AETNA BETTER HEALTH®
d/b/a Aetna Better Health of New Jersey

Aetna Better Health of New Jersey
Provider Manual

Contact Information:
Website: www.aetnabetterhealth.com/newjersey
Provider Services Department: 1-855-232-3596
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER 1: Introduction To Aetna Better Health® of New Jersey</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome ..................................................................................</td>
<td>7</td>
</tr>
<tr>
<td>Aetna Medicaid and Schaller Anderson ......................................</td>
<td>7</td>
</tr>
<tr>
<td>About Aetna Better Health of New Jersey ..................................</td>
<td>7</td>
</tr>
<tr>
<td>Experience and Innovation .....................................................</td>
<td>7</td>
</tr>
<tr>
<td>Meeting the Promise of Managed Care .......................................</td>
<td>7</td>
</tr>
<tr>
<td>About the New Jersey Medicaid Managed Care Program ................</td>
<td>8</td>
</tr>
<tr>
<td>About the Medicaid Managed Care Program ..................................</td>
<td>8</td>
</tr>
<tr>
<td>Disclaimer ...............................................................................</td>
<td>8</td>
</tr>
<tr>
<td>Aetna Better Health of New Jersey Policies and Procedures........</td>
<td>8</td>
</tr>
<tr>
<td>Eligibility ............................................................................</td>
<td>9</td>
</tr>
<tr>
<td>Model of Care .........................................................................</td>
<td>9</td>
</tr>
<tr>
<td>About this Provider Manual ...................................................</td>
<td>9</td>
</tr>
<tr>
<td>About Patient-Centered Medical Homes (PCMH) .......................</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 2: CONTACT INFORMATION ..............................................</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services Department Overview ....................................</td>
<td>12</td>
</tr>
<tr>
<td>Provider Orientation .............................................................</td>
<td>13</td>
</tr>
<tr>
<td>Interested Providers ..................................................................</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 3: PROVIDER SERVICES DEPARTMENT ..................................</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Orientation ..................................................................</td>
<td>13</td>
</tr>
<tr>
<td>Interested Providers ..................................................................</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 4: PROVIDER RESPONSIBILITIES &amp; IMPORTANT INFORMATION ..........</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Responsibilities Overview .......................................</td>
<td>13</td>
</tr>
<tr>
<td>Unique Identifier/National Provider Identifier .......................</td>
<td>14</td>
</tr>
<tr>
<td>Appointment Availability Standards .........................................</td>
<td>14</td>
</tr>
<tr>
<td>Telephone Accessibility Standards ...........................................</td>
<td>15</td>
</tr>
<tr>
<td>Covering Providers ....................................................................</td>
<td>16</td>
</tr>
<tr>
<td>Verifying Member Eligibility ..................................................</td>
<td>16</td>
</tr>
<tr>
<td>Secure Web Portal .....................................................................</td>
<td>17</td>
</tr>
<tr>
<td>Member Care Web Portal ..........................................................</td>
<td>17</td>
</tr>
<tr>
<td>Preventive or Screening Services .............................................</td>
<td>18</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse ...............................................</td>
<td>18</td>
</tr>
<tr>
<td>Laboratory and Radiology Results .............................................</td>
<td>18</td>
</tr>
<tr>
<td>Educating Members on their own Health Care .............................</td>
<td>18</td>
</tr>
<tr>
<td>Emergency Services ..................................................................</td>
<td>18</td>
</tr>
<tr>
<td>Urgent Care Services ..................................................................</td>
<td>19</td>
</tr>
<tr>
<td>Primary Care Providers (PCPs) ...................................................</td>
<td>19</td>
</tr>
<tr>
<td>Specialty Providers ....................................................................</td>
<td>19</td>
</tr>
<tr>
<td>Specialty Providers Acting as PCPs ...........................................</td>
<td>20</td>
</tr>
<tr>
<td>Self-Referrals/Direct Access .....................................................</td>
<td>20</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) Providers ....................................</td>
<td>20</td>
</tr>
<tr>
<td>Home and Community Based Services (HCBS) ..............................</td>
<td>20</td>
</tr>
<tr>
<td>Home Delivered Nutrition Program Providers ..............................</td>
<td>21</td>
</tr>
<tr>
<td>Supportive Living Facilities .....................................................</td>
<td>21</td>
</tr>
<tr>
<td>Out of Network Providers ..........................................................</td>
<td>22</td>
</tr>
<tr>
<td>Second Opinions .......................................................................</td>
<td>22</td>
</tr>
<tr>
<td>Provider Requested Member Transfer ..........................................</td>
<td>22</td>
</tr>
<tr>
<td>Medical Records Review ...........................................................</td>
<td>22</td>
</tr>
</tbody>
</table>
Medical Record Audits ........................................................................................................ 24
Access to Facilities and Records .......................................................................................... 24
Documenting Member Appointments .................................................................................. 24
Missed or Cancelled Appointments .................................................................................... 24
Documenting Referrals ........................................................................................................ 24
Confidentiality and Accuracy of Member Records ............................................................. 24
Health Insurance Portability and Accountability Act of 1997 (HIPAA) ............................... 24
Member Privacy Rights ....................................................................................................... 25
Member Privacy Requests .................................................................................................... 26
Advance Directives ................................................................................................................ 26
Cultural Competency ........................................................................................................... 26
Health Literacy – Limited English Proficiency (LEP) or Reading Skills ............................... 27
Individuals with Disabilities ............................................................................................... 28
Clinical Guidelines ............................................................................................................. 28
Office Administration Changes and Training ....................................................................... 28
Continuity of Care ................................................................................................................ 28
Credentialing/Re-Credentialing ........................................................................................... 28
Licensure and Accreditation ............................................................................................... 29
Discrimination Laws ............................................................................................................ 29
Financial Liability for Payment for Services ....................................................................... 29
Monitoring Gaps .................................................................................................................. 29

CHAPTER 5: COVERED AND NON-COVERED SERVICES .................................................. 30
Covered Services .................................................................................................................. 31
Non-Covered Services ........................................................................................................ 39
Premiums and Copayments for NJ FamilyCare C and D Members .................................... 40
Behavioral Health Services .............................................................................................. 42
Post-Stabilization Services ............................................................................................... 42
Medical Necessity ................................................................................................................ 42
Emergency Services .......................................................................................................... 42
Pharmacy Services .............................................................................................................. 42
Emergency Transportation ............................................................................................... 43
Laboratory Services - Quest Diagnostics ............................................................................ 43
Dental Services – DentaQuest ............................................................................................ 43
Orthodontia ........................................................................................................................ 43
Emergency Dental Services ............................................................................................... 43
Vision Services – March Vision .......................................................................................... 43
Interpretation Services ......................................................................................................... 44

CHAPTER 6: BEHAVIORAL HEALTH .............................................................................. 44
Mental Health/Substance Abuse Services .......................................................................... 44
Availability .......................................................................................................................... 44
Referral Process for Members Needing Mental Health/Substance Abuse Assistance ........... 44
Primary Care Provider Referral .......................................................................................... 44
Coordination Between Behavioral Health And Physical Health Services ............................ 45
Medical Records Standards ............................................................................................... 45

CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES ................................................. 45
Member RIGHTS .................................................................................................................. 46
Member Responsibilities ..................................................................................................... 47
Member Rights Under Rehabilitation Act of 1973 ............................................................. 48

CHAPTER 8: ELIGIBILITY AND ENROLLMENT .................................................................. 48
Eligibility ............................................................................................................................. 48
Overview ................................................................................................................................. 65
Identifying Opportunities for Improvement ............................................................................. 66
Potential Quality of Care (PQoC) Concerns ............................................................................. 67
Performance Improvement Projects (PIPS) ............................................................................. 67
Peer Review ............................................................................................................................... 68
Performance Measures ........................................................................................................... 68
Satisfaction Survey .................................................................................................................. 68
Member Satisfaction Surveys .................................................................................................... 68
Provider Satisfaction Surveys ................................................................................................... 69
External Quality Review (EQR) ............................................................................................... 69
Provider Profiles ...................................................................................................................... 69
Clinical Practice Guidelines .................................................................................................... 70

CHAPTER 15: PHARMACY MANAGEMENT ............................................................................. 70
Pharmacy Management Overview ............................................................................................ 70
Prescriptions, Drug Formulary and Specialty Injectables ......................................................... 70
Prior Authorization Process ...................................................................................................... 70
Step Therapy and Quantity Limits ............................................................................................ 71
CVS Caremark Specialty Pharmacy .......................................................................................... 71
Mail Order Prescriptions ......................................................................................................... 71
New Jersey Prescription Drug Monitoring Program ................................................................ 71

CHAPTER 16: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)........... 72
Advance Directives .................................................................................................................. 72
Patient Self-Determination Act (PSDA) .................................................................................. 72
Physician Orders for Life Sustaining Treatment (POLST) Act .................................................. 72

CHAPTER 17: ENCOUNTERS, BILLING AND CLAIMS .............................................................. 73
Encounters ............................................................................................................................... 73
Billing and Claims ................................................................................................................... 74
  Correct Coding Initiative ........................................................................................................ 75
  Correct Coding ...................................................................................................................... 76
  Incorrect Coding .................................................................................................................. 76
  Modifiers ............................................................................................................................... 76
Online Status through Aetna Better Health of New Jersey’s Secure Website ................................ 77
Claim Resubmission .................................................................................................................. 77
Instruction for Specific Claims Types ........................................................................................ 77
Remittance Advice .................................................................................................................... 78
Claims Submission .................................................................................................................... 79
Risk Pool Criteria ..................................................................................................................... 80
Encounter Data Management (EDM) System ......................................................................... 80
Claims Processing ..................................................................................................................... 80
Encounter Staging Area ............................................................................................................ 81
Encounter Data Management (EDM) System Scrub Edits ...................................................... 81
Encounter Tracking Reports ..................................................................................................... 81
Data Correction ........................................................................................................................ 81

CHAPTER 18: GRIEVANCE SYSTEM ...................................................................................... 82
Member Grievance System Overview ....................................................................................... 82
Complaints ............................................................................................................................... 82
Grievances ............................................................................................................................... 82
Appeals ...................................................................................................................................... 83
State Fair Hearing .................................................................................................................... 85
CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH® OF NEW JERSEY

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 Jerseyans 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 1.2 million individuals in 11 states. An Aetna Medicaid affiliate has recently been awarded additional contracts in both Illinois and Ohio to operate Medicaid/Medicare dual eligibles programs. Aetna Medicaid affiliates currently own administer or support Medicaid programs in Arizona, California, Delaware, Florida, Illinois, Maryland, New York, New Hampshire, Pennsylvania, Texas, and Virginia.

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 25 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 preventive 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 one 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 provides 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 25 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 25 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
- 20 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 CHCS’ inception 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 serve about 1.3 million New Jersey residents:

- Medicaid provides health insurance to 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 Medicaid 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 may also be eligible for NJ FamilyCare.

About the Medicaid Managed Care Program

The Medicaid Managed Care Program, administered by DMAHS, administers the medical assistance program, and the Department of Human Services’ (DHS) functions as regards to all Medicaid/NJ FamilyCare Program benefits provided through Aetna Better Health of New Jersey. Aetna Better Health of New Jersey was chosen by the DHS to be the managed care organization to arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

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

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

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](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 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:

- Families with dependent children
- People who are sixty-five (65) years of age or older, blind, or permanently disabled
- Pregnant Women

**Model of Care**

**Integrated Care Management**

Aetna Better Health of New Jersey’s Integrated Care Management (ICM) Program uses a Bio-Psychosocial (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 will provide 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 services 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 Services 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 Homes (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.

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**CHAPTER 2: CONTACT INFORMATION**

Back to Table of Contents
Providers who have additional questions can refer to the following phone numbers:

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

**Aetna Better Health of New Jersey Department Fax Numbers**

<table>
<thead>
<tr>
<th>Member Services</th>
<th>1-844-679-6853</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>1-844-219-0223</td>
</tr>
<tr>
<td>Provider Claim Disputes</td>
<td>1-860-975-3614</td>
</tr>
<tr>
<td>Care Management</td>
<td>1-860-975-1045</td>
</tr>
<tr>
<td>Medical Prior Authorization</td>
<td>1-844-797-7601</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1-860-975-1045</td>
</tr>
</tbody>
</table>

**Community Resource**

<table>
<thead>
<tr>
<th>New Jersey QUITLINE</th>
<th>1-866-NJSTOP (1-866-657-8677)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Website: <a href="http://njquitline.org/">http://njquitline.org/</a></td>
</tr>
<tr>
<td>Contractors</td>
<td>Phone Number</td>
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<tr>
<td>DentaQuest- Dental Vendor</td>
<td>1-855-225-1727</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Please contact Member Services at 1-855-232-3596 (for more information on how to schedule these services in advance of an appointment)</td>
</tr>
<tr>
<td>March Vision- Vision Vendor</td>
<td>1-888-493-4070, TTY 1-877-627-2456</td>
</tr>
<tr>
<td>Lab – Quest Diagnostics</td>
<td>Please visit the website for additional information.</td>
</tr>
<tr>
<td>Lab – Quest Diagnostics <a href="https://www.questdiagnostics.com/home.html">https://www.questdiagnostics.com/home.html</a></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment-DME</td>
<td>Please see our online provider search tool for details surrounding DME providers. <a href="http://www.aetnabetterhealth.com/newjersey">www.aetnabetterhealth.com/newjersey</a></td>
</tr>
<tr>
<td>Radiology- N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>CVS Caremark – Pharmacy Vendor</td>
<td>1-855-232-3596 (Aetna Better Health of New Jersey)</td>
</tr>
<tr>
<td>CVS Caremark – Pharmacy Vendor</td>
<td>For prior authorizations, pharmacies will call our health plan directly at 1-855-232-3596 and follow the prompts.</td>
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### Agency Contacts & Important Contacts

<table>
<thead>
<tr>
<th>Agency Contacts &amp; Important Contacts</th>
<th>Phone Number</th>
<th>Facsimile</th>
<th>Hours and Days of Operation (excluding State holidays)</th>
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</thead>
<tbody>
<tr>
<td>NJ Department of Human Services Division of Medical Assistance and Health Services</td>
<td>1-800-356-1561</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Emdeon Customer Service</td>
<td>1-800-845-6592</td>
<td>N/A</td>
<td>24 hours / 7 days per week</td>
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</tbody>
</table>
Email Support: hdsupport@webmd.com

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<thead>
<tr>
<th>Health Benefits Coordinator (HBC)</th>
<th>1-800-701-0710</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ Relay</td>
<td>Dial 711</td>
<td>N/A</td>
<td>24 hours / 7 days per week</td>
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</tbody>
</table>

### Reporting Suspected Neglect or Fraud

<table>
<thead>
<tr>
<th>The Division of Youth and Family Services (DYFS) Child Abuse Hotline</th>
<th>1-800-792-8610</th>
<th>N/A</th>
<th>24 hours / 7 days per week</th>
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</thead>
<tbody>
<tr>
<td>State Central Registry (SCR) Hotline (Abuse)</td>
<td>1-877 NJ ABUSE (1-877-652-2873)</td>
<td>N/A</td>
<td>24 hours / 7 days per week</td>
</tr>
<tr>
<td>The National Domestic Violence Hotline</td>
<td>1-800-799-SAFE (7233)</td>
<td>N/A</td>
<td>24 hours / 7 days per week</td>
</tr>
<tr>
<td>The New Jersey Department of Health (DOH)</td>
<td>1-877-582-6995</td>
<td>1-609-943-3479</td>
<td>24 hours / 7 days per week</td>
</tr>
<tr>
<td>The New Jersey Medicaid Fraud Division of the Office of the State Comptroller’s Office (MFD) (Fraud)</td>
<td>1-888-9FRAUD (1-888-973-2835)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)</td>
<td>1-800-HHS-TIPS (1-800-447-8477)</td>
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</tr>
</tbody>
</table>

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**CHAPTER 3: PROVIDER SERVICES DEPARTMENT**

**Provider Services Department Overview**

Our Provider Services 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 Services 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 Services 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 and available prior to joining our network and before you 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 routine 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 Inquires**
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 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.

**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 (excluding holidays).

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**CHAPTER 4: PROVIDER RESPONSIBILITIES & IMPORTANT INFORMATION**

**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 (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 in the scope of practice of treatment, management, and discussion of the 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 Department of Health and Senior Services (DHSS) 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 must 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.

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

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 Adult Members: | 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:
Prenatal Care: Members shall be seen within the following timeframes:

<table>
<thead>
<tr>
<th>Timeframe</th>
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</thead>
<tbody>
<tr>
<td>Three (3) weeks of a positive pregnancy test (home or laboratory)</td>
</tr>
<tr>
<td>Three (3) days of identification of high-risk</td>
</tr>
<tr>
<td>Seven (7) days of request in first and second trimester</td>
</tr>
<tr>
<td>Three (3) days of first request in third trimester</td>
</tr>
</tbody>
</table>

Initial:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Pediatric Appointments:</td>
<td>Within three (3) months of enrollment</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) and New Jersey Care (ABD &amp; Disabled Members):</td>
<td>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.</td>
</tr>
</tbody>
</table>

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, 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.

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:
  o Connects the caller directly to the provider;
  o Contacts the provider on behalf of the caller and the provider returns the call; or
  o 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:
  o Leaves a message for the provider on the PCP/covering provider’s answering machine; or
  o Responds in an unprofessional manner.
• The provider’s answering machine message:
  o 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.
  o 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.

Covering Providers
Our Provider Services 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 Services 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 members 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 Services 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 08 of this Manual.

**Secure Web Portal**
The Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- **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 codes9s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
  - Export CPT/HCPCS code results and information to Excel
  - Ensure staff works from the most up-to-date information on current prior authorization requirements
- **Submit Authorizations** – Submit an authorization request on-line. Three types of authorization types are available:
  - Medical Inpatient
  - Outpatient
  - Durable Medical Equipment – Rental
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Check the status of the member’s 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 securely interact 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 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 Assessments 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), herbs, and supplements)

  • View and provide updates and feedback on “HEDIS Gaps in Care” and “Care Consideration” alerts for their member panel*
  • Secure messaging between provider and Case Manager
  • Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

* Any member can limit provider access to clinical data except for: 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.

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

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
Members will be able to self-refer to any behavioral health provider within our network without a referral from their PCP. However, 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.

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 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 nonurgent or nonemergent 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 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 in-network 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 be 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 including, as appropriate, transitioning young adult members from pediatric to adult providers;
- 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 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 us 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 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 form from the member’s PCP or from another Aetna Better Health of New Jersey participating specialist. 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. If the member requires specialized care from a provider outside of our network, a prior authorization is required.

**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 to warrant a specialist serve 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 arraigning for coverage 24-hours-a-day, 7-days-a-week.

**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, family planning, and services provided by Women’s Health Care Providers (WHCPs). The member must obtain these self-referred services from an Aetna Better Health of New Jersey provider.

Family planning services do not require prior authorization. Members may access family planning services from any qualified provider. Members also have direct access to WHCP 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.

**Skilled Nursing Facility (SNF) Providers**

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members.

SNFs 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 SNF 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 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 Nursing Home claims that come in for members in Custodial or Nursing Home stay. Share of Cost is not deducted on skilled stays.

**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 assessments with our members, in their residence, at least every 90 days. Based on the assessment, Case Managers will then identify the appropriate services that meet the members 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 Provider 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 nursing home stay for the member. While services may have been authorized for caregivers and agencies, providers should not be billing 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.

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 is not occurring.

**Home Delivered Nutrition Program Providers**
All Home Delivered Nutrition programs 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 as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action 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 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 are changes in income.
Note – Home and Community Based Services (HCBS) providers may not submit claims when the member has been admitted to a hospital or nursing home. The day of admission or discharge is allowed, but the days in between are not. Providers submitting claims in the days in between may be subject to Corrective Action Plan (CAP).

**Out of Network Providers**
When a member with a special need or services 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 there are no providers that can meet the member’s special need available in a nearby location. If needed, our Provider Services Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development team for recruitment to join the provider network. The member may be transitioned to a network provider 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. Providers should refer the member to another network provider within an applicable specialty for the second opinion.

**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 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 Services 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.

**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) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). 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.

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.
All medical records, where applicable and required by regulatory agencies, must be made available electronically.

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

- Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number)
- Documentation of identifying demographics including the member’s name, address, telephone number, employer, Medicaid Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining 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, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (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 is 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 - Providers will retain fiscal records relating to services they have 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, shall be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber’s record shall have 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
- 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.
• Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider shall countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated.
• Provider identification - Entries are identified as to author.
• Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Record Audits
Aetna Better Health of New Jersey or CMS may conduct routine medical record audits 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, administrative responsibilities or 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.

Access to Facilities and Records
Providers are required retain and make available all records pertaining to any aspect of services furnished to a members 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.

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.
• Conducting 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.

Documenting Referrals
Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

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 both required and voluntary provision of medical records 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 and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing 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, 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;
- Consider the patient sign-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred 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 and 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 individual’s past, present or future physical or mental health, or condition.
  - 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 it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
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  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
- 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.

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/pvctemplate1.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, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the 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 privacy rights through 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 the 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 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 and are written instructions relating to the provision of health care when the individual is incapacitated.

**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, be sensitive to cultural diversity, and foster 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 that 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, and we develop and implement proven methods for responding to those challenges.

Providers receive education 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 with disabilities.
• Physical and programmatic barriers that impact people with disabilities 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 ethnic and minority patients
• 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, 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.

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 Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, 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, Aetna Better Health of New Jersey makes its telephonic language interpretation service available to providers 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 to 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, Aetna Better Health of New Jersey Member Services Representatives will assist the member via a three-way call to communicate in the member’s native language.
• For outgoing calls, Member Services Staff dial the language interpretation service and
  o 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. Regular provider office will be conducted by our Provider Services staff to ensure that network providers are compliant.

**Clinical Guidelines**

Aetna Better Health of New Jersey has Clinical Guidelines and treatment protocols available to provider to help identify criteria for 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 Guidelines are available on our website at www.aetnabetterhealth.com/newjersey

**Office Administration Changes and Training**

Providers are responsible to notify our Provider Services Department on 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 Services 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. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. 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.

**Credentialing/Re-Credentialing**

Aetna Better Health of New Jersey uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America’s leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers’ most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and 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. Providers 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 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 Handbook. Providers must make certain that they are:
- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health of New Jersey, and 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.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member’s responsibility to pay the full cost of the services.
- Agreeing that when referring a member to another provider for a non-covered service must ensure that the member is aware of his or her obligation to pay in full for such non-covered services.

**Monitoring Gaps**
A Gap in 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 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 Director of LTSS 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 Director of LTSS or their designee reviews the reports and identifies if the gaps are true gaps or if 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 split between non-provision of service and true gaps. They are tracked, aggregated, reviewed, analyzed, and trended quarterly for presentation to the Director of LTSS or their designee, Quality Management Committee and the Compliance Department. 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 total 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 re-occurring gaps, a recommendation would be made for the Provider Services Department to work with that agency to identify strategies to reduce the occurrence of gaps. Continued high numbers of gaps in service would require a corrective action plan to be put in place for that agency. Provider services 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 FEA 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 in the gap in care process 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 Sanction 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**

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**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>DDD Clients</th>
<th>NJ FamilyCare B and C</th>
<th>NJ FamilyCare D</th>
<th>NJ FamilyCare ABP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion and related services</td>
<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
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<td>Blood and plasma products</td>
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<td>Covered</td>
<td>Not covered</td>
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<td>Chiropractor services</td>
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<td>(Manual manipulation of spine)</td>
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<td>Covered Copays</td>
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<td>to FamilyCare C</td>
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<td>self-refer to network</td>
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<td>over may self-refer</td>
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<td>refer to network providers.</td>
<td>self-refer to network providers.</td>
<td>to network providers.</td>
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<td>Court-ordered services</td>
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<td>Call Member Services for</td>
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<td>DDD Clients</td>
<td>NJ FamilyCare B and C</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare ABP</td>
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<tr>
<td><strong>Dental services</strong></td>
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<td>For preventive and routine services — *Member may self-refer to network providers. Major services require prior authorization and include: crowns, bridges, full dentures, partial dentures, gum treatments, root canal, complex oral surgery and orthodontics</td>
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<td>$5 per visit (no copay for preventive care) for FamilyCare C</td>
<td>$5 per visit (no copay for preventive care)</td>
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<tr>
<td><strong>Orthodontic services</strong></td>
<td>Covered (Only medically necessary orthodontic services are covered for children under the age of 19. The member’s dentist must explain the reason for the care.)</td>
<td>Covered (Only medically necessary orthodontic services are covered for children under the age of 19. The member’s must explain the reason for the care.)</td>
<td>Covered (Only medically necessary orthodontic services are covered for children under the age of 19. The member’s dentist must explain the reason for the care.)</td>
<td>Covered (Only medically necessary orthodontic services are covered. The member’s dentist must explain the reason for the care.)</td>
<td>Covered (Age limits apply (Only medically necessary orthodontic services are covered. The member’s dentist must explain the reason for the care.)</td>
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<td><strong>Diabetic education</strong></td>
<td>Covered with prior authorization (in home)</td>
<td>Covered with prior authorization (in home)</td>
<td>Covered with prior authorization (in home)</td>
<td>Covered with prior authorization (in home)</td>
<td>Covered with prior authorization (in home)</td>
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<tr>
<td><strong>Diabetic supplies and equipment</strong></td>
<td>Covered with Prior authorization</td>
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<tr>
<td><strong>Durable Medical Equipment (DME)/assistive technology devices</strong></td>
<td>Covered Prior authorization required if greater than $500.</td>
<td>Covered Prior authorization required if greater than $500.</td>
<td>Covered Prior authorization required if greater than $500.</td>
<td>Limited Call Member Services at 1-855-232-3596 (TTY: 711) Prior authorization required if greater than $500.</td>
<td>Covered Prior authorization required if greater than $500.</td>
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<td><strong>DYFS residential treatment</strong></td>
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<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
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<td><strong>Educational or special remedial services</strong></td>
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<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
<td>Not covered</td>
<td>Medicaid FFS</td>
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<tr>
<td><strong>Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and</strong></td>
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<td>Covered</td>
<td>Covered with limitations</td>
<td>Covered Limited to well-child visits, including,</td>
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<td><strong>Diabetic education</strong></td>
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<td><strong>Diabetic supplies and equipment</strong></td>
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<td><strong>Durable Medical Equipment (DME)/assistive technology devices</strong></td>
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<td><strong>Educational or special remedial services</strong></td>
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<td><strong>Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and</strong></td>
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<td>Covered with limitations</td>
<td>Covered Limited to well-child visits, including,</td>
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<td>DDD Clients</td>
<td>NJ FamilyCare B and C</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare ABP</td>
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<td><strong>immunizations</strong> (0 – 21 yrs. of age)</td>
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<td>Covered $35 (no copay if referred by PCP for services normally rendered in PCP office or if admitted to the hospital)</td>
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<td><strong>Emergency medical transportation</strong> (Ambulance)</td>
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<td><strong>Routine eye exams and optometrist services</strong></td>
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<td>Member may self-refer one routine eye exam per year.</td>
<td>Member may self-refer one routine eye exam per year.</td>
<td>Member may self-refer one routine eye exam per year.</td>
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<td>Frames are limited to $100 allowance for name- brand frames.</td>
<td>Frames are limited to $100 allowance for name- brand frames.</td>
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<td>Member may self-refer to participating OB/GYN</td>
<td>Member may self-refer to participating OB/GYN</td>
<td>Member may self-refer to participating OB/GYN</td>
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<td>Medicaid FFS When furnished by a non-participating doctor</td>
<td>Medicaid FFS When furnished by a non-participating doctor</td>
<td>Medicaid FFS When furnished by a non-participating doctor</td>
<td>Medicaid FFS When furnished by a non-participating doctor</td>
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<td>$5 copay for non-preventive services for FamilyCare C</td>
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<td>NJ FamilyCare B and C</td>
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<td>NJ FamilyCare ABP</td>
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<td>authorization Limited to children 15 years or younger</td>
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<td>Covered Member may self-refer.</td>
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<td>Covered Member may self-refer.</td>
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<td>Covered with prior authorization</td>
<td>Covered Limited to skilled nursing and medical social services with prior authorization. 60 business days per incident/injury per year</td>
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<td>Infertility testing and services</td>
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<td>Not covered</td>
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<td>Inpatient hospitalization (acute care, rehabilitation and special hospitals)</td>
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<td>Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.</td>
<td>Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.</td>
<td>Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.</td>
<td>Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.</td>
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<td>Covered with prior authorization $5 copay</td>
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<td>Not covered</td>
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<td>NJ FamilyCare B and C</td>
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<tr>
<td>Methadone and Methadone maintenance</td>
<td>Methadone for pain management is covered by Aetna Better Health of New Jersey; Methadone maintenance for substance abuse treatment is covered by Medicaid FFS.</td>
<td>Methadone for pain management is covered by Aetna Better Health of New Jersey; Methadone maintenance for substance abuse treatment is covered by Medicaid FFS.</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Methadone for pain management is covered by Aetna Better Health of New Jersey; Methadone maintenance for substance abuse treatment is covered by Medicaid FFS.</td>
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<td>Nurse Practitioners/ Certified Nurse Midwives</td>
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<td>Organ transplants (Experimental organ transplants not covered)</td>
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<td>NJ FamilyCare B and C</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare ABP</td>
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<td>Outpatient surgery, same day surgery,</td>
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<td>Podiatry care — routine preventive</td>
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<td>(Office-based, Non-surgical)</td>
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<td>brand name for NJ</td>
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* $5 per visit that is not for preventive care for FamilyCare C
* $5 per visit that is not for preventive care.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>DDD Clients</th>
<th>NJ FamilyCare B and C</th>
<th>NJ FamilyCare D</th>
<th>NJ FamilyCare ABP</th>
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<tbody>
<tr>
<td>Private duty or skilled nursing care</td>
<td>Covered with prior authorization</td>
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<tr>
<td>Prostate screening exams</td>
<td>Covered Annual for men 50+; If family history, annual at age 40. Member may self-refer</td>
<td>Covered Annual for men 50+; If family history, annual at age 40. Member may self-refer</td>
<td>Covered Annual for men 50+; If family history, annual at age 40. Member may self-refer</td>
<td>Covered Annual for men 50+; If family history, annual at age 40. Member may self-refer</td>
<td>Covered Annual for men 50+; If family history, annual at age 40. Member may self-refer</td>
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<tr>
<td>Prosthetics</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
<td>Prosthetics — Limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services are covered when due to congenital growth.</td>
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<td>Radiation/chemotherapy/hemodialysis</td>
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<td>Radiology scans (MRI, MRA, PET)</td>
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<td>Covered with prior authorization</td>
<td>Covered with prior authorization $5 copay</td>
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<tr>
<td>Rehabilitation/cognitive rehabilitation</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered Limited to 60 consecutive business days per therapy, per incident, per calendar year</td>
<td>Covered limited to 60 consecutive business days, per therapy, per incident, per calendar year. $5 copay Speech therapy — delays in speech development is not covered unless resulting from disease, injury, or congenital defect.</td>
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<tr>
<td>(Outpatient occupational therapy/physical therapy/speech therapy)</td>
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<td>Respite Care</td>
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<td>Not Covered</td>
<td>Covered with prior authorization</td>
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<tr>
<td>Benefits</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>DDD Clients</td>
<td>NJ FamilyCare B and C</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare ABP</td>
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<tr>
<td>Second medical/surgical opinions</td>
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<td>Skilled nursing facility care (LTC)</td>
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<td>Smoking cessation products</td>
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<td>Speech tests</td>
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<tr>
<td>Thermograms and thermography</td>
<td>Covered with Prior authorization</td>
<td>Covered with Prior authorization</td>
<td>Covered with Prior authorization</td>
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<tr>
<td>Transportation — emergency</td>
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<td>Medicaid FFS</td>
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<td>Medicaid FFS</td>
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<td>(non-emergency)</td>
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<td>Medicaid FSS</td>
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<td>Transportation — non-emergency (bus, train, car service, etc.)</td>
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<td>Medicaid FSS</td>
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<td>Care required within 24 hours.</td>
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**Behavioral Health**

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<tbody>
<tr>
<td>Atypical antipsychotic drugs within the Specific Therapeutic Drug Classes H7T and H7X</td>
<td>Covered Prior authorization may be required for drugs not in our formulary</td>
<td>Covered Prior authorization may be required for drugs not in our formulary</td>
<td>Covered Prior authorization may be required for drugs not in our formulary</td>
<td>Covered Prior authorization may be required for drugs not in our formulary</td>
<td>Covered Prior authorization may be required for drugs not in our formulary</td>
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<td>Inpatient psychiatric hospital services for individuals under 21 or 65 and over</td>
<td>Medicaid FFS</td>
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<tr>
<td>Inpatient substance abuse (diagnosis, treatment and detoxification)</td>
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<td>Medicaid FFS limited to detox only.</td>
<td>Medicaid FFS</td>
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<tr>
<td>Intermediate Care Facilities/</td>
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<td>Benefits</td>
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<td>DDD Clients</td>
<td>NJ FamilyCare B and C</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare ABP</td>
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<tr>
<td>Intellectual Disability (ICF/ID)</td>
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<td>Medicaid FFS</td>
<td>Medicaid FFS $25 copay per visit</td>
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<td>Outpatient Mental Health</td>
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<td>Medicaid FFS</td>
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<tr>
<td>Substance Abuse (diagnosis, treatment and detoxification)</td>
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<td>Medicaid FFS</td>
<td>Medicaid FFS Limited to detox only. $5 copay per visit</td>
<td>Medicaid FFS</td>
<td>Medicaid FFS</td>
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</tbody>
</table>

**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 (Medicaid and NJ FamilyCare A 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
- Services provided in an inpatient psychiatric institution that is not an acute-care hospital to members over 21 years old and under 65
- 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 D members, these additional services are not included:**
- Intermediate Care Facilities/Intellectual Disability
- Private duty nursing, unless authorized by Aetna Better Health of New Jersey
- Personal care assistant services
- Medical day care services
- Chiropractic services
- Orthotic devices
- Residential treatment center psychiatric programs
- Religious nonmedical institutions care and services
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (except for well-child care, including immunizations and lead screening and treatments)
- Transportation services, including nonemergency ambulance, invalid coach and livery transportation such as taxi or bus
• Hearing aid services, except for children up to age 16
• Blood and blood plasma (except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered)
• Cosmetic surgery (except when medically necessary and with prior approval)
• Custodial care
• Special remedial and educational services
• Experimental and investigational services
• Rehabilitative services for substance abuse
• Weight reduction programs or dietary supplements (except surgical operations, procedures or treatment of obesity when approved by the contractor)
• Acupuncture and acupuncture therapy (except when performed as a form of anesthesia in connection with covered surgery)
• Temporomandibular Joint Disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth
• Recreational therapy
• Sleep therapy
• Court-ordered services
• Thermograms and thermography
• Biofeedback
• Radial keratotomy
• Nursing facility services, except when the admission is for rehabilitative services
• Audiology services, except for children up to age 16

**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. Eskimos 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 C copayments**

<table>
<thead>
<tr>
<th>Service</th>
<th>NJ FamilyCare C copayment</th>
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</thead>
<tbody>
<tr>
<td>Outpatient hospital clinic visits</td>
<td>$5 for each visit that is not for preventive services</td>
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<tr>
<td>Emergency room services</td>
<td>$10 per visit</td>
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<tr>
<td>Service</td>
<td>NJ FamilyCare D copayment</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Physician services</td>
<td>$5 per visit (except for well-child visits, lead screening and treatment, immunizations, prenatal care or pap smears)</td>
</tr>
<tr>
<td>Independent clinic services</td>
<td>$5 per visit except for preventive services</td>
</tr>
<tr>
<td>Podiatrist services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Optometrist services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Chiropractor services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Drugs</td>
<td>$1 for generic drugs, $5 for brand name drugs</td>
</tr>
<tr>
<td>Nurse midwives</td>
<td>$5 per visit except for prenatal care visits</td>
</tr>
<tr>
<td>Dentist</td>
<td>$5 per visit except for preventive services</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>$5 per visit except for preventive services</td>
</tr>
<tr>
<td>NJ FamilyCare D copayments</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>NJ FamilyCare D copayment</td>
</tr>
<tr>
<td>Outpatient hospital clinic visits including diagnostic testing</td>
<td>$5 per visit except for preventive services</td>
</tr>
<tr>
<td>Hospital outpatient mental health visits</td>
<td>$5 per visits for members under the age of 19</td>
</tr>
<tr>
<td>Outpatient substance abuse services for detoxification</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$35 per visit. No copay required if member was sent to the ER by his/her PCP for services that the PCP could have provided or if member is admitted to the hospital.</td>
</tr>
<tr>
<td>Primary Care Provider services during normal office hours</td>
<td>$5 per visit except for well-child visits, lead screening and treatment, immunizations, prenatal care or preventive dental services. $5 for the first prenatal visit.</td>
</tr>
<tr>
<td>Primary Care Provider services during non-office hours and for home visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Podiatrist services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Optometrist services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Drugs</td>
<td>$5 per drug. $10 per drug for greater than 34-day supply.</td>
</tr>
<tr>
<td>Nurse midwives</td>
<td>$5 for the first prenatal visit, $10 for services provided during non-office hours and home visits. No copay for preventive services or newborns covered under Medicaid Fee-for-Service.</td>
</tr>
<tr>
<td>Physician specialist office visit during normal office hours</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Physician specialist office visit during non-office hours or home visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>$5 per visit except for preventive services</td>
</tr>
<tr>
<td>Psychologist services</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>----------------------------</td>
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</tr>
<tr>
<td>Laboratory and X-ray services</td>
<td>$5 per visit that is not part of an office visit</td>
</tr>
<tr>
<td>Dental services</td>
<td>$5 per visit except for preventive services</td>
</tr>
</tbody>
</table>

**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) will receive mental health and substance abuse services from Aetna Better Health of New Jersey.

Aetna Better Health of New Jersey covers some services related to mental health and substance abuse disorder.

For additional information about behavior health services and provider responsibilities and important information, please review Chapter 03.

**Post-Stabilization Services**

Aetna Better Health of New Jersey covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of New Jersey authorized the services
- Such services were administered to maintain the member has stabilized condition within one (1) hour after a request to Aetna Better Health of New Jersey for authorization of further post-stabilization services.
- When Aetna Better Health of New Jersey does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the member’s care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the member’s care until a contracted provider either concurs with the treating provider’s plan of care or assumes responsibility for the member’s care.

**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 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.

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 Services 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. Aetna Better Health of New Jersey will cover emergency services provided outside of the contracting area except in the following circumstances:

- When services are for elective care.
- When care is required as a result of circumstances that could reasonably have been foreseen prior to the member's departure from the contracting area.
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy 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 more comprehensive description of covered services in Chapter 15.

**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 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 - Quest Diagnostics**
Lab services will be provided through Quest Diagnostics.

**Dental Services – DentaQuest**
Dental services are provided through DentaQuest. DentaQuest is responsible for covering routine and specialty dental services, the administration of the dental network, and claim payment for 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
- Demonstration that long-term psychological health requires orthodontic correction

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](https://www.njmmis.com/downloadDocuments/22-14.pdf). All orthodontic treatment requires precertification.

**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 the member does not have dental benefits, we will not pay for emergency dental services unless a doctor other than a dentist gives medical treatment, and the doctor also needs to perform emergency dental work during treatment; if the member does have dental benefits and is in need of emergency care, the member must contact their dentist right away. If the dentist’s office is closed, the member should leave a message and wait for a call back. If the dentist is not able to see the member, the member should call DentaQuest at 1-855-225-1727 for help in scheduling an appointment or finding another dentist; 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 DentaQuest 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:

- A broken tooth
- A permanent tooth falls out
- Very bad pain in the gum around a tooth, and you are running a 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:

- 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 D, one exam is covered once every twelve (12) months for members. 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. 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.

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**CHAPTER 6: BEHAVIORAL HEALTH**

**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. 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.

Behavioral health services are covered for members who are clients of the Division of Developmental Disabilities (DDD). Non-DDD members are covered under the Medicaid Fee-for-Service (FFS) program for behavioral health services. 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 the diagnoses of diseases of organic origin categorized as altering the mental status of a member.

**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 05 of this Manual.

**Referral Process for Members Needing Mental Health/Substance Abuse Assistance**
Members will be able to self-refer to any participating MH/SA provider with our network without a referral from their Primary Care Provider (PCP).

**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).

**Coordination Between Behavioral Health And Physical Health Services**

We are committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use disorder, dual or multiple diagnoses, mental retardation 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 are screened for co-existing medical issues. Behavioral health providers will 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 members 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 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 and test results within twenty-four (24) hours of receipt of results in urgent or emergent cases, and notification within ten (10) business days of receipts of results for non-urgent or non-emergent lab results. Members will be able to self-refer to any participating MH/SA provider with our network without a prior authorization or a referral from their PCP.

**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 03 of this Manual.

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**CHAPTER 7: MEMBER RIGHTS AND RESPONSIBILITIES**

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’s 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 Committee and 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; 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 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, or to forgo or withdraw life-sustaining treatment
- Receiving 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 request written information in an alternative format
- The right to be free from any form 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:

- Choosing 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
- Requesting specific, condition-related information from a PCP
- Requesting information about procedures and who will perform them
- Deciding who should be in attendance at treatments and examinations
- Choosing to have a female in the room for breast and pelvic exams
- Refusing a treatment, services, or PCPs, including leaving the hospital even though a doctor advises against it, and requesting 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 a 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 applies to services provided by Aetna Better Health of New Jersey’s subcontractors and vendors.

**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
• 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 participate 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

For questions or concerns, please contact our Provider Services 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.

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

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**CHAPTER 8: ELIGIBILITY AND ENROLLMENT**

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 to 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 – 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 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 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% FPL, and childless adults between 19-64 with income up to and including 133% FPL.

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 Youth and Family Services (DYFS) clients

Health Benefits Coordinator (HCB)
The Health Benefits Coordinator (HCB) is responsible for assisting members with the selection and disenrollment of health plans; determine 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, and not 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 Aetna Better Health of New Jersey ID card instead in order to receive services. They will NOT use their Medicare card.

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)
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

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. The 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 EPSDT
The New Jersey Immunization Information System, 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 ask that you participate and enroll in their registry database.

The New Jersey Immunization Information System
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- 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;
- Health interpret the complex immunization schedule; and
- Provide immunization coverage data for your 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, are required to enroll with the Department of Health (DOH) Vaccines for Children (VFC) Program. Additionally, providers must use the free vaccines for 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.

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

Periodicity Schedule

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
- 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 will be 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.
- 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).
- Participate in the Department of Health and Senior Services (DHSS) Vaccine 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 (NJIIIS).
- 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 and readable.
- 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.
- 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 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:
  o Comprehensive health and developmental history (including assessment of both physical and mental health development)
  o Comprehensive unclothed physical exam
  o Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines)
  o Laboratory tests
  o 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 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 disease prevention
  o Vision services, including periodic screening and treatment for defects in vision, including eyeglasses
  o 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 dental health
  o Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
  o Lead toxicity screening, consists of two components, verbal risk assessment and blood lead testing in accordance with CMS and New Jersey state requirements. 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 Provider Services 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) EPSDT periodicity schedule.

**Direct-Access Immunizations**

Member 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 will apply for all other immunizations that are medically necessary.

**EPSDT Services**

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.
• 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. Contractor and its 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 must be provided by the contractor. 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 shall 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 shall 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 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 shall be done for each child beginning at age three.

Dental Services
Dental services may not be limited to emergency services. Dental exams in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after 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.

Hearing Services
At a minimum, include 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 shall be 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 shall be used to evaluate the member.

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 shall 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 screening must be done 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 ten (10) 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 18-26 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 ten (10) 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 ten (10) 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 fifteen (15) µg/dl, or two (2) consecutive tests with results between 10 – 14 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 shall 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 > 10 µg/dl.
CHAPTER 10: MEMBERS WITH SPECIAL NEEDS

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.

Aetna Better Health of New Jersey developed methods for:

- Promoting well-child care 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 (HIS) for new members will assist us in identifying those with special needs. We will 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 will 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.

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.

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 is trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses 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 or a member upon diagnosis requires very complex, highly specialized health care services, 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. The specialist or specialty care center will 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 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. If approval is obtained to receive 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. 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
• 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, 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 or crises for dental services, the member must contact their dentist right away. If the dentist’s office is closed, the member should leave a message and wait for a call back. If the dentist is not able to see the member, the member should call DentaQuest at 1-855-225-1727 for help in scheduling an appointment or finding another dentist; 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 DentaQuest for help to find a dentist.

Aetna Better Health of New Jersey’s require our contracted providers must assure the use of 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 will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

**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. Monitoring network capacity and availability and accessibility to care delivery systems, recredentialing review activities

Our Provider Services Department educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Services Staff may take referrals from a provider to have a member reached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services Staff may also take referrals from providers who identify problems through EPSDT exams.
CHAPTER 11: MEDICAL MANAGEMENT

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 are eligible 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 Care 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 (His) tool. Aetna Better Health of New Jersey staff members go over the IHS with the member or caregiver 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

CM 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, 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 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 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, non-Demonstration approved, investigational, or cosmetic 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.

CHAPTER 12: CONCURRENT REVIEW

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 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 Milliman Care Guidelines®. Admission certification is conducted within one business day of receiving 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 conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members. Our medical directors make rounds on site as necessary.

Milliman Care Guidelines
Aetna Better Health of New Jersey uses the Milliman Care Guidelines® to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. The Milliman Care 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.

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 (CRN) 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, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Discharge from a Skilled Nursing Facility
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.
Primary care providers (PCP) or treating providers (includes MLTSS provider) are responsible for initiating and coordinating a members request for authorization. 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 if the member was admitted for the treatment of an emergency medical condition. 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. However, notification is encouraged for appropriate coordination of care and discharge planning. The notification will be documented by the Prior Authorization Department or concurrent review clinician.

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

- The post-stabilization services were approved by Aetna Better Health of New Jersey.
- 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.
- The provider could not reach Aetna Better Health of New Jersey to request prior approval for the services;
- The Aetna Better Health of New Jersey representative and the treating provider could not reach an agreement concerning the member’s care, and an Aetna Better Health of New Jersey medical director was not available for consultation.
  - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health of New Jersey medical director; therefore, the treating provider may continue with the member’s care until a medical director is reached or any of the following criteria are met;
  - An Aetna Better Health of New Jersey provider with privileges at the treating hospital assumes responsibility for the member’s care;
  - An Aetna Better Health of New Jersey provider assumes responsibility for the member’s care through transfer;
  - Aetna Better Health of New Jersey and the treating provider reach an agreement concerning the member’s care; or
  - The member is discharged.

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 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 may include:
  - International Classification of Diseases, 9th Edition (ICD-9),
  - 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 or provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-9 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**

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 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 and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is 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 following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of New Jersey’s population needs and updated as applicable when nationally 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 Better Health of New Jersey Clinical Policy Bulletins (CPBs)
• Aetna Better Health of New Jersey Policy Council Review

If MCG state “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna Better Health of New Jersey CPBs, should be 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
• LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM)
• Aetna Better Health of New Jersey Clinical Policy Bulletins (CPB’s)
• Aetna Better Health of New Jersey 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). Aetna Better Health of New Jersey adheres to the following decision/notification time standards. Notice shall 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 pre-prior authorizations must meet the timeliness standards appropriate to the services required.

**Decision/Notification Requirements**

<table>
<thead>
<tr>
<th>Decision</th>
<th>Decision/notification timeframe</th>
<th>Notification to</th>
<th>Notification method</th>
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</thead>
<tbody>
<tr>
<td>Urgent pre-service approval</td>
<td>within twenty four (24) hours of receipt of necessary information, but no later than 72 hours from receipt of request</td>
<td>Practitioner/Provider</td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Urgent pre-service denial</td>
<td>24 hours of receipt of necessary information, but no later than 72 hours from receipt of request</td>
<td>Practitioner/Provider and Member</td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Non-urgent pre-service approval</td>
<td>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</td>
<td>Practitioner/Provider</td>
<td>Telephone or in writing</td>
</tr>
<tr>
<td>Non-urgent pre-service denial</td>
<td>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</td>
<td>Practitioner/Provider and Member</td>
<td>Telephone and in writing within 2 business days of decision</td>
</tr>
<tr>
<td>Continued / extended services approval (non-ED/acute inpatient)</td>
<td>1 business day of receipt of necessary information</td>
<td>Practitioner/Provider and Member</td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Continued / extended service denial (non-ED/acute inpatient)</td>
<td>1 business day of receipt of necessary information</td>
<td>Practitioner/Provider and Member</td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Decision</td>
<td>Decision/notification timeframe</td>
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<tr>
<td>Post-service approval of a service for which no pre-service request was received.</td>
<td>30 calendar days from receipt of the necessary information</td>
<td>Practitioner/Provider</td>
<td>Telephone or in writing</td>
</tr>
<tr>
<td>Post-service denial of a service for which no pre-service request was received.</td>
<td>30 calendar days from receipt of the necessary information</td>
<td>Practitioner/Provider and Member</td>
<td>In writing</td>
</tr>
</tbody>
</table>

**Prior Authorization Period of Validation**

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed sixty (60) days after the date of service authorized. The member must be enrolled and eligible on each date of service.

For information about how to verify member eligibility, please review Chapter 08 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 approval. 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, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies 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, or 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 have the opportunity to discuss medical, dental, and behavioral healthcare UM denial decisions 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 (with written permission of the member) right to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing
- 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, 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 members rights

Continuation of Benefits
Aetna Better Health of New Jersey will continue member’s benefits during the appeal process if
• The member or the provider files the 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 in writing 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 State 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 referrals from Primary Care Providers (PCP), or treating providers. Member may self-refer 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.

Member 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 14: QUALITY MANAGEMENT

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 conformance with desired medical standards and 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 Service Improvement (SIC), Credentialing and Performance, Appeals/Grievance, and Quality Assurance and Utilization Management further support our QAPI Program. Aetna Better Health of New Jersey encourages provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Services Representative if they wish to participate. Aetna Better Health of New Jersey can be reached by calling 1-855-232-3596.

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 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, 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 is 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 an 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 (i.e., member services, prior authorization, and care management). Through established formalized review processes (i.e., 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, 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 Credentialing and Performance Committee, or identify the need for possible quality improvement initiatives.

**Performance Improvement Projects (PIPs)**

Performance improvement projects (PIPs), 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 follow CMS protocols. Aetna Better Health of New Jersey participates in state-mandated PIPs and selects PIP 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
• 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 proposals that are reviewed and approved by our Medical Director, Quality Assurance Committee, Provider Advisory Committee, and the Quality Management Oversight Committee (QMOc) prior to submission to DMAHS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health of New Jersey, as well as from network providers who are members of our Provider Advisory Committee.

The QM department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP 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 the Credentialing and Performance Committee. This committee may take 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, 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 Services, or other departments. Aetna Better Health of New Jersey may request external consultants with special expertise (e.g., oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plans 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) are 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 shared with 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 their patients enrolled in disease management.

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 the provider profile, which include but are not limited to:

- Frequency of individual patient visits to the PCP
- 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 distributes profile reports 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

Aetna Better Health of New Jersey’s CMO and medical directors regularly visit individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our CMO and 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 represent best practices and are based on national 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.

Clinical guidelines are made available to providers on the Aetna Better Health of New Jersey website; providers are informed of the availability of new guidelines and updates in the provider newsletter. Providers may request a copy of a guideline at any time by contacting their provider services representative or the Aetna Better Health of New Jersey office of the chief medical officer.

CHAPTER 15: PHARMACY MANAGEMENT

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 Family Cares 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.

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, and
- 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 a “A” rated 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 medication. 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 is required

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/lut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP1An_z0zDr9gnRHRQDauup/ 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.
CHAPTER 16: ADVANCE DIRECTIVES (THE PATIENT SELF DETERMINATION ACT)

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 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.
- Educate patients on Advance Directives (durable power of attorney and living wills).

For additional information about medical record requirements, please visit Chapter 03 of this Manual.

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

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

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.
CHAPTER 17: ENCOUNTERS, BILLING AND CLAIMS

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 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, 9th Edition, Clinical Modification (ICD-9 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-9 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD-9 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.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

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. 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 CMS 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-9 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-9 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” diagnosis. 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 the program.
- 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 is later.

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 as Original Medicare guidelines.

**How to File a Claim**

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and professional services</td>
<td>CMS 1500 Form</td>
</tr>
<tr>
<td>Hospital inpatient, outpatient, skilled nursing and emergency room services</td>
<td>CMS UB-04 Form</td>
</tr>
<tr>
<td>Dental services that are considered medical services (oral surgery, anesthesiology)</td>
<td>CMS 1500 Form</td>
</tr>
</tbody>
</table>

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 untimely filing.

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 at the correct address.
   a) Electronic Clearing House
      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 Services 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

<table>
<thead>
<tr>
<th>Claims</th>
<th>Mail To</th>
<th>Electronic Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Aetna Better Health of New Jersey</td>
<td>Through Electronic Clearinghouse</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 61925</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85082-1925</td>
<td></td>
</tr>
</tbody>
</table>

**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/](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. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.
Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

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.
- Downcoding 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.”

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.

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 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. 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:
  o Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
  o 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 and member identification number.
    – Date of service.
    – Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission
Providers have 90 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute a reconsideration or claim dispute.

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.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny 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 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 Original Medicare claim processing rules.

**Skilled Nursing Facilities (SNF)**
Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS 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](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/](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.

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 amount 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 amount of days needed for the claim based on the date span.

**Same Day Readmission**
Providers submitting claims for inpatient facilities should use CMS UB-04 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 with twenty-four (24) hours.

*Example:* Discharge Date: 10/2/10 at 1100 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**
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.

**HCPCS Codes**
There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare 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 weekly. 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 make
corrections for any claims requiring resubmission. Call our Provider Services 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 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 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. This includes:
  - 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 payment cycle.
- 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 attained. 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 Services Department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

**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 CM 1500 or UB 04 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 UB 04 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 electronic 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 CM 1500 or UB 04 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

Risk Pool Criteria

If the claims paid exceed the revenues funded to the account, the providers shall fund part or the entire shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating providers.

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 DMAHSS requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to DMAHSS. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to DMAHSS. Our EDM System processes CMS1500, U030 (or U092), Dental, Pharmacy and Long Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-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 and 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 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 the DMAHS. This means that we can align our encounter edit configuration with the 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) Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If 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, 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 described above. In this way, we will 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 the 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 the 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 supports the timely resubmission of corrected encounters.
CHAPTER 18: GRIEVANCE SYSTEM

Member Grievance System Overview
Members or their designated representative can file a complaint orally and grievance or 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. A network provider, acting on behalf of a member, and with the member’s written consent, may file a grievance or appeal with Aetna Better Health of New Jersey. Members’ and their representatives including providers with written consent may also file an Independent Utilization Review or State Fair Hearing.

Aetna Better Health of New Jersey informs members and providers of the grievance system processes for complaints, grievances, appeals, Independent Utilization Reviews and State 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.

Aetna Better Health of New Jersey’s processes for resolving member grievances and appeals are described below.

Complaints
A complaint is a verbal expression of dissatisfaction filed with Aetna Better Health of New Jersey by the member or their designated representative that can be resolved within five (5) business days. Complaints that cannot be resolved within five (5) business days will automatically transferred to a grievance with the original received date. Complaints requesting the review of an action will be transferred to the informal utilization management appeal, also called a Stage 1 Appeal.

Grievances
A grievance is an expression of dissatisfaction by the member or their designated representative received orally that could not be resolved within five (5) business days or received in writing about a matter other than an action, grievance subjects may include but are not limited to dissatisfaction with access to coverage and drug utilization review programs applying 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

If we are unable to resolve a grievance within the specified timeframe, the grievance decision date may be extended by fourteen (14) calendar days. Members can request the extension or in cases when the delay is in the members best interest Aetna Better Health of New Jersey will request an extension with prior approval from the New Jersey Division of Medical Assistance and Health Services (DMAHS). In these cases, we will provide information describing the reason for the delay in writing to the member within the original timeframe.

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 and 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 State Fair Hearing or Independent Utilization Review if applicable.
**Appeals**

Members or their designated representative 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.

An appeal is a request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action), with Aetna Better Health of New Jersey. Authorized member representatives, including providers, may also file an appeal on the member’s behalf with the written consent of the member.

Appeals are classified into three stages:

- **Stage 1**
  - Informal Utilization Management Appeals
  - Expedited Informal Utilization Management Appeals

- **Stage 2**
  - Formal Utilization Management Appeals
  - Expedited Formal Utilization Management Appeals

- **Stage 3**
  - Independent Utilization Review
  - Expedited Independent Utilization Review

The member or authorized representative may also appeal directly to DMAHS through the State fair hearing process. State fair hearing appeals may be submitted at the same time as, instead of, or after the completion of the member appeal with Aetna Better Health of New Jersey. The State Fair Hearing process is described in greater detail in the G&A section of this Manual.

Member Stage 1 and Stage 2 Appeals must be filed with Aetna Better Health of New Jersey no later than ninety (90) 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 Stage 1 appeal and/or request a State Fair Hearing
- 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
- 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.

- 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
  Grievance System Manager
  3 Independence Way, Suite 400
  Princeton, NJ 08540
  FAX: 1-844-321-9566

If the member’s ability to attain, maintain, or regain maximum function is not at risk the appeal will be processed within the standard timeframe. These issues are known as standard appeals.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member’s life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member’s condition cannot be adequately managed without urgent care or services. Aetna Better Health of New Jersey resolves expedited appeals effectively and efficiently as the member’s health requires. Written confirmation or the member’s written consent is not required to have the provider act on the member’s behalf for an expedited appeal. If a member requests an expedited appeal and it does not meet expedited criteria, it will automatically be transferred to a standard request. Aetna Better Health of New Jersey will make reasonable effort to provide verbal notification and will sent written notification within two (2) calendar days.

Brief Overview of Stage 1 Appeal Processes

Standard and Expedited Informal Utilization Management Appeals

- Informal Utilization Management Appeals must be requested within ninety (90) calendar days of the Notice of Action
- 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 ten (10) calendar days of receipt of the appeal and 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 ten (10) calendar days.
- Aetna Better Health of New Jersey will render a decision on an Expedited Informal Utilization Management Appeal as expeditiously as the member health condition requires within three (3) business days of receipt of the appeal and 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 (3) business days.
• If Aetna Better Health of New Jersey does not agree with the member’s appeal and the denial is upheld, members can ask for a Formal Utilization Management, also called a Stage 2 Appeal, and or a State 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 State 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.

Brief Overview of Stage 2 Appeal Processes

Standard and Expedited Formal Utilization Management Appeals

• Informal Utilization Management Appeals must be requested within ninety (90) calendar days of the Notice of Action and acknowledged in writing within three (3) business days

• Verbal inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal)

• Verbal appeals will be summarized in the acknowledgment letter requesting but not mandating the member to sign and return the letter that they are in agreement with the summary.

• 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.

• Members and or their authorized representative’s may be present either onsite or via telephone when the Appeal Committee reviews their Formal Utilization Management appeal.

• 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 in writing, including an explanation for the decision, within the same thirty (30) calendar days.

• Aetna Better Health of New Jersey will render a decision on an Expedited Informal Utilization Management Appeal as expeditiously as the member health condition requires within three (3) business days of receipt of the appeal and communicate the decision verbally and in writing, including an explanation for the decision, within the same three (3) business days.

• If Aetna Better Health of New Jersey is unable to resolve a Formal Utilization Management Appeal within the specified timeframes, the appeal decision date may be extended by fourteen (14) calendar days. Members can request the extension or in cases when the delay is in the members best interest Aetna Better Health of New Jersey will request an extension with prior approval from DMHAS. In these cases, we will provide information describing the reason for the delay in writing to the member within the original timeframe.

• If Aetna Better Health of New Jersey does not agree with the member’s appeal and the denial is upheld, members can ask for a State Fair Hearing or an Independent External Review.

• 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.

• If final decision 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.

• If Aetna Better Health of New Jersey, the Fair Hearing Officer, or the Independent Utilization Reviewer reverses the original decision and approves the appeal, services will begin immediately.

State Fair Hearing

Members or their designated representative including a provider acting on their behalf with written consent, may request a State Fair Hearing through DMHAS at the same time as filing an Stage 1 or Stage 2 appeal with Aetna Better Health of New Jersey, after the Aetna Better Health of New Jersey Stage 1 or Stage 2 appeal decision or instead of filing for an Stage 1 or Stage 2 appeal with Aetna Better Health of New Jersey. This request must be completed within twenty (20) calendar days of the adverse action. Information on how to submit a State fair hearing appeal is included in Aetna Better Health of New Jersey Notice of Action (denial) letter and in the Stage 1 and Stage 2 Appeal Decision Letters.

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 State Fair Hearing must be submitted in writing within twenty (20) 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)
Office of Administrative Hearings
PO Box 712
Trenton, NJ 08625 -0712

If members wish services to continue while their State Fair Hearing is reviewed, they must request a State Fair Hearing within ten (10) calendar days from the adverse action letter. At the State 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 State Fair Hearing. If the State Fair Hearing decision favors the member, then Aetna Better Health of New Jersey will commence the services immediately. If the member’s services were continued while the appeal 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 State Fair Hearing Appeals Division.

**Independent Utilization Review**

Members’ may request an Independent Utilization Review after completion of the appeals process. They must do so in writing to the New Jersey Department of Banking and Insurance within four (4) months of receiving the Stage 2 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 Independent Utilization Review and will send a letter telling the member if they are eligible for Independent Utilization Review and if their request was complete. Eligible means the member has completed the 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 Independent Utilization Review 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 independent utilization review. 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 the services immediately.

**Provider Payment Disputes**

Network providers may file a payment dispute verbally or in writing direct to Aetna Better Health of New Jersey to resolve billing, payment and other administrative disputes for any reason including but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other reason for billing disputes. Provider Payment Disputes do not include disputes related to medical necessity. Providers can file a verbal dispute with Aetna Better Health of New Jersey by calling Provider Services Department at 1-855-232-3596. To file a dispute in writing, providers should write to:

Aetna Better Health of New Jersey
Provider Services
3 Independence Way, Suite 400
The Provider may also be asked to complete and submit the Dispute Form with any appropriate supporting documentation. The Dispute Form is accessible on Aetna Better Health of New Jersey’s website, via fax or by mail.

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) Department. For all disputes, Aetna Better Health of New Jersey will notify the Provider of the dispute resolution by phone, email, and fax or in writing.

Provider Complaints
Both network and out-of-network providers may file a verbal complaint with Aetna Better Health of New Jersey. Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of New Jersey that can be resolved outside of the formal appeal and grievance process. Provider complaints include but are not limited to dissatisfaction with:

- Policies and procedures
- A decision made by the Aetna Better Health of New Jersey
- A disagreement as to whether a service, supply or procedure is a covered benefit, is medically necessary or is performed in the appropriate setting

Provider complaints requesting review of an action; that cannot be resolved through the informal complaint process; or that require a written decision will automatically be transferred to the provider appeal process. In addition, provider complaints about Aetna Better Health of New Jersey staff, contracted vendors or other issues, not requesting review of an action, that require a written decision will automatically transferred to the provider grievance process. In cases where the complaint was transferred to the formal appeal or grievance process they will be transferred with the original received date.

Complaints from a provider on behalf of a member with written consent, with the exception of an expedited request that does not require written consent from the member, will be transferred to the member complaint process and subject to member complaint processes.

Providers can file a complaint with Aetna Better Health of New Jersey by calling the Provider Services Department at 1-855-232-3596.

Provider Grievances
Both network and out-of-network providers may file a formal grievance in writing directly with Aetna Better Health of New Jersey in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action. Providers can also file a verbal grievance with Aetna Better Health of New Jersey when it is related to Aetna Better Health of New Jersey staff or contracted vendor behavior by calling 1-855-232-3596. To file a grievance in writing, providers should write to:

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

The Appeals and Grievance Manager assumes primary responsibility for coordinating and managing provider grievances, and for disseminating information to the Provider about the status of the grievance.

An acknowledgement letter will be sent within three (3) business days summarizing the grievance and will include instruction on how to:

- Revise the grievance within the timeframe specified in the acknowledgement letter
- Withdraw a grievance at any time until Grievance Committee review

If the grievance requires research or input by another department, the Appeals and Grievance Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of New Jersey’s written policies and procedures, collecting pertinent facts from all parties. The grievance with all research will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with same or similar specialty if the grievance is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the grievance.
Aetna Better Health of New Jersey will resolve all provider grievances within forty-five (45) 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.

**Provider Appeals**
A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with Aetna Better Health of New Jersey within ninety (90) 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:

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

The Appeals and Grievance Manager assumes primary responsibility for coordinating and managing Provider appeals, and for disseminating information to the Provider about the status of the appeal.

An acknowledgement letter will be sent within three (3) business days summarizing the appeal and will include instruction on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter
- Withdraw an appeal at any time until Appeal Committee review

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision.

Aetna Better Health of New Jersey will inform providers through the Provider Manual and other methods, including periodic provider newsletters, training, provider orientation, the website and by the provider calling their Provider Services Representative about the provider appeal process.

**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 complaints, grievances and appeals
- Coordinating resolutions
- Maintaining the appeals and grievance database
- Tracking and reviewing complaint, 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 of the grievance system processes includes:

- Review of individual quality of care grievances
- Aggregation and analysis of complaint, 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 Services Department, is responsible for informing and educating members and providers about a member’s right to file a complaint, grievance, appeal, Independent Utilization Review or State Fair Hearing and for assisting members in filing a complaint, grievance, or appeal throughout the Grievance System.
Members are advised of their complaint, grievance, appeal, Independent Utilization Review, State 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.

CHAPTER 19: FRAUD, WASTE, AND ABUSE

Fraud, Waste and Abuse
Aetna Better Health of New Jersey has an aggressive, proactive fraud, waste, and abuse program that comply 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, shares 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 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.

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 (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 clinical needs.
- 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, will 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 $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
   o Knowingly presenting a false or fraudulent claim for payment or approval
   o 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
   o 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 (PFCSRA), 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 $5,500 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 $5,500 and $11,000 per false claim.**

- **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 $5,500 and $11,000 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 programs under 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; (2) recklessly commit health care claims fraud in the course of providing services; and (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).

- 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.

- 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 (if applicable).
- 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 disarming
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, 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

CHAPTER 20: MEMBER ABUSE AND NEGLECT

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 State Central Registry (SCR) or 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 Youth and Family Services (DYFS) 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 will 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 when placed in foster homes after normal agency business hours.

Additional information can be located on the New Jersey Hospital Associates website at:

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.

**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:**

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
• Reports injury by parents

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

Neglect
Types of Neglect:
• The intentional withholding of basic necessities and care
• Not providing basic necessities and care because of lack of experience, information, or ability

Signs of Neglect:
• Malnutrition or dehydration
• Un-kept 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

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

Additional Resources
• 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.onecl...6-1.html)
• http://www.wilentz.com/files/articlesandpublicationsfilefiles/226/articlepublicationfile/new%20jersey%20expands%20reporting%20requirements%20to%20include%20immunity%20provisions.pdf

CHAPTER 21: FORMS

The following forms will be available online:

• Abortion Certification Form
  To be completed by the provider attesting to the need for an abortion based on the criteria indicated in the form.

• Consent to Sterilization
  A consent to sterilization must be signed by both the enrollee and the provider performing the sterilization.

• Acknowledgment of Hysterectomy Information
  An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.
• **Provider Claims Dispute Form**
  To be completed by a provider who needs to file a claim dispute.

• **Pharmacy Coverage Determination Request Form**