Aetna Better Health® of New Jersey
Provider Orientation Kit Overview

Below is a description of the documents included in the Provider Orientation Kit.

Provider Welcome Letter	The Welcome Letter welcomes providers to our network.
Provider Quick Reference Guide	The Provider Quick Reference Quick Reference Guide is a snap shot of the Provider Manual.
Contact List	The Contact List is a document comprised of our contact information as well as our vendors.
Provider Dispute Form	The Provider Dispute Form is used in the event a provider is dissatisfied with us.
Identifying & Reporting Abuse, Neglect, and Exploitation of an Enrollee Training	The Abuse, Neglect, and Exploitation training document provides important resources and information pertaining to identifying and reporting abuse.
Fraud, Waste & Abuse Training	The Fraud, Waste, and Abuse (FWA) training document was created to help us detect, report, and prevent fraud, waste, and abuse. Our training includes CMS requirements surrounding provider FWA.
Cultural Competency Training	The Cultural Competency training document assists the provider in understanding the social, linguistic, moral, intellectual, and behavioral characteristics of our enrollee.
Access & Availability Standards	The Access & Availability Standards document outlines the requirements a provider must follow when scheduling appointments with enrollees.
Medical Authorization Form	The Medical Authorization Form is used by providers when asking for medical service authorization.
Additional forms are available on our site at http://www.aetnabetterhealth.com/newjersey/	

AETNA BETTER HEALTH® OF NEW JERSEY

3 Independence Way, Suite 400
Princeton, NJ 08540

Aetna Better Health of New Jersey
Provider Relations
Phone: 1-855-232-3596
Toll Free Fax: 1-844-219-0223
www.aetnabetterhealth.com/newjersey

Dear Contracted Provider:

Aetna Better Health® of New Jersey is proud to have been chosen by the Division of Medical Assistance and Health Services (DMAHS) to participate in the State of New Jersey's Medicaid Managed Care Program. Aetna Better Health of New Jersey will arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

The goals of Aetna Better Health of New Jersey's plan are to:

- Create a person-centered care management approach to improve the quality of care members receive.
- Comprehensively manage benefits across the continuum of care, including social and community services.
- Integrate services for all physical, behavioral, long-term care, and social needs.

Aetna Better Health of New Jersey is offered in the following counties:

- Bergen
- Camden
- Essex
- Hudson
- Middlesex
- Passaic
- Somerset
- Union

Our network in these areas is made up of doctors, hospitals, pharmacies, and providers of long-term and community-based services and supports. Care managers and care teams will help members receive the services that they need.

Our ability to serve our members well is dependent upon the quality of our provider network. Our providers are the cornerstone of our service delivery approach. By joining our network you help us achieve our goal of providing our members with access to high quality health care services.

We have assembled the enclosed Provider Orientation Kit to help acquaint you and your staff with the Aetna Better Health of New Jersey plan. We hope you find this information to be useful. Should you have any questions or concerns, please contact us directly at: 1-855-232-3596 or via email at AetnaBetterHealth-NJ-ProviderServices@AETNA.com

Sincerely,

Provider Relations Staff
Aetna Better Health of New Jersey

PARTICIPATING PROVIDER QUICK REFERENCE GUIDE

Participating Provider Quick Reference Guide
This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Aetna Better Health of New Jersey Provider Manual located at:
www.aetnabetterhealth.com/newjersey

Eligibility Verification

Please contact us at 1-855-232-3596 or log into our Secure Web Portal to verify eligibility.

Tools & Resources

Website
- Provider Manual
- Member Handbook
- 24/7 Secure Web Portal (See below for full details)
- Clinical Guidelines
- Forms
- Provider Education

Secure Web Portal (24/7)
The Secure Web Portal allows participating providers to perform a variety of tasks such as:
- Verifying eligibility
- Download various forms used to submit authorization requests
- Submission and verification of prior authorization requests, including status checks
- Review prior authorization requirement search tool
- Checking claims status
- Pull PCP roster of assigned members

Participating providers must complete our user agreement in order to access the Secure Web Portal.

Claims

Claim Inquires
Participating providers may review the status of a claim by checking the Secure Provider Web Portal located on our website at www.aetnabetterhealth.com/newjersey or by calling our Claims Investigation and Research Department (CICR) at 1-855-232-3596.

Claims & Resubmissions
Aetna Better Health of New Jersey requires clean claims submissions for processing.
To submit a clean claim, the participating provider must submit:
- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Participating providers are required to submit valid, current HIPAA compliant codes that most accurately identify the member's condition or service(s) rendered.

Please note :
- 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 dates of services, whichever is later.

Electronic Claims Submission
Aetna Better Health of New Jersey encourages participating providers to electronically submit claims through Emdeon. Please use the following Payer ID when submitting claims to Aetna Better Health of New Jersey:
- Payer ID# 46320

For electronic resubmissions, participating providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

Paper Claims Submissions and or Resubmissions
Please use the following address when submitting claims to Aetna Better Health of New Jersey:

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

For resubmissions, please stamp or write one of the following on the paper claims:
- Resubmission, Rebill, Corrected Bill, Corrected or Rebilling

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

Claim Resubmission
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:
- Use the Resubmission Form located on our website.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Claim Resubmission Cont.
Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to be denied as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the resubmission, reconsideration and or the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Provider 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

Prior Authorizations

How to request Prior Authorizations
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 at 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 Secure Provider 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 Provider Web Portal, please review Chapter 4 of the Provider Manual. If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-855-232-3596.

Requesting Prior Authorization
When requesting prior authorization, please provide the following:

- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service (DOS)

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- For post stabilization services, hospitals may request prior authorization by calling 1-855-232-3596.

Online Provider & Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our online search tool located on our website at:
www.aetnabetterhealth.com/newjersey

Please note: Laboratories and radiology participating providers are included in the online search tool.

Requesting Prior Authorization Cont.

Important Note:

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

Decision/Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval	Within twenty four (24) hours of receipt of necessary information, but no later than 72 hours from receipt of request
Urgent pre-service denial	Within twenty four (24) hours of receipt of necessary information, but no later than 72 hours from receipt of request
Non-urgent pre-service approval	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
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
Continued / extended services approval (non-ED/acute inpatient)	Within one (1) business day of receipt of necessary information
Continued / extended service denial (non-ED/acute inpatient)	Within one (1) business day of receipt of necessary information
Post-service approval of a service for which no pre-service request was received.	Within thirty (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

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 Services 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 Services 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 Services
3 Independence Way, Suite 400
Princeton, NJ 08540

Please note this is for all medical type of providers including (HCBS, MLTSS, Ancillary, Hospital etc.) Please contact DentaQuest 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.

Provider Inquires

Providers may contact us at 1-855-232-3596 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, or email us 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 Services Staff will respond within 48 business hours.

Contact Information

(For a complete list of contact information, please review the Provider Manual)

Aetna Better Health of New Jersey	1-855-232-3596, TTY 711 (follow the prompts in order to reach the appropriate departments e., Care Management, Member Services, Provider Services, Behavioral Health/Mental Health etc.)
Aetna Better Health of New Jersey Compliance Hotline (Reporting Fraud, Waste or Abuse)	1-855-282-8272 (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 **(**24 hours / 7 days per week)
DentaQuest- Dental Vendor	1-855-225-1727
March Vision- Vision Vendor	1-888-493-4070, TTY 1-877-627-2456
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, TTY 711 (Aetna Better Health of New Jersey) 8 a.m.-5 p.m. EST Monday-Friday
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, TTY 711 and follow the prompts for more information.
Durable Medical Equipment- DME	Please see our online provider search tool for details surrounding DME providers. www.aetnabetterhealth.com/newjersey
Lab – Quest Diagnostics https://www.questdiagnostics.com/home.html	Please visit the website for additional information.

Sample ID Cards (Front & Back):

Front of "A"


AETNA BETTER HEALTH®

aetna

NJ FamilyCare A

Member ID# XXXXXXXXXXXX Date of Birth 00/00/0000

Member Name Last Name, First Name Sex X

PCP Last Name, First Name

PCP Phone 000-000-0000 Effective Date 00/00/0000

COPAYS

PCP $0 Brand $0 RxBIN: 610591

ER $0 Generic $0 RxPCN: ADV

RxGRP: RX8829

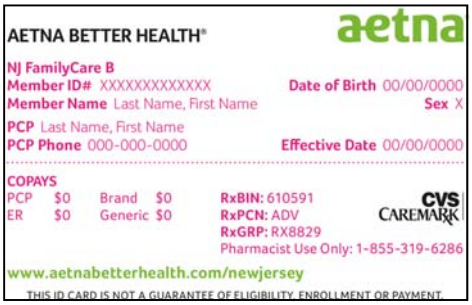
Pharmacist Use Only: 1-855-319-6286

CVS CAREMARK

www.aetnabetterhealth.com/newjersey

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Front of "B"


AETNA BETTER HEALTH®

aetna

NJ FamilyCare B

Member ID# XXXXXXXXXXXX Date of Birth 00/00/0000

Member Name Last Name, First Name Sex X

PCP Last Name, First Name

PCP Phone 000-000-0000 Effective Date 00/00/0000

COPAYS

PCP $0 Brand $0 RxBIN: 610591

ER $0 Generic $0 RxPCN: ADV

RxGRP: RX8829

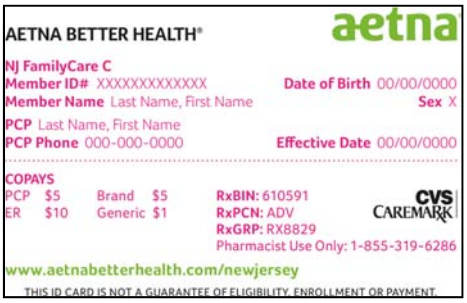
Pharmacist Use Only: 1-855-319-6286

CVS CAREMARK

www.aetnabetterhealth.com/newjersey

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Front of "C"


AETNA BETTER HEALTH®

aetna

NJ FamilyCare C

Member ID# XXXXXXXXXXXX Date of Birth 00/00/0000

Member Name Last Name, First Name Sex X

PCP Last Name, First Name

PCP Phone 000-000-0000 Effective Date 00/00/0000

COPAYS

PCP $5 Brand $5 RxBIN: 610591

ER $10 Generic $1 RxPCN: ADV

RxGRP: RX8829

Pharmacist Use Only: 1-855-319-6286

CVS CAREMARK

www.aetnabetterhealth.com/newjersey

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Front of "D"


AETNA BETTER HEALTH®

aetna

NJ FamilyCare D

Member ID# XXXXXXXXXXXX Date of Birth 00/00/0000

Member Name Last Name, First Name Sex X

PCP Last Name, First Name

PCP Phone 000-000-0000 Effective Date 00/00/0000

COPAYS

PCP $5 Rx $5 RxBIN: 610591

ER $35 Rx >34 days $10 RxPCN: ADV

After hours $10 RxGRP: RX8829

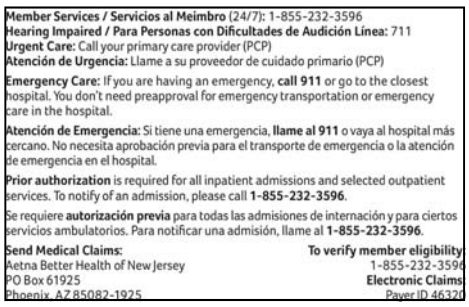
Pharmacist Use Only: 1-855-319-6286

CVS CAREMARK

www.aetnabetterhealth.com/newjersey

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Back of ALL


Member Services / Servicios al Meimbro (24/7): 1-855-232-3596

Hearing Impaired / Para Personas con Dificultades de Audición Línea: 711

Urgent Care: Call your primary care provider (PCP)

Atención de Urgencia: Llame a su proveedor de cuidado primario (PCP)

Emergency Care: If you are having an emergency, **call 911** or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.

Atención de Emergencia: Si tiene una emergencia, **llame al 911** o vaya al hospital más cercano. No necesita aprobación previa para el transporte de emergencia o la atención de emergencia en el hospital.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call **1-855-232-3596**.

Se requiere **autorización previa** para todas las admisiones de internación y para ciertos servicios ambulatorios. Para notificar una admisión, llame al **1-855-232-3596**.

Send Medical Claims:
Aetna Better Health of New Jersey
PO Box 61925
Phoenix, AZ 85082-1925

To verify member eligibility:
1-855-232-3596
Electronic Claims
Payer ID 46320

CONTACT INFORMATION

Providers who have additional questions can refer to the following Aetna Better Health of New Jersey phone numbers:

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

Aetna Better Health of New Jersey Department Fax Numbers	Fax Number
Member Services	1-844-679-6853
Provider Services & Provider Claim Disputes	1-844-219-0223
Care Management (includes behavioral health services)	1-860-975-1045
Medical Prior Authorization	1-844-797-7601
Pharmacy Prior Authorization	1-855-296-0323

Community Resource	Contact Information
State of New Jersey Quit Line	1-866-NJSTOP (1-866-657-8677) Website: http://njquitline.org/

CONTACT INFORMATION

Providers who have additional questions can refer to the following Aetna Better Health of New Jersey phone numbers:

Contractors	Phone Number	Facsimile	Hours and Days of Operation
DentaQuest—Dental Vendor	1-855-225-1727	N/A	8 a.m.-5 p.m. EST Monday-Friday
Interpreter Services Language interpretation services, including: sign language, special services for the hearing impaired, oral translation, and oral interpretation.	Please contact our Member Services Department at 1-855-232-3596 (for more information on how to schedule these services in advance of an appointment)	N/A	24-hours-a-day, 7-days-a-week
March Vision	1-888-493-4070, TTY 1-877-627-2456	N/A	8 a.m.-5 p.m. EST Monday-Friday
Durable Medical Equipment-DME	Please see our online provider search tool for details surrounding DME providers. http://www.aetnabetterhealth.com/newjersey	N/A	N/A
Lab – Quest Diagnostics https://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.
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

Important Addresses	
Aetna Better Health of New Jersey (Provider Claim Disputes)	Aetna Better Health of New Jersey Provider Services Manager 3 Independence Way Suite 400 Princeton, NJ 08540
Aetna Better Health of New Jersey (Claims Submission & Resubmission)	Aetna Better Health of New Jersey P.O. Box 61925 Phoenix, AZ 85082-1925

CONTACT INFORMATION

Providers who have additional questions can refer to the following Aetna Better Health of New Jersey phone numbers:

Reporting Suspected 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)	1-888-9FRAUD (1-888-973-2835)		
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)		

Agency Contacts & Important Contacts			
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

AETNA BETTER HEALTH® OF NEW JERSEY

Participating Provider Dispute Form
Aetna Better Health of New Jersey

Mail and/ or fax dispute to:

Mail:

Aetna Better Health of New Jersey
Provider Relations Department
Attention: Provider Dispute
Grievance System Manager
3 Independence Way, Suite 400
Princeton, NJ 08540

Toll Free Fax:

1-860-975-3614

Provider Information (required)

Provider Name:	
Submitter's name:	
Provider Street Address:	
Provider City, State & ZIP	
Provider Phone Number:	

Member Information (required)

Member Name	
Member ID #	

Claim dispute - provide the following information:

Type of claim dispute (circle one)	**Corrected Claim or Resubmission**
Date(s) of Service	
Remittance Advice Date	
Amount Billed	
Amount Paid	
Claim Number(s)	

- 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 is later.

Please use the space below to **document a contractual dispute involving something other than a claim determination**; and to supply any other necessary information, along with your attachments, to enable a thorough reconsideration of all disputes.

_____

Signature of Sender Date

IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Definitions

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances (such as cruelty, recklessness, and malice in causing injury to others) are often considered by the courts in imposing more severe sentence than a typical sentence for similar offenses.

Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

Imminent danger is a condition which could cause serious or life-threatening injury or death.

Financial exploitation is when someone uses coercion, harassment or deception to misuse or steal a person's money or property.

Mandated Reporters are professionals who, in the ordinary course of their work and because they have regular contact with children, disabled persons, senior citizens, or other identified vulnerable populations, are required to report (or cause a report to be made) whenever financial, physical, sexual or other types of abuse have been observed or are suspected, or when there is evidence of neglect.

Neglect

Types of Neglect

- The intentional withholding of basic necessities and care
- Not providing basic necessities an care because of lack of experience, information , or ability

Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

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

Behaviors of Abusers (Caregiver and /or Family Member)

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Financial Exploitation

Examples of Financial Exploitation

- Caregiver, family member, or professional expresses 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

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 when placed in foster homes after normal agency business hours.

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 shall 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.

Reporting

Children

If the child is in immediate danger, call 911 as well as 1-877 NJ ABUSE (1-877-652-2873) or the Division of Youth and Family Services (DYFS) at 1-800-792-8610.

Within four (4) hours after the time the incident and/or event was first discovered by the staff.

- DODD Abuse/Neglect Hotline 1-866-313-6733

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.

Aetna Better Health's Compliance Hotline

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health.

- 1-855-282-8272

What Should be Reported?

Information the reporter should have ready to provide:

- 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)

Additional Resources

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf
- 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

NJ PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

Welcome!
We designed this training to assist you in helping Aetna Better Health of New Jersey detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions
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.

Criminal Fraud
Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code § 1347)

What Does That Mean?
Intentionally submitted false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse
Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste and abuse.
One of the primary differences is intent and knowledge.
Fraud requires the person to have an intent and obtain payment and knowledge that their actions are wrong.

Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

What are my responsibilities as a provider?

You are a vital part of an effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

First you are require to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.
Second you have a duty to the program to report any violations of laws that you may be aware of.
Third you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

A provider's best practice for preventing fraud, waste, and abuse is to (also applies to laboratories as mandated by 42 CFR 493):

- 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.

How Can I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, and polices.
- Ensure data/billing is both accurate and timely
    - Monitor claims for accuracy, ensuring coding reflects services provided.
- Verify information provided by you
    - Monitor medical records, ensuring documentation supports services rendered.
    - Perform regular internal audits.
    - Be on the lookout for suspicious activity.
    - Establish effective lines of communication with colleagues and staff members.
- Make sure you understand and follow Aetna Better Health of New Jersey's Polices and Procedures.
- Comply with Aetna Better Health of New Jersey's Compliance Program.
- Ensure polices and procedures are in place at your facility to address fraud, waste, and abuse.

Now that you know what fraud, waste and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste and abuse, and in 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 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.

Examples of Fraud, Waste, and Abuse

Billing for services and/or supplies that were never performed or provided.

- Billing for a higher-level treatment than was actually provided.
- Billing separately for services that are already included in the primary procedure.
- Health care provider not providing enough care or delaying needed care. This is done in order to maximize the health care provider's service funds.
- Billing for services or procedures that are not needed.
- Utilizing false or inflated diagnosis codes for encounter information to increase premiums.
- Writing scripts from brand name pharmaceuticals even though generic is stated in the plan formulary.
- Use of medical benefits by an unauthorized individual.

Reporting Fraud, Waste, 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: New Jersey Medicaid Fraud Division of the Office of the State Comptroller's Office (MFD), at 1-888-973-2835

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.

Laws You Need to Know About

<u>The False Claim Act (FCA)</u>
Prohibits:

- 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

<u>Anti-Kickback Statue</u>
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.

<u>Self-Referral Prohibition Statute (Stark Law)</u>
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.

<u>Exclusions</u>
No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General. (42 U.S.C. § 1395(e0(1), 42 C.F.R. §1001.1901)

<u>HIPAA</u>
Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry. Safeguards to prevent unauthorized access to protected health care information. As a provider who has access to protected health care information, you are responsible for adhering to HIPAA.

<u>Consequences of Committing Fraud, Waste, or Abuse</u>
The following are potential penalties. The actual consequences depends on the violation.

- Civil Money Penalties
- Criminal Convictions/Fines
- Imprisonment
- Loss of Provider License
- Exclusion from Federal health Care Program

<u>Additional References</u>

- Aetna Better Health of New Jersey Provider Manual
- New Jersey State Administrative Codes
- Code of Federal Regulations (C.F.R.), Title 21

CULTURAL COMPTENCY

To improve patient health and build health communities, providers need to recognize and address the unique culture, language and health literacy of diverse patients and communities.

Aetna Better Health® of New Jersey promotes cultural competency and offers sensitivity education and training in an effort to help eliminate health care inequalities. We offer free online cultural competency courses that providers and their staff can take advantage of to help with daily interactions with patients.

To access Aetna Better Health's online cultural competency courses, please visit: http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Our Quality Interactions® course series is designed to help our providers to:

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

Additional provider-focused cultural competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: http://www.hrsa.gov/culturalcompetence/index.html

Furthermore, the Physician's Practical Guide to Culturally Competent Care offered by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) at: https://cccm.thinkculturalhealth.hhs.gov/GUIs/GUI_AboutthisSite.asp is a self-directed training course for providers with a specific interest in cultural competency in the provision of care. With growing concerns about racial and ethnic disparities in health and about the need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern. To train providers to care for diverse populations, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) has commissioned the Cultural Competency Curriculum Modules (CCCMs). The modules, encompassed in "*A Physician's Practical Guide to Culturally Competent Care,*" will equip providers with competencies that will enable them to better treat the increasingly diverse U.S. population.

WHAT IS CULTURAL COMPETENCY?

Is a set of congruent behaviors, attitudes, and polices that come together in a system, agency or among processionals that enables effective work In cross – cultural situations.

Things to remember:
Providers and their office staff are responsible for ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all patients.

This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure that patients are effectively receiving understandable, respectful and timely care compatible with their cultural health beliefs, practices and preferred languages from all staff members. Providers should also honor member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds.

Providers are prohibited from segregating DMAHS members from other persons receiving services. Examples of prohibited practices, based on race, color, creed, religion, sex, age, national origin, ancestry, marital status, sexual preference, income status, program membership or physical or mental disability, includes, but may not be limited to, the following:

- Denying or not providing to a member any covered service or access to a facility.
- Providing to a member a similar covered service in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large.
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.
- Assigning times or places for the provision of services.
- Closing a provider panel to members but not to other patients.

When treating a person with a disability remember to:

- talk to the patient, not someone who accompanies them.
- avoid making assumptions.
- ask, "How can I help you?" and respect the answer.
- ensure that educational materials are easily accessible.
- allow time for history taking & exam.

When treating a person who is blind or visually impaired, provide written material

- in an auditory format.
- on computer disc.
- in Braille or large print.

When treating a person who is deaf or hard of hearing:

- ask how to best communicate.
- provide written educational material.
- look at the person while speaking.
- avoid shouting.
- minimize background noise.
- provide interpreter, if necessary for effective communication.
- patients cannot be charged for interpretation
- family members should not be pressured to interpret to save time or expense.

When treating a person who is a wheelchair user:

- provide access to exam areas.
- provide assistance if necessary (for a full and complete exam, even if it requires more time or assistance).
- respect personal space, including wheelchairs & assistive devices.
- avoid propelling wheelchair unless asked.
- obtain adjustable exam tables for your facility, if possible.

Tools:

- Interpreter Services- Aetna Better Health of New Jersey offers twenty-four (24) hour interpreter access available through our call center to communicate with those members with communication-affecting disorders.
- NJ Relay System– The NJ Relay System is available by dialing 711.

Resources:

Pertinent Articles on Disability Issues and Research

1. Health Resources, and Service Administration (HRSA), http://www.hrsa.gov/culturalcompetence/index.html
2. World Institute on Disability (WID), http://wid.org/access-to-health-care/health-access-and-long-term-services/access-to-medical-care-adults-with-physical-disabilities/?searchterm=Adults with Physical Disabilities
3. U.S. Department of Health & Human Services (HHS), Office of Minority Health (OMH), https://cccm.thinkculturalhealth.hhs.gov/GUIs/GUI_AboutthisSite.asp
4. U.S. Department of Health and Human Services (HRSA), http://www.hrsa.gov/

AETNA BETTEE HEALTH OF NEW JERSEY ACCESS AND APPOINTMENT AVAILABILITY STANDARDS

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of and the need for the services.

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
Lab and Radiology Services	N/A	Within forty-eight (48) hours	N/A	Within three (3) weeks	N/A

1) Non-symptomatic office visits will include but will not be 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	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Children 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
Supplemental Security Income (SSI) and New Jersey Care (ABD & 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.

Office Waiting Time

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, 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 if 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 will 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 will 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 where 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 after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Telephone Accessibility Standards Cont.

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

- Answering the member telephone inquiries on a timely basis.
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- 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 for noncompliant individuals who are mentally deficient.
- 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, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations.
    - Instructs the caller to leave a message for the provider.
- No answer;
- Listed number no longer in service;
- Provider no longer participating in the contractor's network;
- On hold for longer than five (5) minutes;
- Answering Service refuses to provide information for survey;
- Telephone lines persistently busy despite multiple attempts to contact the provider.

Provider 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 less 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 Services 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.

AETNA BETTER HEALTH®

Prior Authorization Form
Phone: 1-855-232-3596
Fax: 1-844-797-7601

Date of Request: _____

For urgent requests (required within 24 hours), call Aetna Better Health of New Jersey at 1-855-232-3596

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____Physician Name: _____

Other Insurance: _____ Gender (circle one): **F** **M**

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider	**Place of Service or Facility Name**
Name: _____	Name: _____
Address: _____	Address: _____
Telephone #: _____	Telephone #: _____
Fax #: _____	Fax #: _____
Specialty: _____	Specialty: _____
National Provider Identification (NPI): _____	National Provider Identification (NPI): _____
Contact Person: _____	Contact Person: _____

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis (ICD-9 Code(s)): _____

_____

Procedure / Test Requested (CPT Code(s)): _____

_____

Date of Appointment or Service: _____ **Number of Visits Required:** _____

Type of Procedure (circle one): Inpatient Outpatient In Office

Other Clinical Information - Include clinical notes, lab and X-ray reports, etc. (For procedures, please attach additional pages as necessary.): _____

www.aetnabetterhealth.com/newjersey