Aetna Better Health® of New Jersey
PO Box 818003
Cleveland, OH 44181-8003

Summary of EPSDT/PDN Services

EPSDT/PDN services are covered for all eligible beneficiaries under 21 years of age who reside in the community and whose medical condition and treatment plan justify the need for private duty nursing. It is important to note that these services are provided exclusively in community settings and are not available in hospital inpatient or nursing facility environments.

Provider Specifications

Private Duty Nursing services must be delivered by a registered nurse (RN) or a licensed practical nurse (LPN) under the direction of the enrollee's physician. These services should be provided by licensed home health agencies, voluntary non-profit homemaker agencies, private employment agencies, and temporary-help service agencies that are approved by the Division of Medical Assistance and Health Services (DMAHS) or the Managed Care Organization (MCO). Accreditation for these agencies must be maintained both initially and on an ongoing basis.

Billing Information

The following HIPAA-compliant billing codes should be used for Private Duty Nursing services:

- T1000_UA: Combination of LPN and RN
- T1002_UA: RN
- T1003_UA: LPN

The unit of service is defined as 15 minutes.

Please note, once a determination is made and authorization has been provided, we are no longer able to make changes to the authorization; including, changes to hours and/or alternating S9123/S9124 codes for services already rendered. This information must be submitted with the initial authorization request.

For more information on prior authorizations, please review the Prior Authorization Quick Guide.

Service Limitations

Private Duty Nursing services are subject to medical necessity as defined in the contract. For beneficiaries aged 21 and above, these services are only covered for those enrolled in MLTSS or the DDD Supports Plus program. When private duty nursing services are being funded by another source, the benefit will supplement those hours up to a maximum of 16

hours per day, provided that the services are medically necessary and the cost is less than institutional care.

Thank you for your continued commitment to providing high-quality care to our members. If you have any questions or require additional information, please do not hesitate to contact your provider relations representative.

Prior Authorization Quick Guide

How to request prior authorization

- Fax prior authorization request to: *1-844-797-7601*
- Confirm status of prior authorization, call: **1-855-232-3596**, prompt 6 and 5.
- Find forms online: *AetnaBetterHealth.com/newjersey/providers/materials-forms.html*
- Under Resources, click Prior Authorization
  - BH Prior Authorization Request Form
- *AetnaBetterHealth.com/content/dam/aetna/medicaid/new-jersey-medicaid/provider/pdf/ aetna_bh_prior_auth_form.pdf*
- Fax UM prior authorization IP/CCR to **959-333-2850**
- Submit through the Availity Portal: **https://apps.availity.com/availity/web/public.elegant.login**

Please submit the following with each authorization request:

- Member Information (correct and legible spelling of name, ID number, date of birth, etc.)
- Diagnosis code(s)
- Treatment or Procedure Codes-Number of Units being requested
- Requesting and servicing provider information—including NPI numbers, addresses and fax numbers which correspondence(s) regarding authorization request can be sent
- Include an office/department contact name and telephone number
- Anticipated start and end dates of service(s) if known
- Description of the service requested and reason for request
- All supporting relevant clinical documentation to support the medical necessity in legible format

If a provider has written member consent, the provider may file a formal appeal on behalf of a member in writing, with Aetna Better Health® of New Jersey within sixty (60) calendar days from the Aetna Better Health® of New Jersey Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

All written appeals should be sent to the following address:

Aetna Better Health® of New Jersey
P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181

Request on prior authorization

All out of network services must be authorized. Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Decision	Decision/notification timeframe
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from
Urgent pre-service denial	Within 24 hours of receipt of necessary information, but no later than 72 hours from
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed
Continued / extended services approval (non-ED/acute inpatient)	Within one business day of receipt of necessary information
Continued / extended service denial (non-ED/acute inpatient)	Within one business day of receipt of necessary information
Post-service approval of a service for which no pre-service request was received	Within 30 calendar days from receipt of the necessary information
Post-service denial of a service for which no pre-service request was received	Within 30 calendar days from receipt of the necessary information

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. All out of network services must be authorized except for emergency services.

Provider inquiries

Providers may contact us at **1-855-232-3596** from 8 AM and 5 PM, Monday through Friday. You can also email **AetnaBetterHealth-NJ-ProviderServices@Aetna.com** for any and all questions including checking on the status of an inquiry, complaint, grievance and or appeal that has been field on behalf of a member. Our Provider Services Staff will respond within 48 business hours.

Electronic Visit Verification (EVV)

All claims submitted for designated home health services must have supporting EVV data and license/ certification numbers included on applicable claims. Failure to comply may result in limiting referrals or transition of existing members to providers who have achieved compliance. Providers can submit the EVV **authorization form** to the care management department by faxing to **1-860-907-4598**.

If you have questions regarding EVV integration requirements, please contact **HHAeXchange Support** or contact the NJ specific Support Line at **(866) 245-8337**. You may also inform Aetna of your status with this requirement by emailing **AetnaEVVCompliance@Aetna.com**.