have 365 days from the date of service to resubmit a revised version of a processed claim.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- An updated copy of the claim; all lines must be rebilled
- For resubmissions providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.
- Any additional documentation required
- A brief note describing requested correction
- Clear label at the top of the claim in black ink denoting it as "Resubmission"; mail to appropriate claims address

Failure to accurately label and mail the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their resubmitted claim has been processed. Providers may call our CICR Department during regular office hours to speak with a representative about their claim. The CICR Department will be able to verbally acknowledge receipt of the resubmission. Our staff will be able to discuss, answer questions and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed and/or adjusted claim. These claims will be noted as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on the following website: www.aetnabetterhealth.com/newjersey

Instruction for Specific Claims Types

Aetna Better Health of New Jersey General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with CMS claim processing rules.

Skilled Nursing Facilities (SNF) including Nursing Facilities and Special Care Nursing Facilities

Providers submitting claims for SNFs should use the CMS 1450 Form.

Providers must bill in accordance with standard CMS billing requirement rules for Aetna Better Health of New Jersey, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp

Home Health Claims

Providers submitting claims for Home Health should use CMS 1500 Form.

Providers must bill in accordance with contract. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: http://www.cms.gov/HomeHealthPPS/

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment. Under Medicaid Regulations a DME rental is considered a purchase after 10 months.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between NJ Medicaid and NJ FamilyCare Programs. Units billed for the program equal 1 per month. Units billed for Medicaid equal the number of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the number of days needed for the claim based on the date span.

Same Day Readmission

Providers submitting claims for inpatient facilities should use CMS 1450 Form.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission within twenty-four (24) hours.

> ***Example:*** *Discharge Date: 10/2/10 at 11:00 a.m.*
> *Readmission Date: 10/3/10 at 9:00 a.m.*

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Hospice Claims

When a member has Medicare as primary coverage, the only claims payable during a hospice election period by Aetna Better Health of New Jersey would be additional benefits covered under Aetna Better Health of New Jersey that would not normally be covered under the covered services. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not. For members who do not have Medicare primary coverage, hospice is covered by Aetna Better Health of New Jersey.

HCPCS Codes

There may be differences in what codes are covered under Medicare versus Medicaid. We follow the state of New Jersey's billing requirement rules, which could result in separate billing for claims under Aetna. While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

Remittance Advice

Provider Remittance Advice

Aetna Better Health of New Jersey generates checks biweekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and to make corrections for any claims requiring resubmission. Call our Provider Relations Department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of New Jersey for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of New Jersey due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of New Jersey after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the last four digits of the bank account

to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. Thisincludes:
    - Member Name
    - ID
    - Birth Date
    - Account Number
    - Authorization ID, if Obtained
    - Provider Name
    - Claim Status
    - Claim Number
    - Refund Amount, if Applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this paymentcycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Relations Department for assistance with this process.

Claims Submission

Claims Filing Formats

Providers can elect to file claims with Aetna Better Health of New Jersey in either an electronic or a hard copy format. Claims must be submitted using either the CMS 1500 or CMS 1450 formats, based on your provider type as detailed below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of New Jersey encourages providers to electronically submit claims, through Emdeon.
- Please use the Payer ID number 46320 when submitting claims to Aetna Better Health of New Jersey for both CMS 1500 and CMS 1450 forms. You can submit claims by visiting Emdeon at http://www.emdeon.com/. Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Emdeon.

Important Points to Re-member

- Aetna Better Health of New Jersey does not accept direct EDI submissions from its providers.
- Aetna Better Health of New Jersey does not perform any 837 testing directly with its providers, but performs such testing with Emdeon.
- For resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

Paper Claims Submission

Providers can submit hard copy CMS 1500 or CMS 1450 claims directly to Aetna Better Health of New Jersey via mail to the following address:

Aetna Better Health of New Jersey
P.O. Box 61925
Phoenix, AZ. 85082-1925

Encounter Data Management (EDM) System

Aetna Better Health of New Jersey uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to DMAHS requirements. The EDM System also warehouses encounter data from vendors and formats it for submission to DMAHS. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness and completeness; we then submit encounter data to DMAHS. Our EDM System processes CMS 1500, CMS 1450 (or UB92), Dental, Pharmacy and Long Term Care claims and use the most current coding protocols (e.g., standard CMS procedure or service codes, such as, ICD-10CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize NDC coding in accordance with the Department's requirements.

The EDM System has top-of-the-line functionality to accurately and consistently track encounters throughout the submission continuum, including collection, validation, reporting and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and/or P) electronic claim transaction, 835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format; we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EDM System for processing, including data from our QNXT ™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims Processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation report. The Encounter Management Unit researches, tracks and reports any discrepancy until that discrepancy is completely resolved.

Encounter Staging Area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third party vendors (e.g., Pharmacy Benefit Management, dental or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and is populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Encounter Data Management (EDM) System Scrub Edits

This EDM System feature allows the Encounter Management Unit to apply DMAHS edit profiles to identify records that may be unacceptable to the DMAHS. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of DMAHS. This means that we can align our encounter edit configuration with DMAHS's configuration to improve encounter acceptance rates.

Encounter Tracking Reports

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for each plan.
Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM by claim adjudication date and date of service. Using these highly responsive and functional reports, our Encounter Management Unit can monitor the accuracy, timeliness and completeness of encounter transactions from entry into EDM System, submission to and acceptance by the Department. Reports are run to ensure that all appropriate claims have been extracted from the claims processing system.

Data Correction

As described above, the Encounter Management Unit is responsible for the EDM System. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the Department.

Our Encounter Management Unit uses two processes to manage encounter correction activities:

1) For encounters where re-adjudication is unnecessary, the Encounter Management Unit will execute corrections to allow resubmission of encounter errors in accordance with the Department encounter correction protocol.
2) Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system and the adjusted claim is imported into the EDM for resubmission to the Department in accordance with the encounter correction protocol, which is tailored to the Department's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement and/or corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Department's acceptance process, we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit as described above. In this way, we expand our EDM System scrub edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our Encounter Management Unit is important to the timely, accurate and complete processing and submission of encounter data to DMAHS. Our Encounter Management Unit has specially trained correction analysts with experience, knowledge and training in encounter management, claim adjudication and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis and are responsible for oversight and monitoring of encounter files submissions to DMAHS. The team includes a technical supervisor and a project manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from the Department and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. These data facilitate the monitoring and resolution of encounter errors and support the timely resubmission of corrected encounters.

CHAPTER 20: GRIEVANCE AND APPEAL

Back to Table of Contents

Grievances

A grievance is an expression of dissatisfaction by the member or their designated representative received orally or in writing about a matter other than an adverse action. Grievance subjects may include but are not limited to dissatisfaction with access to coverage and drug utilization review programs that apply drug utilization review standards. Grievances may be filed with Aetna Better Health of New Jersey orally or in writing by the member or the designated representative, including providers. Aetna Better Health of New Jersey responds to grievances within the following timeframes:

- Thirty (30) calendar days of receipt for a standard grievance
- Three (3) business days of receipt for an expedited grievance

For expedited grievances, Aetna Better Health of New Jersey will make reasonable effort to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The Notice of Resolution includes the decision reached, the reasons for the decision and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to obtain information on filing a Medicaid Fair Hearing or Independent Utilization Review if applicable.

Aetna Better Health of New Jersey informs members and providers of the grievance system processes for grievances, appeals, Independent Utilization Reviews and Medicaid Fair Hearings. This information is contained in the Member Handbook and Provider Manual and is available on the Aetna Better Health of New Jersey website. When requested, we give members reasonable assistance

in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability at no cost to the member.

Aetna Better Health of New Jersey will ensure that no punitive action is taken in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing a complaint, grievance or appeal with Aetna Better Health of New Jersey.

Provider Grievances

Both participating and non-participating providers may file a formal written grievance with ABHNJ regarding dissatisfaction with our policies and procedures; dissatisfaction with a decision made by the ABHNJ; disagreement with the ABHNJ as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting; any other issue of concern to the provider. Providers can also file a verbal grievance by calling **1-855-232-3596**.

To file a grievance electronically, visit the Availity Provider Portal. See Secure Web Portal section on page 18 for more information.

To file a grievance in writing, providers should write to:

Aetna Better Health of New Jersey
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Aetna Better Health of New Jersey will resolve all provider grievances within thirty (30) calendar days of receipt of the grievance and will notify the provider of the resolution within ten (10) calendar days of the decision.
Please note: Provider grievances are reported quarterly to the State.

Utilization Management Appeals on behalf of a Member

An appeal is a request to reconsider a decision (e.g., utilization review recommendation, benefit payment or administrative action) with Aetna Better Health of New Jersey. Authorized member representatives and Providers may also file an appeal on the member's behalf with the written consent of the member.
Such procedures shall not be applicable to any disputes that may arise between Aetna Better Health and any provider regarding the terms, conditions, or termination or any other matter arising under contract between the provider and Aetna Better Health.

Members or their designated representative (including a provider) can file an appeal with Aetna Better Health of New Jersey orally or in writing. A representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider or an attorney. Representatives must be designated in writing.

Appeals are classified into two types:

- Internal Appeal
  - Formal Utilization Management Appeals
  - Expedited Formal Utilization Management Appeals
- External Appeal
  - Independent Utilization Review Expedited
  - Independent Utilization Review

The member or authorized representative may also appeal directly to DMAHS through the Medicaid Fair Hearing process. Medicaid Fair Hearing appeals may be submitted after the completion of the member appeal with Aetna Better Health of New Jersey. The Medicaid Fair Hearing process is described in greater detail in the G&A section of this Manual.

The member, or the provider on the member's behalf, must avail themselves of Aetna Better Health of New Jersey's Internal Appeal process prior to seeking an Independent Utilization Review (IURO) Appeal and/or a Medicaid Fair Hearing.

Member Appeals must be filed with Aetna Better Health of New Jersey no later than sixty (60) calendar days from the date on the Aetna Better Health of New Jersey Notice of Action letter. The expiration date to file an appeal is included in the Notice of Action.

The Notice of Action informs the member of the following:

- Our decision and the reasons for our decision
- A clear explanation of further appeal rights and the time frame for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to an appeal
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- Their right to request an expedited resolution and the process for doing so
- The policies or procedures which provide the basis for the decision
- That members may request that their benefits continue through the appeal process, when all of the following criteria are met:
    - The member or provider on behalf of the member files the appeal within ten (10) calendar days of the postmarked notice of adverse action or prior to the effective date of Aetna Better Health of New Jersey's notice of adverse action; and
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
    - The services were ordered by an authorized provider; and
    - The original period covered by the initial authorization has not expired; and
    - The member requests extension of benefits
- That the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member

Appeals may be filed either verbally by contacting the Member Services Department or by submitting a request in writing. Unless the member is requesting an expedited appeal resolution, an oral appeal will be summarized in the acknowledgment letter. Members are requested but not mandated to sign and return the letter that they are in agreement with the summary.

Members may appeal the decision and request a further review of Aetna Better Health of New Jersey's actions. Examples of appeals include but are not limited to:

- An adverse determination under a utilization review program
- Denial of access to specialty and other care
- Denial of continuation of care
- Denial of a choice of provider
- Denial of coverage of routine patient costs in connections with an approved clinical trial
- Denial of access to needed drugs
- The imposition of arbitrary limitation on medically necessary service
- Denial in whole or in part, of payment for a benefit
- Denial or limited authorization of a requested service, including the type or level of services
- The reduction, suspension, or termination of a previously authorized service
- The failure to provide service in a timely manner
- Denial of a service based on lack of medical necessity
- The denial of a Member's request to obtain services outside of the Contracting area when Aetna Better Health of New Jersey is the only HMO servicing a rural area.

Members may file an appeal by:

- Calling Member Services at 1-855-232-3596
- Writing Aetna Better Health of New Jersey at:

    Aetna Better Health of New Jersey
    PO Box 81139
    5801 Postal Road
    Cleveland, OH 44181
    FAX: 1-844-321-9566

Neither the Utilization Management Committee, nor the utilization team will take any action with respect to a member or a health care provider that is intended to penalize or discourage the member or the member's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the Utilization Management Committee, nor the utilization team will take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

Availability of Assistance

In handling grievances and appeals, ABHNJ will provide members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Brief Overview of Internal Appeal Processes

- Standard and Expedited Informal Utilization Management Appeals.
- Utilization Management Appeals must be requested within sixty (60) calendar days of the Notice ofAction.
- Verbal appeals are acknowledged at the time of receipt.
- Aetna Better Health of New Jersey will make reasonable effort to verbally acknowledge written appeals upon receipt.
- Aetna Better Health of New Jersey will provide members with access to necessary medical records and information to file their appeals and to view their appeal file.
- Members and their designated representatives are advised of their rights to provide more information and documentation for their appeal either in person or in writing.
- Aetna Better Health of New Jersey will render a decision on a standard Informal Utilization Management Appeal as expeditiously as the member health condition requires, within thirty (30) calendar days of receipt of the appeal, and will communicate the decision verbally and, in the case of a denial, will also send written notification, including an explanation for the decision, within the same thirty (30) calendar days.
- Members, or providers on the member's behalf, may request an Expedited Appeal, verbally or in writing. Aetna Better Health will then evaluate, based upon the circumstances of the denial and the appeal whether itmeets the criteria to be expedited or not. If the request for an Expedited Appeal involves a risk to the member's health or related urgent issue, Aetna Better Health of New Jersey will render a decision as expeditiously as the member's health condition requires, no later than three (3) calendar days after the receipt of the request. Aetna Better Health will communicate the decision verbally and, in the case of a denial, will also send written notification including an explanation for the decision, within the same three
- business days.
- If the appeal does not meet expedited criteria as described above, Aetna Better Health of New Jersey will notify the requestor that the appeal request will be responded to as a standard appeal, with all applicable procedures and timeframes for such a case.
- If Aetna Better Health of New Jersey does not agree with the member's appeal and the denial is upheld, members can ask for an Independent Utilization Review, and/or a Medicaid Fair Hearing.
- Members or their designated representative may request to continue to receive benefits while the hearing is pending. Benefits will continue if the request meets the criteria described in greater detail in the G&A section of this Manual.
- If Aetna Better Health of New Jersey or the Medicaid Fair Hearing officer does not agree with the member's appeal, the denial is upheld, and the member continued to receive services, the member may be responsible for the cost of services received during the review.

Medicaid Fair Hearing

Members or their designated representative, including a provider acting on their behalf with written consent, may request a Medicaid Fair Hearing through DMAHS after the Aetna Better Health of New Jersey Internal appeal decision. This request must be completed within one hundred twenty (120) calendar days of the adverse action. Information on how to submit a Medicaid Fair Hearing appeal is included in Aetna Better Health of New Jersey Internal Appeal Decision Letters. Members in Medicaid/ FamilyCare Plan A (including the ABP) have a right to a Fair Hearing. Members in FamilyCare Plans B, C and D do not have Fair Hearing rights.

Denials include reductions in service, suspensions, terminations and denials. Members and their authorized representatives may also appeal a denial of payment for Medicaid covered services and failure to act on a request for services within required timeframes. The request for a Medicaid Fair Hearing must be submitted in writing within one hundred twenty (120) calendar days of Aetna Better Health of New Jersey's notification of adverse action to the following:

New Jersey Division of Medical Assistance and Health Services (DMAHS) Fair Hearing Unit
PO Box 712
Trenton, NJ 08625-0712

If members wish services to continue while their Medicaid Fair Hearing is reviewed, they must request a Medicaid Fair Hearing within ten (10) calendar days from the adverse action letter. At the Medicaid Fair Hearing, members may represent themselves or be represented by a lawyer, their provider or their authorized representative, with the member's written permission.

The Department renders the final decision about services. If the decision agreed with Aetna Better Health of New Jersey's previous decision, and the member continued to receive services, the member may be responsible for cost of services received during the Medicaid Fair Hearing. If the Medicaid Fair Hearing decision favors the member, then Aetna Better Health of New Jersey will commence coverage of the services immediately. If the member's services were continued while the Medicaid Fair Hearing was pending, Aetna Better Health of New Jersey will provide reimbursement for those services according to the terms of the final decision rendered by the Department's Medicaid Fair Hearing Appeals Division.

External Appeal

Members' may request an External Appeal done by an Independent Utilization Review Organization (IURO) after completion of the Internal appeals process. They must do so in writing to the New Jersey Department of Banking and Insurance within sixty (60) days of receiving the Internal Appeal Decision Letter at the following address:

New Jersey Department of Banking and Insurance Consumer Protection Services
Office of Managed Care PO Box 329
Trenton, NJ 08625-0329
Phone 888-393-1062

The Independent Utilization Review Organization (IURO) will review the request for External Appeal and will send a letter telling the member if they are eligible for External Appeal and if their request was complete. Eligible means the member has completed the internal appeal process and their appeal is about medical necessity or the service is experimental or investigational. If the member is eligible and the request is incomplete, the IURO will send written notification to the member to tell them what is needed to make the request complete.

The member will have five (5) business days from notification of acceptance for External Appeal to submit any additional information.

The IURO will review the request and render a written decision as expeditiously as the member's health condition requires not exceeding forty-five (45) calendar days. For requests related to urgent, emergent care, admission, availability or continued stay when the member has not been discharged, the IURO will render a quick decision. These cases are classified as an expedited External Appeal. The IURO will review expedited requests and render a decision within forty-eight (48) hours. If the IURO is unable to communicate a verbal decision, they will send written notification of the decision within forty-eight (48) hours.

If the IURO does not agree with our decision, Aetna Better Health of New Jersey will commence coverage of the services immediately.

Provider Appeals

Participating and Non-Participating Providers have the right to appeal ABHNJ claims determination(s) within **sixty** (**60**) calendar days of receipt of the claim denial. To appeal ABHNJ claims determination(s), providers must utilize the Health Care Provider Application to Appeal a Claims Determination.

A provider MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF our determination:

- Resulted in the claim not being paid at all for reasons other than an UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate the provider did not expect based upon a contact with us or the terms of the member's Medicaid/FamilyCare coverage.
- Resulted in the claim being paid at a rate the provider did not expect because of differences in Our treatment of the codes in the claim from what the provider believes is appropriate
- Indicated that we require additional substantiating documentation to support the claim and the provider believes that the required information is inconsistent with Our stated claims handling policies and procedures or is not relevant to the claim.

A provider also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- The provider believes we have failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law, and the terms of the provider's contract (if any)
- Our determination indicates we will not pay because of lack of appropriate authorization, but the provider believes they obtained appropriate authorization from Us or another carrier for the services
- The provider believes we have failed to appropriately pay interest on the claim
- The provider believes Our statement that We overpaid one or more claims is erroneous, or that the amount We have calculated as overpaid is erroneous

Oversight of the Grievance and Appeal Processes

The Compliance Department has the responsibility for oversight of the Grievance System processes. The Grievance System Manager has overall responsibility for management of the Grievance System processes and reports to the Director of Operations. This includes:

- Documenting individual grievances and appeals
- Coordinating resolutions
- Maintaining the appeals and grievance database
- Tracking and reviewing grievance and appeal data for trends in quality of care or other service-related issues
- Reporting all data to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health of New Jersey's grievance and appeals processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility for the grievance system processes includes:

- Review of individual quality of care grievances
- Aggregation and analysis of grievance and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and recredentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

The Aetna Better Health of New Jersey Grievance System Manager will serve as the primary contact person for the grievance system processes with the Aetna Better Health of New Jersey QM Coordinator in the QM Department serving as the back-up contact person. The Member Services Department, in collaboration with the QM Department and Provider Relations Department, is responsible for informing and educating members and providers about a member's right to file a grievance, appeal, Independent Utilization Review or Medicaid Fair Hearing and for assisting members in filing a complaint, grievance, or appeal throughout the Grievance System.

Members are advised of their grievance, Internal Appeal, External Appeal, Medicaid Fair Hearing rights and processes at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual during provider orientations, within the provider agreement and on Aetna Better Health of New Jersey's website.

Availability of Assistance

In handling grievances and appeals, ABHNJ will provide members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

CHAPTER 21: FRAUD, WASTE, AND ABUSE

Back to Table of Contents

Fraud, Waste and Abuse

Aetna Better Health of New Jersey has an aggressive, proactive fraud, waste and abuse program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates and reports any suspected or confirmed cases of fraud, waste or waste to appropriate State and federal agencies as mandated by New Jersey Administrative Code. During the investigation process, the confidentiality of the patient and/or people referring the potential fraud and abuse case is maintained.

Aetna Better Health of New Jersey uses a variety of mechanisms to detect potential fraud, waste and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and Members, share the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation and data analysis.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste and abuse, and is responsible to investigate cases of alleged fraud, waste and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information or who want to report potential fraud, waste or abuse. The number is 1-800-338-6361. The hotline has proven to be an effective tool and Aetna Better Health of New Jersey encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement, as appropriate, to conduct in-depth analyses of case-related data.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health of New Jersey all cases of suspected fraud, waste and abuse, inappropriate practices and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of New Jersey Compliance Hotline at 1-855-282-8272; or
- By phone to our confidential Special Investigation Unit (SIU) at 1-800-338-6361.

Note*:* If you provide your contact information, your identity will be kept confidential.

You can also report provider fraud to the New Jersey Medicaid Fraud Division of the Office of the State Comptroller's Office (MFD) at 1-888-9FRAUD (1-888-973-2835) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477).

The New Jersey Medicaid Fraud Division (MFD) is a Division of the Office of the State Comptroller created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste and Abuse control activities for all State agencies responsible for services funded by Medicaid.

A provider's best practice for preventing fraud, waste and abuse (this also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy - ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Fraud, Waste and Abuse Defined

- **Fraud**: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
- **Waste**: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste, and Abuse

Examples of Fraud, Waste, and Abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of New Jersey due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, Waste and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinicalneeds
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members a cash payment as an inducement to enroll in a specific plan
- Selecting or denying members based on their illness profile or other discriminating factors
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider)
- Soliciting, offering, or receiving a kickback, bribe or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep; another example is a "multi patient" in which a provider visits a nursing home billing for twenty (20) nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of New Jersey and the member or billing Aetna Better Health of New Jersey and another member
- Misrepresenting the date services were rendered or the identity of the member who received the services
- Misrepresenting who rendered the service or billing for a covered service rather than the non-covered service that was rendered

Fraud, Waste and Abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addition

In addition, member fraud is also reportable and examples include:

- Falsifying identity, eligibility or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another members ID)
- Forging and altering prescriptions
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs; doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market)

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of New Jersey's commitment to compliance and that address specific areas of potential fraud, waste and abuse
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program
3. Effective Compliance Training: Development and implementation of regular, effective education and training
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers and directors and members of the compliance committee, as well as related entities
    a. Includes a system to receive, record and respond to compliance questions or reports of potential or actual non-compliance, while maintaining confidentiality
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of New Jersey
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $11,181 to $22,363 per false claim. Penalty amounts are subject to adjustment for inflation. The False Claims Act prohibits, among other things:
    - Knowingly presenting a false or fraudulent claim for payment or approval
    - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
    - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

    "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

    Providers contracted with Aetna Better Health of New Jersey must agree to be bound by and comply with all applicable State and federal laws and regulations.

- Anti-Kickback Statute
    - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

- Self-Referral Prohibition Statute (Stark Law)
    - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies

- Red Flag Rule (Identity Theft Protection)
    - Requires "creditors" to implement programs to identify, detect and respond to patterns, practices or specific activities that could indicate identity theft

- Health Insurance Portability and Accountability Act (HIPAA) requires:
    - Transaction standards
    - Minimum security requirements
    - Minimum privacy protections for protected health information
    - National Provider Identification (NPIs) numbers

- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $11,181 for each false claim or statement and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of New Jersey services through NJ Medicaid/NJFamilyCare.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of New Jersey providers shall follow federal and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting

fraud, waste and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of New Jersey services through NJ Medicaid/NJFamilyCare.

- The New Jersey False Claims Act (NJFCA), P.L. 2007, Chapter 265, codified at N.J.S.A. 2A:32C-1 through 2A:32C-17, and amending N.J.S.A. 30:4D-17(e), which was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts: (a) the main part authorizes the New Jersey Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act and has similar whistleblower protections; (b) another part amends the New Jersey Medicaid statute to make violations of the New Jersey False Claims Act give rise to liability under N.J.S.A. 30:4D-17(e); and (c) a third part amends the New Jersey Medicaid statute to increase the $2000 per false claim civil penalties under N.J.S.A. 30:4D-17(e)(3) to the same level provided for under the Federal False Claims Act, which is currently between $11,181 and $22,365 per false claim. Penalty amounts are subject to adjustment for inflation.

- Under the criminal provisions of the New Jersey Medical Assistance and Health Services Act (MAHSA), codified at N.J.S.A. § 30:4D-17(a) – (d), providers with Aetna Better Health of New Jersey shall refrain from engaging in fraud or other criminal violations relating to Title XIX (Medicaid)-funded programs. Prohibited conduct includes, but is not limited to: (a) fraudulent receipt of payments or benefits; (b) false claims, statements or omissions or conversion of benefits or payments; (c) kickbacks, rebates and bribes; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments. Providers engaging in criminal violations may be excluded from participation in Medicaid and other health care programs under N.J.S.A. § 30:4D-17.1(a).

- Under the civil provisions of the MAHSA, codified at N.J.S.A. §§ 30:4D-7(h) and 30:4D-17(e) – (i), providers with Aetna Better Health of New Jersey: (1) shall repay with interest any amounts received as a result of unintentional violations; and (2) are liable to pay up to triple damages and (as a result of the New Jersey False Claims Act) between $11,181 to $22,363. Penalty amounts are subject to adjustment for inflation. Per false claim when violations of the Medicaid statute are intentional or when there is a violation of the New Jersey False Claims Act. Providers engaging in civil violations may be excluded from participation in Medicaid and other health care program sunder
  N.J.S.A. § 30:4D-17.1(a)

- Under the Health Care Claims Fraud Act (HCCFA), codified at N.J.S.A. §§ 2C:21-4.2, 2C:21-4.3 and 2C:51-5, providers with Aetna Better Health of New Jersey services who (1) knowingly commit health care claims fraud in the course of providing professional services; (2) recklessly commit health care claims fraud in the course of providing services; or (3) commit acts of health care claims fraud as described in (1) and (2), if the commission of such acts would be performed by an individual other than the professional who provided services (e.g., claims processing staff), are guilty of a crime. Providers may lose his/her license as part of the penalties of this act.

- Under the Uniform Enforcement Act (UEA), codified at N.J.S.A. § 45:1-21(b) and (o), licensed providers are prohibited from engaging in conduct that amounts to, “dishonesty, fraud, deception, misrepresentation, false promise or false pretense” or involves false or fraudulent advertising.

- Under the New Jersey Consumer Fraud Act (CFA), codified at N.J.S.A. §§ 56:8-2, 56:8-3.1, 56:8-13, 56:8-14, and 56:8-15, provider agencies and the individuals working for them shall be prohibited from the unlawful use of “any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact”, with the intent that others rely upon it, in connection with the sale, rental or distribution of any product or service by the provider agency or its employees, or with the subsequent performance of that provider agency or its employees.

- Under the Conscientious Employee Protection Act (CEPA), codified at N.J.S.A. §34:19-1, et seq., provider agencies are prohibited from taking retaliatory action against employees who: (a) disclose or threaten to disclose to a supervisor or any public agency an activity, policy or practice of the provider agency or another business with which the provider agency shares a business relationship, that the employee reasonably believes to be illegal, fraudulent and/or criminal; (b) provides information or testimony to any public agency conducting an investigation, hearing or inquiry into any violation of law, rule or regulation by the provider agency or another business with which the provider agency shares a business relationship; or (c) objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes is illegal, fraudulent, criminal or incompatible with a clear mandate of public policy concerning the public health, safety or welfare, or protection of the environment.

- The Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and or providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (ifapplicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
    - Automatic disbarment
    - Prison time

Exclusion Lists & Death Master Report

We are required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, State of New Jersey debarment list, Federal exclusions database, N.J Treasure's exclusion database, N.J. Division of Consumer Affairs licensure database, N.J. Department of Health licensure database, Certified nurse aide and personal care assistant registry (if applicable, and any other such databases as the New Jersey Division of Medical Assistance and Health Services (DMAHS) may prescribe.

Aetna Better Health of New Jersey does not participate with or enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers and/or who have been terminated from the Medicaid or any programs by DMAHS for fraud, waste or abuse. The provider must agree to assist Aetna Better Health of New Jersey as necessary in meeting our obligations under the contract with the DMAHS to identify, investigate and take appropriate corrective action against fraud, waste and/or abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional Resources

- http://www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC54.pdf
- http://www.nj.gov/oag/dcj/njmedicaidfraud/
- http://oig.hhs.gov/hotline.html
- http://www.nj.gov/comptroller/divisions/medicaid/disqualified/
- https://exclusions.oig.hhs.gov/
- http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
- http://www.njconsumeraffairs.gov/Pages/verification.aspx
- http://www.state.nj.us/health/guide/find-select-provider/
- http://njna.psiexams.com/search.jsp
- https://www.npdb.hrsa.gov/hcorg/pds.jsp.

CHAPTER 22: MEMBER ABUSE AND NEGLECT

Back to Table of Contents

Mandated Reporters

As mandated by New Jersey Administrative Code and New Jersey Statues Annotated (N.J.A.C. 8:43G-12.10(b), & N.J.S.A. 52:27D-409), all providers who work or have any contact with an Aetna Better Health of New Jersey member are required as "mandated reporters" to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. A full version of the New Jersey Administrative Code can be found on the State of New Jersey Office of Administrative Law website at http://www.state.nj.us/oal/rules/accessp/.

Children

Providers must report suspected or known child abuse and/or neglect to the Division of Child Protection and Permanency (DCP&P) and, if relevant, the law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

If the child is in immediate danger, call 911 as well as 1-877 NJ ABUSE (1-877-652-2873) or the Division of Child Protection and Permanency (DCP&P) at 1-800-792-8610.

Vulnerable Adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment and/or financial exploitation of a vulnerable adult immediately to one of the following State agencies:

- The National Domestic Violence Hotline at 1-800-799-SAFE (7233); or
- The New Jersey Department of Health and Senior Services at 1-800-792-9770

For members age 60 or older living in a long-term care community, providers may report verbally or in writing to the New Jersey Department of Health (DOH):

- Toll-free at 1-877-582-6995 or in writing via fax at 1-609-943-3479 (Please use the "Reportable Event Record/Report" located on DOH's website when faxing reports.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.

Reporting Identifying Information

Any provider who suspects that a member may be in need of protective services should contact the appropriate State agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened and any other pertinent information)

After reporting the incident, concern, issue or complaint to the appropriate agency, the provider office must notify Aetna Better Health of New Jersey's Compliance Hotline at: 1-855-282-8272.

Our providers must fully cooperate with the investigating agency and must make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to Determine Abuse or Neglect

When a State agency notifies Aetna Better Health of New Jersey of a potential case of neglect and/or abuse of a member, our case managers will work with the agency and the Primary Care Provider (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of New Jersey also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health of New Jersey case managers will provide member with information about shelters and domestic violence assistance programs along with providing verbal support.

Emergency Room Criteria

As mandated by New Jersey Administrative Code, emergency room providers are required to examine children for suspected physical abuse and/or neglect and also when placed in foster homes after normal agency business hours. These visits are covered by Aetna Better Health of New Jersey.

Additional information can be located on the New Jersey Hospital Associates website at:
http://www.njacep.org/downloads/110309_ED_Regs.pdf

To remain in compliance with N.J.A.C. 8:43G-12.10(b), regularly assigned emergency department staff should attend training or educational programs related to the identification and reporting of child abuse and/or neglect in accordance with N.J.S.A. 9:6-1 et seq.; sexual abuse; domestic violence; and abuse of the elderly or disabled adult.

Examples, Behaviors and Signs

Abuse

Examples of Abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior Indicators of a Child Wary of Adult Contacts:

- Apprehension when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Fear of parents
- Fear of going home
- Report of injury by parents

Behaviors of Abusers (Caregiver and /or Family Member):

- Refusal to follow directions
- Speaking for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect:

- The intentional withholding of basic necessities and care
- Failure to provide basic necessities and care because of lack of experience, information, orability

Signs of Neglect:

- Malnutrition or dehydration
- Un-kempt appearance; dirty or inadequate
- Untreated medical condition
- Being unattended for long periods or having physical movements unduly restricted

Examples of Neglect:

- Inadequate provision of food, clothing or shelter
- Failure to attend to health and personal care responsibilities, such as washing, dressing and bodily functions

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member or professional expressing excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

Additional Resources

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf
- http://www.nj.gov/ooie/pdf/EOreportinggridFinal.pdf
- http://www.kidlaw.org/main.asp?uri=1003&di=84
- New Jersey State Code N.J.S.A. 9:6-1 et seq (http://law.onecle.com/new-jersey/9-children-juvenile-and-domestic-relations-courts/6-1.html)
- http://www.wilentz.com/files/articlesandpublicationsfilefiles/226/articlepublicationfile/new%20jersey%20expands%20reporting%20requirements%20to%20include%20immunity%20provisions.pdf

CHAPTER 23: FORMS

Back to Table of Contents

The following forms are among those available online. Please check the website for additional forms:

- **Consent to Sterilization (7473 M ED)**
  An informed consent to any medical procedure, treatment or operation for the purpose of rendering a person permanently incapable of reproducing (also known as procedures to induce sterilization) must be signed by both the enrollee and the provider performing the sterilization. Consent for sterilization covers both male and female members.
  https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/Sterilization Consent.pdf

- **Hysterectomy Receipt of Information Form (FD-189)**
  An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.
  https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/HysterectomyConsentForm-NJ.pdf

- **Health Care Provider Application to Appeal a Claims Determination Form**
  https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/ABHNJ%20Claim%20appeal_DOBI%20mandated%20form.pdf

- **Pharmacy Prior Authorization Forms**
  https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/Prior Authorization Form.pdf

CHAPTER 24: CONTRACT COMPLIANCE

Back to Table of Contents

The State of New Jersey requires that any provider/subcontractor who agrees to serve Medicaid/NJ FamilyCare members comply with all the following provisions. Any changes made to the required verbatim language by the State of New Jersey shall be deemed to be incorporated herein by reference without amendment, and provider/subcontractor shall remain apprised of, and comply with, any such changes. The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. Subjection of provider contract/subcontract

This provider contract/vendor subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS and continue through the end of State Fiscal Year the date established by DMAHS, dependent upon available appropriation. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on the date established by DMAHS. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

2. The Any Willing Plan status also expires on the date established by DMAHS.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

4. Any Willing and Qualified Provider (AWQP): MLTSS. AWQP refers to any New Jersey Based nursing facility (NF) provider that meets the criteria defined below in Section N. In order to be an AWQP and in the Contractor's network, the New Jersey- Based NF must meet any four of the following seven quality performance measures in what is herein known as the NF Quality Improvement Initiative. The first five measures are part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified NFs as part of the Minimum Data Set (MDS):

a. The NF shall be at or above the statewide average of the percentage of long stay residents who are immunized against influenza. This measure is calculated annually during the influenza season.

b. The NF shall be at or below the statewide average of the percentage of long stay residents who receive an antipsychotic medication. The measure could be met with any four of the most recent six quarters examined.

c. The NF shall be at or below the statewide average of the percentage of long-stay, high risk residents with a pressure ulcer. The measure could be met with any four of the most recent six quarters examined.

d. The NF shall be at or below the statewide average of the percentage of long stay residents who are physically restrained. The measure could be met with any four of the most recent six quarters examined.

e. The NF shall be at or below the statewide average of the percentage of long stay residents who experience one or more falls with a major injury. The measure could be met with any four of the most recent six quarters examined.

f. These two additional measures are also included in the NF Quality Improvement Initiative:

i. The CoreQ Long-Stay Resident Experience Questionnaire and the CoreQ Long-Stay Family Questionnaire will measure NF resident and family satisfaction across all NFs. It will provide the average CoreQ satisfaction rating for each NF, which combines the satisfaction scores of both the long-stay residents and their family members. There will be benchmarks of the average resident score and the CoreQ satisfaction rating that the NF shall meet or exceed.

ii. This performance measure will ask the NF whether the facility is using INTERACT, Advancing Excellence Tools, TrendTracker or another validated tool to measure 30-day re-hospitalizations and overall hospital utilization. The NF shall directly provide a response of yes or no.

5. While the following are general provisions in the AWQP policy, they will be outlined in guidance and procedures and issued by the State prior to the implementation of the NF Quality Improvement Initiative:

- In cooperation with the State, the Contractor shall be responsible for notifying NFs, which fail to meet any four out of seven performance quality measures, that no new MLTSS enrollments for their members will be forthcoming; and for MLTSS members currently residing in the NF, the Contractor will enter into single case agreements.
- The Contractor may not contract with a NF for new MLTSS admissions that does not meet any four out of seven performance quality measures.
- The Contractor shall focus their NF care management on working with the NFs to improve their performance quality measures.
- The NF shall be able to appeal to the State for reconsideration of network exclusion. Exceptions may be made by the State for NFs that have a population with disproportionate needs, etc.
    - To meet geographic access
    - To maintain family cohesion
    - Because of a NF appeals network exclusion due to the unique features and population of that NF
- The NF shall be able to enter into a corrective action plan with the State if it doesn't meet any four of the seven measures
- Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) claims within the following timeframes:

    1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;
    2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. Compliance with federal and state laws and regulations

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.

3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. Approval of provider contracts/subcontracts and amendments

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. Effective date

This provider contract/subcontract shall become effective only when the Contractor's agreement with the State takes effect.

E. Non-renewal/termination of provider contract/subcontract

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor's network. If the termination was "for cause," as related to fraud, waste, and abuse, the Contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. Enrollee-provider communications

1. The Contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/ subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractor s shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or

b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the Contractor to reimburse providers/subcontractors for benefits not covered.

G. Restriction on termination of provider contract/ subcontract by contractor

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of the Contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. Termination of provider contract/subcontract – state

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law., including laws involving fraud, waste, and abuse.

I. Non-discrimination

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are “qualified individuals with a disability” covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A “qualified individual with a disability” as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to the Contractor a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to the Contractor copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. Obligation to provide services after the period of the contractor contractor's insolvency and to hold enrollees and former enrollees harmless

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. Inspection

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. Record maintenance

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. Record retention and provider/subcontractor documentation requirements

Provider/Subcontractor Documentation Requirements - The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8. The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A 30:4D-12(e) and N.J.A.C. 10:49- 5.5(a)13.i. through iv. may apply to these documentation requirements.

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed. If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality. If an enrollee disenrolls from the Contractor, the Provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

Compliance with Specific Requirements - Providers/subcontractors must comply with the following requirements:

1) Medical supplies and DME:

a) Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:

i) The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;

ii) A detailed description of the specific supplies and/or equipment prescribed;

(1) For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;

iii) The length of time the medical equipment items or supplies are required;

iv) A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and

v) The prescriber's printed name, address and signature.

2) Orders for laboratory tests:

a) All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.

b) If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:

i) In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;

ii) A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or

iii) Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.

c) Standing orders shall be:

i) Patient specific, and not blanket requests from the physician or licensed practitioner;

ii) Medically necessary and related to the diagnosis of the recipient; and

iii) Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.

d) The laboratory must ensure that all orders described in (a) through (c) above contain the following information:

i) The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;

ii) The patient's name or unique patient identifier;

iii) The sex (if known) and date of birth of the patient;

iv) The specific test(s) to be performed;

v) The source of the specimen, when appropriate;

vi) The date and, if appropriate, time of specimen collection;

vii) For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;

viii) For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;

ix) Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

e) All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

f) The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

g) All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.

h) If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

3) Services Provided by a Psychologist

a) Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).

b) For the initial examination, the record shall include, as a minimum, the following:

i) Date(s) of service rendered;

ii) Signature of the psychologist;

iii) Chief complaint(s);

iv) Pertinent historical, social, emotional, and additional data;

v) Reports of evaluation procedures undertaken or ordered;

vi) Diagnosis; and

vii) The intended course of treatment and tentative prognosis.

c) For subsequent progress notes made for each Medicaid/ NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:

i) Date(s) and duration of service (for example, hour, half-hour);

ii) Signature of the psychologist;

iii) Name(s) of modality used, such as individual, group, or family therapy;

iv) Notations of progress, impediments, or treatment complications; and

v) Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

vi) One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):

(1) Symptoms and complaints;
(2) Affect;
(3) Behavior;
(4) Focus topics; and
(5) Significant incidents or historical events.

4) Mental Health Services Provided by an Independent Clinic

a) An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:

i) Evaluates the beneficiary's mental condition;

ii) Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;

iii) Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment
needs; and

iv) Is made part of the beneficiary's records.

v) The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

b) A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:

i) A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.

(1) Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;

ii) A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

iii) The type of personnel that will be furnishing the services; and

iv) A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

c) The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

i) This documentation, at a minimum, shall consist of:

(1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;

(2) the date and time that services were rendered;

(3) The duration of services provided;

(4) The signature of the practitioner or provider who rendered the services;

(5) The setting in which services were rendered; and

(6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

d) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

e) The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

f) Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.

i) The periodic review shall determine:

(1) The beneficiary's progress toward the treatment objectives;

(2) The appropriateness of the services being furnished; and

(3) The need for the beneficiary's continued participation in the program

ii) Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

5) APN Services:

a) The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

b) Documentation of services performed by the APN shall include, as a minimum:

i) The date of service;

ii) The name of the beneficiary;

iii) The beneficiary's chief complaint(s), reason for visit;

iv) Review of systems;

v) Physical examination;

vi) Diagnosis;

vii) A plan of care, including diagnostic testing and treatment(s);

viii) The signature of the APN rendering the service; and

ix) Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:

i) Chief complaint(s);

ii) A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;

iii) Pertinent medical history;

iv) Pertinent family and social history;

v) A complete physical examination;

vi) Diagnosis; and

vii) Plan of care, including diagnostic testing and treatment.

d) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

i) In an office or residential health care facility:

(1) The beneficiary's chief complaint(s), reason for visit;

(2) Pertinent medical, family and social history obtained;

(3) Pertinent physical findings;

(4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and

(5) A diagnosis.

ii) In a hospital or nursing facility setting:

(1) An update of symptoms;

(2) An update of physical symptoms;

(3) A resume of findings of procedures, if any done;

(4) Pertinent positive and negative findings of lab, X-ray or any other test;

(5) Additional planned studies, if any, and the reason for the studies;
And

(6) Treatment changes, if any.

e) To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:

i) Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;

ii) Performed a physical examination, as appropriate;

iii) Confirmed or revised the diagnosis; and

iv) Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

f) The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.

g) For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:

i) A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.

ii) A developmental and nutritional assessment.

iii) A complete, unclothed, physical examination to also include the following:

(1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and

(2) Vision, dental and hearing screening;

iv) The assessment and administration of immunizations appropriate for age and need;

v) Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

vi) Mandatory referral to a dentist for children age twelve months or older;

vii) The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines.

viii) Health education and anticipatory guidance; and

ix) An offer of social service assistance; and, if requested, referral to a county welfare agency.

h) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

i) The beneficiary's chief complaint(s), reason for visit;

ii) Pertinent medical, family and social history obtained;

iii) Pertinent physical findings;

iv) The procedures, if any performed, with results;

v) Lab, X-ray, ECG, etc., ordered with results; and

vi) Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

6) Physician Services

a) Physician Recordkeeping; general

i) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

ii) The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

iii) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

iv) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

v) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b) Minimum documentation; initial visit; new patient

i) The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit--New patient:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family and social history;

(5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;

(6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;

(7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and

(8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

c) Minimum documentation; established patient

i) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

(1) In an office or Residential Health Care Facility:

(a) The purpose of the visit;

(b) The pertinent physical, family and social history obtained;

(c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;

(d) Procedures performed, if any, with results

(e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

(f) Prognosis and diagnosis.

d) Minimum documentation; home visits and house calls

i) For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

e) Minimum documentation; hospital or nursing facility

i) In a hospital or nursing facility, documentation shall include:

(1) An update of symptoms;

(2) An update of physical findings;

(3) A resume of findings of procedures, if any are applicable;

(4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;

(5) Any additional planned studies, if any, including the reasons for any studies; and

(6) Treatment changes, if any.

f) Minimum documentation; hospital discharge medical summary

i) When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.

ii) The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.

g) Minimum documentation; mental health services

i) For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:

(1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;

(2) The date and the time services were rendered;

(3) The duration of services provided, for example, one hour, or one half hour;

(4) The signature of the physician who rendered the service;

(5) The setting in which services were rendered;

(6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

(7) Notations of progress, impediments, treatment, or complications; and

(8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

ii) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or

duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

7) Pharmaceutical services

a) Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.

b) Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABPVAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.

c) Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.

d) Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.

e) Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and nonlegend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address and registration number.

N. Data reporting

The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. Disclosure

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

P. Limitations on collection of cost-sharing

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. Indemnification by provider/subcontractor

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. Confidentiality

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department’s prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider’s/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. Clinical laboratory improvement

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. Fraud, waste, and abuse

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the Contractor's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors, that for purposes of audits of inpatient hospital admissions by DMAHS or MFD or its subcontractors, MCG criteria will be applied.

7. Hospital Acquired Conditions and Provider–Preventable Conditions. All Network hospitals agrees to comply with the Contractors no payment policy and quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions according to federal regulations at CFR 434,438, and 447. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html. The Contractor's specific policies that have been prior approved by DMAHS are included in the Contractor's Provider Manual.

U. Third party liability

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to

the appropriate third party before submitting a claim to the Contractor.

3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.

a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

d. The claim is for a child who is in a DCP&P supported out of home placement.

e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.

a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

d. The provider/subcontractor agrees to cooperate with the Contractor's and the State's efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.

V. Enrollee protections against liability for payment

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family Member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

d. The service is not a trauma service covered by the provisions of NJAC 11:24- 6.3(a)3.i; and

e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or the Contractor for the service; or

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

W. Off-shore

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

X. Further delegation of any delegated activity is not permissible.