A Provider Manual for

Aetna Assure Premier Plus (HMO D-SNP)
2025-2026

aetna®

For more information visit www.AetnaBetterHealth.com/New-Jersey-hmosnp.

Contents

Chapter 1: Introduction to Aetna Assure Premier Plus 13

Welcome 13

About this Provider Manual 13

Experience and Innovation 13

About Aetna Assure Premier Plus (HMO D-SNP) 13

What is a Dually Eligible Member? 14

Service Areas 14

Disclaimer 14

Aetna Assure Premier Plus (HMO D-SNP) Policies and Procedures 15

Model of Care 15

CMS Website Links 16

- Medicare Managed Care Manua 16
- Medicare Prescription Drug Manual 16
- Aetna Assure Premier Plus (HMO D-SNP)Model of Care Overview– 16

Member Rights and Responsibilities 16

Chapter 2: Contact Information 18

Chapter 3: Provider Experience Department 22

Provider Experience 22

Provider Experience Job Roles 22

Provider Orientation 23

Join the Medicare Network 23

Join the Medicaid Network 23

Chapter 4: Provider Responsibilities & Information 24

Provider Responsibilities Overview 24

Unique Identifier/National Provider Identifier 24

Appointment Availability Standards 24

Telephone Accessibility Standards 26

Covering Providers 27

Verifying Member Eligibility 27

- Telephone Verification: 27

- Secure Portal Verification: 27

Secure Web Portal 27

- Member Eligibility Search 27
- Provider List 27
- Remittance Advice Search 28
- Provider Prior Authorization Look up Tool 28
- Submit Authorizations 28

Member Care Web Portal 28

Member Temporary Move Out-of-Service Area 29

Coverage of Renal Dialysis – Out of Area 29

Preventive or Screening Services 29

Mental Health / Substance Abuse 29

Educating Members on their own Health Care 30

Urgent Care Services 30

Primary Care Providers (PCPs) 30

Specialty Providers 31

Specialty Providers Acting as PCPs 32

Nursing Home Providers 32

Home and Community-Based Services (HCBS) 33

Example 33

Supportive Living Facilities 33

Second Opinions 34

Provider Requested Member Transfer 34

Medical Records Review 34

Medical Record Audits 36

Access to Facilities and Records 37

Documenting Member Appointments 37

Missed or Cancelled Appointments 37

Confidentiality and Accuracy of Member Records 37

Health Insurance Portability and Accountability Act of 1997 (HIPAA) 37

Breach of PHI[1] 38

Member Privacy Rights 40

Member Privacy Requests **40**
Advance Directives **40**
Provider Marketing **41**
Cultural Competency **42**
Interpretation and Translation Requirements **43**
Health Literacy – Limited English Proficiency (LEP) or Reading Skills **43**
Alternative Formats **44**
- Voiance: 44
- Akorbi: 44

Americans with Disabilities Act (ADA) Individuals with Disabilities **45**
Cognitive Impairment **45**
Olmstead² Decision **45**
Filing an Olmstead Complaint **46**
Clinical Guidelines **47**
Shared Decision-Making Aids **47**
Office Administration Changes and Training **47**
Additions or Provider Terminations **48**
Continuity of Care **48**
Credentialing/Re-Credentialing **48**
Overview 48
Initial Credentialing Individual Practitioners 48
Recredentialing Individual Practitioners 49
Facilities (Re)Credentialing 49
Ongoing monitoring 49
Licensure and Accreditation **49**
Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination **49**
Financial Liability for Payment for Services **49**
Out of Network Providers – Transition of Care **50**
Risk Arrangements **50**
Urgent/Emergent Results **50**
Non-Urgent or Non-Emergent Results **50**
Hospital Acquired Conditions and Provider–Preventable Conditions **50**

Chapter 5: Covered Services 51

Covered Services 51

Additions Benefits 98

Non-Participating Providers 105

Outside Service Area 105

Post-Stabilization Services 105

Emergency Services 105

Dental Emergency Services 106

Billing 106

Paper Claims: 106

Through Electronic Clearinghouse 106

Website: 107

Laboratory Services 107

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) 107

Vision Services 107

Direct-Access Immunizations 108

Out of Area Benefits 108

Interpretation Services 108

Cost Sharing 108

Benefit limits apply. 108

Annual Notice of Change 109

Medicare Coverage Overview 109

Chapter 6: Dental Benefits 110

Dental Services 110

Dental Services Covered under the Medical Benefit 110

Definitions 111

Consultation 111

Dental records 111

Primary Care Dentist (PCD 111

Children with Special Health Care Needs 111

Member with Special Needs 111

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 111

Dental Vendor **112**
Credentialing of Dentists **112**
Dental Specialists and Specialty Care **112**
Requirements for Dental Providers using Mobile Dental Services **113**
Definitions **113**
Mobile Dental Practice 113
Mobile Dental Van 113
EPSDT Dental Services and Fluoride Varnish Program **114**
Utilization Management for Dental Care **115**
Second Dental Opinion **115**
Continuity of Care for Dental Services **116**
Dental Care for Members with Special Needs **116**
Special Considerations for Orthodontia **119**
The new HLD (NJ-Mod3) Assessment Tool **120**
Minor Treatment to Control Harmful Habits **120**
Orthodontic Treatment Services **120**
Limited orthodontic treatment **121**
Interceptive and Comprehensive Orthodontic Treatment **121**
Interceptive orthodontics **122**
Comprehensive Orthodontic **122**
Requesting Prior Authorization **123**
Beginning Treatment 123
Continuing treatment 124
Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC Medicaid Program **124**
Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment **125**
Conclusion of Active Treatment **125**
Documentation for Completion of Comprehensive Cases – Final Records **125**
Behavior Not Conducive to Favorable Treatment Outcomes **125**
Grievances and Appeals for Dental Services or Issues **126**
Dental Forms **127**
Chapter 7: Member Rights & Responsibilities 128

Member Rights **128**
Member Responsibilities **132**
Member Rights under Rehabilitation Act of 1973 ..... **133**
Chapter 8: Eligibility & Enrollment 135
Eligibility 10.5.2 ..... **135**
Non-Eligible Populations 10.5.2B **135**
Verifying Eligibility **135**
Enrollment Effective Dates **136**
Welcome Packet **136**
PCP Changes **136**
Sample ID Cards **137**
Medical Plan ID Card: 137
Dental Plan ID card: 137
Chapter 9: Quality Management 138
Overview **138**
Identifying Opportunities for Improvement **140**
- Formal Feedback from External Stakeholder Groups 140
- Findings from External Program Monitoring and Formal Reviews 140
- Internal Review of Individual Member or Provider Issues 140
- Findings from Internal Program Assessments: 140
- Clinical and Non-Clinical Performance Measure Results: 140
- Data Trending and Pattern Analysis: 141
- Other Service Performance Monitoring Strategies: 141

Potential Quality of Care (PQoC) Concerns **141**
Performance Improvement Projects (PIPs)/Chronic Condition Improvement Program(s) **142**
Peer Review **142**
Member Safety **143**
Performance Measures **143**
Satisfaction Surveys **143**
External Quality Review (EQR) **144**
Provider Profiles **145**

Clinical Practice Guidelines and Medical Necessity Criteria 146

Chapter 10: Medical Management 147

Identifying Members Needs 147

Interdisciplinary Care Team (ICT) 147

Documenting & Communicating Meetings 148

Chapter 11: Utilization Management 149

Emergency Services 149

Services Requiring Authorization 149

How to request Prior Authorizations 150

Timeliness of Decisions and Notifications 150

Out-of-Network Providers 152

Referrals 152

Pharmacy Prior Authorization-Pharmacy 152

Concurrent Review Overview 153

Discharge Planning Coordination 153

D-SNP Medicare Outpatient Observation Notice Requirement (MOON) 154

How to comply 154

Chapter 12: Behavioral Health 155

Mental Health/Substance Abuse Services 155

Availability 155

Primary Care Provider Referral 155

Coordination of Mental Health and Physical Health Services 155

Medical Records Standards 156

Specific Screening Tools 156

Services 157

Chapter 13: Pharmacy Management 160

Overview 160

Updating the List of Covered Drugs (Formulary) 160

Quantity Limits 160

Step Therapy 161

Notification of List of Covered Drugs (Formulary) Updates 161

Pharmacy Transition of Care Process **162**
LTC/ Nursing Facility **163**
Part D Pharmacy Co-Payments **163**
Medical exception and precertification **163**
Chapter 14: Member Coverage Determinations, Exceptions, Appeals, Grievance for Part D Prescription Drugs 165
Medicare Part D Prescription Drug Coverage Determinations **165**
Grievance and Redetermination Overview **166**
Grievances **166**
Expedited Grievance Resolution **167**
Quality Improvement Organization - Quality of Care Grievances **167**
Regulatory Complaints **167**
Redeterminations **168**
Expedited Redeterminations **170**
Qualified Independent Contractor (QIC) **170**
Administrative Law Judge (ALJ) **171**
Medicare Appeals Council (MAC) **171**
Judicial Review **172**
Chapter 15: Advance Directives (The Patient Self-Determination Act) 173
Patient Self-Determination Act (PSDA) **173**
Practitioner Orders for Life-Sustaining Treatment (POLST) **174**
Do Not Resuscitate (DNR) **174**
Medical Records **175**
Concerns **175**
Chapter 16: Encounters, Billing, and Claims 176
Billing Encounters and Claims Overview **176**
CMS Risk Adjustment Data Validation **176**
Billing and Claims **178**
When to Bill a member 178
When to File a Claim 178
Timely Filing of Claim Submissions 178
Injuries Due to an Accident 179

Claims Submission **179**
Claims Filing Formats 179
Electronic Claims Submission 179
Important Points to Remember 179
Paper Claims Submission 179
Clean Claims **180**
Risk Pool Criteria **181**
How to File a Claim 181
Correct Coding Initiative **183**
Correct Coding **183**
Incorrect Coding **183**
Modifiers **184**
Modifier 59 184
Modifier 25 184
Modifier 50 – Bilateral Procedure 184
Checking Status of Claims **185**
Online Status through our Secure Web Portal 185
Calling the Provider Experience Department 185
Payment of Claims **185**
Claim Resubmission **186**
Claim Reconsiderations **186**
Instruction for Specific Claims Types **186**
General Claims Payment Information 186
Nursing Homes 187
Home Health Claims 187
Home Health Agencies 187
Dental Claims 187
Personal Emergency Response System 187
Durable Medical Equipment (DME) Rental Claims 187
Same Day Readmission 187
Hospice Claims 188
HCPCS Codes 188

Remittance Advice **188**
Provider Remittance Advice 188
Encounter Data Management (EDM) System **190**
Claims Processing **190**
Encounter Staging Area **191**
Encounter Data Management (EDM) System Scrub Edits **191**
Encounter Tracking Reports **191**
Data Correction **191**
Chapter 17: Grievance & Appeal 193
Member Grievance and Appeal Overview **193**
Grievances **194**
Grievance Extension **194**
Expedited Grievance Resolution **194**
Quality Improvement Organization - Quality of Care Grievances **195**
Regulatory Complaints **195**
Appeals **195**
Continuation of Benefits **197**
Appeal Process **197**
Expedited Appeal Resolution **197**
Appeal Extension **198**
Failure to Make a Timely Decision **198**
The State of New Jersey Division of Medical Assistance & Health Services (DMAHS) State Fair Hearing **199**
Independent Review Entity (IRE) **199**
Administrative Law Judge (ALJ) **200**
Medicare Appeals Council (MAC) **200**
Judicial Review **200**
Claim Reconsiderations for PAR Providers (Dispute) **201**
Claim Reconsiderations for non-PAR Providers (Appeal) **202**
Claim Resubmission (Corrected Claim) **202**
Provider Grievances **203**
Provider Disputes **204**

Management of the Process **204**
DOBI Independent Utilization Review Process **204**
Chapter 18: Fraud, Waste, and Abuse 206
Fraud and Abuse **206**
Special Investigations Unit (SIU) **206**
Reporting Suspected Fraud and Abuse **207**
Fraud, Waste and Abuse Defined **208**
Elements to a Compliance Plan **210**
Relevant Laws that Apply to Fraud, Waste, and Abuse **210**
Administrative Sanctions 214
Potential Civil and Criminal Penalties 214
Remediation 214
Reporting 215
Exclusion Lists **215**
Chapter 19: Abuse, Neglect, Exploitation and Misappropriation of Member Property 216
Mandated Reporters **216**
CMS Guidance–Nursing Home / Long-Term Care Facilities **217**
Information to Report **217**
Examinations to Determine Abuse or Neglect **219**
Examples, Behaviors and Signs **220**
Abuse and Examples of Abuse 220
Behaviors of Abusers (Caregiver and /or Family Member) 220
Neglect and Types of Neglect 220
Signs of Neglect 220
Examples of Neglect 220
Financial Exploitation And Examples of Financial Exploitation 220
Children **220**
Reporting Identifying Information **221**
Emergency Room Criteria **221**
Chapter 20: Forms 222
Par Provider Dispute Form **222**

Non-Par Provider Appeals Form **222**

Waiver of Liability Form **222**

Pharmacy Coverage Determination Request Form **222**

Consent to Sterilization **222**

English: 222

Spanish: 222

Special Needs Form **222**

Glossary 223

Chapter 1: Introduction to Aetna Assure Premier Plus

Welcome

Welcome to Aetna Assure Premier Plus (HMO D-SNP) plan. Our ability to provide excellent service to our Members is dependent on the quality of our Provider network. By joining our network, you are helping us serve those New Jersey members who need us most.

About this Provider Manual

The Provider Manual serves as a resource and outlines operations for the Plan. This Provider Manual allows Providers to locate information on the majority of issues that may affect working with us. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Experience Department at **1-844-362-0934** for concerns. Medical, dental, and other procedures are clearly denoted within the manual.

Our Provider Operations Team will update the Provider Manual at least annually and will distribute bulletins as needed to incorporate any revisions/changes. Please check our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp** for the most recent version of the Provider Manual.

Experience and Innovation

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 Providers 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.

About Aetna Assure Premier Plus (HMO D-SNP)

Aetna Medicare and Medicaid has been a leader in managed care since 1986 and currently serves just over 3 million individuals in 13 states. Aetna affiliates currently own, administer or support Medicare and Medicaid programs in Arizona, Florida, Illinois, Kentucky, Michigan, New York, Pennsylvania, Ohio, Texas, Louisiana, New Jersey, Virginia and West Virginia.

Aetna 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 has particular expertise in serving high need Medicare and Medicaid Members, including those who are dual eligible and fully integrated dual eligible. Aetna utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

The Plan has been approved by the New Jersey Department of Human Services, Division of Medical Assistance & Health Services (DMAHS) program, to participate in the State of New Jerseys Full Integrated Dual Eligible Special Needs Plan (FIDE D- SNP) program, which will provide services to qualified individuals who are currently eligible for both Medicare Part A and B and full Medicaid eligibility.

Aetna Assure Premier Plus (HMO D-SNP) is a Medicare Advantage plan that integrates all covered Medicare and Medicaid managed care benefits into one plan. It will provide individuals with a single healthcare plan that will encompass both Medicare and Medicaid benefits in addition to extra services at no cost.

This program will seek to:

- Arrange for care and services by specialists, hospitals, and Providers of long-term services and supports (LTSS) and other non-Medicaid community-based services and supports
- Allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services

- Cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals
- Utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid

The State of New Jersey Division of Medical Assistance & Health Services (DMAHS) has chosen the capitated managed care model offered by CMS. Through the Plan, managed by the DMAHS, New Jersey will develop a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare and Medicaid Members, including Behavioral health and Long-Term Services and Supports (LTSS). The State of New Jersey Division of Medical Assistance & Health Services (DMAHS) has chosen several Managed Care Organizations (health plans) to implement the HMO D-SNP plan which is designed to integrate Medicare-Medicaid benefits to selected regions across the state.

Aetna Assure Premier Plus (HMO D-SNP) will provide the following features to dual eligible Members enrolled in our Plan:

- Seamless access to all Medicare and Medicaid managed care services, including Behavioral health and MLTSS services (if applicable) and extra benefits not available under traditional Medicare and NJ FamilyCare (Medicaid).
- Dedicated Care Manager and Interdisciplinary care team to create a customized Plan of Care and arrange for necessary services.
- Zero ($0) cost sharing for plan service and covered prescription drugs, as long as Members use participating (in-network) Providers and pharmacies.
- Continuity of care provisions to ensure seamless transition into the program
- Articulated network adequacy and access standards
- Fully coordinated care
- New Health Education and Wellness benefits
- Medicare Part D and Medicaid prescription drugs

What is a Dually Eligible Member?

HMO D-SNP members are defined as New Jersey individuals eligible for Medicare Parts A and Part B and have full Medicaid eligibility. These dually eligible individuals usually have complex health needs including a broad range of care needs such as chronic health conditions, and functional or cognitive impairments (including mental health conditions or developmental disabilities). Many have both.

Service Areas

We offer the Aetna Assure Premier Plus (HMO D-SNP) plan in all New Jersey counties.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the Aetna Provider Agreement, including all requirements described in this Manual, in addition to all state and federal regulations governing a Provider. While this Manual contains basic information about Aetna Assure Premier Plus (HMO D-SNP), DMAHS, and
CMS Providers are required to fully understand and apply DMAHS and CMS requirements when administering covered services.
Please refer to the DMAHS and CMS websites for further information:

- **https://state.nj.us/humanservices/dmahs/clients/medicaid**
- **www.cms.hhs.gov**

Aetna Assure Premier Plus (HMO D-SNP) Policies and Procedures

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

Model of Care

Our model of care offers an integrated care management approach, which offers enhanced assessment and management for our Members. The processes, oversight committees, Provider collaboration, care management and coordination efforts applied to address Member needs result in a comprehensive and integrated plan of care for the Member.
The integrated model of care addresses the needs of Members who are often frail, elderly, or coping with disabilities, and have compromised daily living activities, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues.

Our program's combined Provider and care management activities, coordinated through our Interdisciplinary Care Management Team (ICMT) model, are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve seamless transitions of care across healthcare settings and Providers
- Promote appropriate utilization of services and cost-effective service delivery
- Our efforts to promote cost-effective health service delivery include, but are not limited to the following:
- Review of network for adequacy and resolve unmet network needs
- Clinical reviews and proactive discharge planning activities
- In integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of our integrated care management program influence Member health.
These include:

- Comprehensive Member assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow Members to reside in the least restrictive environment possible.
- Assessments and person-centered service planning and care plans that identify a member's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Care Manager referrals and predictive modeling software that identify Members at increased risk for nursing home placement, functional decline, hospitalization, emergency department visits,

and death. This information is used to intervene with the most vulnerable Members in a timely fashion.

CMS Website Links

We administer our plan in accordance with the contractual obligations, requirements, and guidelines established by CMS. There are several manuals on the CMS website that may be referred to for additional information. Key CMS On- Line Manuals are listed below:

- Medicare Managed Care Manual – **https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs_Items/CMS019326.html**
- Medicare Prescription Drug Manual - **https://www.cms.gov/medicare/prescription_drug-coverage/prescriptiondrugcovcontra/partdmanuals.html**
- Aetna Assure Premier Plus (HMO D-SNP)Model of Care Overview– **www.AetnaBetterHealth.com/New-Jersey-hmosnp**

Member Rights and Responsibilities

1. Be treated with courtesy, consideration, respect, dignity and need for privacy
2. Be provided with information about the plan, its policies and procedures, its services, the practitioners providing care, and members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed
3. Be able to choose a Primary Care Providers (PCP) within the limits of the plan network, including the right to refuse care from specific practitioners
4. Participate in decision making regarding your health care, to be fully informed by the PCP, other health care Provider or Care 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
5. Have a candid discussion of appropriate or medically necessary treatment options for your condition(s) regardless of cost or benefit coverage, including the right to refuse treatment or medication
6. Voice grievances about the plan or care provided and recommend changes in policies and services to plan staff, Providers and outside representatives of your choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its Providers
7. File appeals about a plan action or denial of service and to be free from any form of retaliation
8. Formulate advance directives
9. Have access to your medical records in accordance with applicable federal and state laws
10. Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect
11. Be free of hazardous procedures
12. Receive information on available treatment options or alternative courses of care
13. Refuse treatment and be informed of the consequences of such refusal
14. Have services provided that promote a meaningful quality of life and autonomy for you, independent living in your home and other community settings as long as medically and socially feasible, and preservation and support of your natural support systems
15. Have available and accessible services when medically necessary
16. Access care 24 hours a day, 7 days a week, for urgent and emergency conditions — for life-threatening conditions, call 911
17. Be afforded a choice of specialist among participating Providers

18. Obtain a current directory of participating Providers in the plan including addresses and telephone numbers, and a listing of Providers who accept members who speak languages other than English
19. Obtain assistance to Providers with experience in treatment of patients with chronic disabilities
20. Be free from balance billing by Providers for medically necessary services that were authorized by the plan
21. Get a second opinion
22. Receive prompt notification of termination or changes in benefits, services or Provider network

Chapter 2: Contact Information

Providers who have additional questions can refer to the following Aetna Assure Premier Plus (HMO D-SNP) plan phone numbers:

Contacts	Phone Number	Hours of Operations (excluding State of New Jersey holidays)
Aetna Assure Premier Plus (HMO D-SNP)	1-844-362-0934 (follow the prompts in order to reach the appropriate departments)	7 Days a week 8am-8pm
Aetna Assure Premier Plus (HMO D-SNP) Compliance Hotline, Special Investigations Unit (SIU), (Reporting Fraud, Waste or Abuse)	1-855-282-8272	24 hours/7 days a week

Aetna Assure Premier Plus (HMO D-SNP) Department	Facsimile
Member Services	1-855-259-2087
Provider Experience Center (forms)	1-844-721-0622
Care Management (includes behavioral health services)	1-833-346-0122
Medical Prior Authorization	1-833-322-0034
Pharmacy Prior Authorization	1-844-328-7517

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

Contractors	Phone Number	Website	Hours of Operation
Liberty Dental	1-888-352-7924	**www.libertydentalplan.com/Providers/Providers**	Monday-Friday 8am-5pm
Interpreter Services Language interpretation services, including sign	Please contact Member Services at **1-844-362-0934** (for	N/A	24 hours / 7 days per week

language, special services for the hearing impaired, oral translation, and oral interpretation.	more information on how to schedule these services in advance of an appointment)		
March Vision	1-888-686-0274 TTY 1-877-627-2456	www.marchvisioncare.com/doctors	Monday-Friday 8am-5pm

Important Contacts	Phone Number	Website	Hours of Operations
State of New Jersey Division of Medical Assistance & Health Services (DMAHS)	Provider Hotline: 1-800-356-1561	Main Website: state.nj.us/humanservices/dmahs/clients/Medicaid Provider Website: state.nj.us/humanservices/dmahs/info	8 a.m.-4:30 p.m. EST Monday- Friday
ECHO Health, Inc.		Submit Electronic Claims: www.echohealthinc.com Customer Support: allpayer@echohealthinc.com to submit a Service Request.	24-hours-a- day, 7-days-a-week
New Jersey York Relay	Dial 711	N/A	24-hours-a- day, 7-days-a-week

Reporting Suspected Neglect or Fraud	Phone Number	Website	Hours of Operation
New Jersey Attorney General		To report online: https://www.nj.gov/oag/medicaidfr_aud/ report.html	8:00am to 5pm EST (Excluding holidays

Complaints Hotline	1-609-292-1272 1-877-55-FRAUD		and weekends. Voice mail service will be available whenever the Hotline is closed)
The New Jersey Insurance Fraud Prosecutor	1-877-55-FRAUD	N/A	
The National Domestic Violence Hotline	1-800-799-SAFE (7233)	N/A	24-hours-a-day, 7-days-a-week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	1-800-HHS-TIPS (1-800-447-8477)	N/A	24-hours-a-day, 7-days-a-week

Important Addresses	
Aetna Assure Premier Plus (HMO D-SNP) Participating Provider Disputes	Aetna Assure Premier Plus (HMO D SNP) Attn: PAR Provider Disputes PO Box 61925 Phoenix, AZ 85082-1925 -OR- Secure Provider Web Portal www.AetnaBetterHealth.com/NewJersey-hmosnp/Providers/portal Access our Par Provider Dispute Form at

	www.AetnaBetterHealth.com/New Jersey-hmosnp/providers/forms.html
Aetna Assure Premier Plus (HMO D-SNP) Appeals (Non-participating Providers)	Aetna Assure Premier Plus (HMO D SNP) Attn: Appeals PO Box 818070 5801 Postal Road Cleveland, OH 44181
Aetna Assure Premier Plus (HMO D-SNP) (Claims Submission & Resubmission)	Aetna Assure Premier Plus (HMO D SNP) PO Box 61925 Phoenix, AZ 85082-1925

Chapter 3: Provider Experience Department

Provider Experience

In New Jersey, Provider Experience representatives are the first point of contact a Provider will reach when calling in to the department.

Providers often have questions regarding the status of their claim or a recently processed claim, so it works nicely to pair them with Provider Experience, who can use problem solving and analytical skills to resolve these inquiries by phone. The Provider Experience department is also available to:

- Provide an explanation of the claim adjudication process
- Help track the disposition of a claim
- Correct errors in claims processing

The Provider Experience department supports our Providers by:

- Responding to network inquires including Provider requests for information regarding policy and procedures, credentialing status and claims status
- Responding to Provider concerns or issues raised by Providers and other internal/external customers
- Conducting initial Provider orientation and ongoing training and education to Providers and their office staff

Provider Experience Job Roles

There are three areas of the Provider Experience

- Provider Relations (internal and external): Provider onboarding, education and general support
- Provider Data Support: claims, credentialing and configuration
- Network/Contracting: negotiating Provider contracts (including value-based arrangements)

Our staff are available by phone or email to provide 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 prior authorizations
- Review or search the Preferred Drug List
- Notify the plan of a Provider termination
- Notify the plan of changes to their 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

Provider Toll-Free Help Line
The Provider Toll-Free Help Line,1-844-362-0934, will be staffed by Provider Experience representatives between the hours of 8:00am to 5:00pm., EST, Monday through Friday excluding State of New Jersey holidays.

State of New Jersey holidays are as follows:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

An automated system and secure voicemail will be available to Providers between the hours of 5:00pm and 8:00am., EST, Monday through Friday and 24 hours on weekends and holidays. Voicemails will be returned in a timely manner by our Provider Experience staff.

Provider Orientation

Newly contracted Providers initial orientation will be within 180 days after joining our network. In follow-up to initial orientation, our website will provide a variety of forums for ongoing Provider training and education, such as routine office/site visits, webinars, group or individualized training sessions on select topics, (e.g., claims coding, Member benefits, website navigation), distribution of Periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at **www.AetnaBetterHealth.com/New_Jersey-hmosnp/providers/index.html.**

Join the Medicare Network

If you are already participating with the Medicare Advantage program there is no need to sign up as you will automatically be placed in our system.

If you are interested in applying for participation in our Medicare network, please visit the Medicare website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp/providers** and complete the Provider online request form. If you would like to speak to a representative, please contact **1-800-624-0756.**

Join the Medicaid Network

If you would like more information about joining our Medicaid network call us at 1-855-232-3596 or send us an email at **AetnaBetterHealth-NJ-ProviderServices@aetna.com**

Chapter 4: Provider Responsibilities & Information

Provider Responsibilities Overview

This section outlines general Provider responsibilities; however, additional responsibilities are included throughout this 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 plan, their Provider Agreement, and all responsibilities outlined in this Manual. The plan may or may not specifically communicate such terms in forms other than the Provider Agreement and this Manual.

Providers must act lawfully in their 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

Providers must also act lawfully in their scope when providing information regarding the nature of treatment options risks of treatment, alternative treatments, and 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 make certain to use the most current diagnosis and treatment protocols and standards established by the state 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 the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

Providers that provide Medicaid services to our Members do not have to have an active Medicaid ID but must be registered with NJ Medicaid. Providers that have been excluded from participation in any federally or state funded health care program are not eligible to become part of our network.

Unique Identifier/National Provider Identifier

Providers who Provide services to Aetna Assure Premier Plus (HMO D-SNP) 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 Centers for Medicare and Medicaid Services (CMS). For questions, please contact our Provider Experience Department at **1-844- 362-0934**.

Appointment Availability Standards

Providers are required to schedule appointments for eligible Members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the Member's past and current medical history. Aetna Assure Premier Plus (HMO D-SNP) will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from Providers that do not meet accessibility standard. Providers are contractually required to meet the State of New Jersey Division of Medical Assistance & Health Services (DMAHS) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The table on the next page shows appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/SA) Providers.

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventative & Routine Care	Wait Time Standard
Primary Care Provider (PCP)	Immediate	Within twenty-four (24) hours	Within seventy-two (72) hours	Within twenty-eight (28) days	No more than 45 minutes
Specialty Referral	Immediate	Within twenty-four (24) hours of referral	Within four (4) weeks or shorter as medically indicated	Within twenty-eight (28) days	No more than 45 minutes
Dental Care	Immediate	Within twenty-four (24) hours	Within forty-eight(48) hours	Within Twenty-eight (28) days.	No more than 45 minutes
Mental Health/Substance Abuse (MH/SA)	Immediate	Within twenty-four (24) hours	Within ten (10) days of the request	Within ten (10) days of the request	No more than 45 minutes
OB/GYN	Immediate		Prenatal Care- 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester		No more than 45 minutes

- 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 EPSDT guidelines.
- Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar.

Our 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, except when the Provider is unavailable due to an emergency. 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. The above access and appointment standards are Provider contractual requirements. Aetna Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) 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

- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental staff to provide covered services within normal working hours. Protocols should be in place to provide coverage in the event of a Provider's absence.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, Aetna Assure Premier Plus (HMO D-SNP) 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 Experience 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 Experience Team must be notified if a covering Provider is not contracted or affiliated with Aetna Assure Premier Plus (HMO D-SNP). This notification must occur in advance of providing authorized services. Failure to notify the covering Provider's affiliation 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 eligibility 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.

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

- Telephone Verification: Call our Member Services Department to verify eligibility at **1-844-362-0934**. To protect the Member's confidentiality, Providers are asked for at least three pieces of identifying information such as the Members identification number, date of birth and or address before any eligibility information can be released.
- Secure Portal Verification: Member eligibility search & panel rosters are found on our Secure Website Portal. Contact our Provider Experience Team for additional information about securing a confidential username and password to access the site. Note eligibility files are only updated once a month and are only available to PCPs and those Providers acting as PCPs.

Additional Member eligibility requirements are noted in Chapter 7 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 Procedure Coding System (CPT/HCPCS) codes simultaneously
- Review Prior Authorization requirement by specific procedures or service groups
- Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
- Export CPT/HCPS code results and information to Excel
- Make certain 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®) – Once available, 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 or call our Provider Experience Team at **1-844-362-0934.**

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Assure Premier Plus (HMO D-SNP) that allows Providers access to our web- based application, the CaseTrakker™ Dynamo system. This portal allows Providers to view care management and relevant Member clinical data, and securely interact with the Interdisciplinary Care Management Team (ICMT).

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

- Providers can view their own demographics, addresses, phone, and fax numbers for accuracy.
- Provider can update their own fax number and email address. For their Patients:
- View and print Member's care plan* and provide feedback to Care 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 TCMT 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), herbals, 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 Care 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. (Code of Federal Regulations) Part 2 (substance abuse). Those Members 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 Provider Web Portal Navigation Guide located on our website.*

Member Temporary Move Out-of-Service Area

The Centers of Medicare and Medicaid (CMS) defines a temporary move as an absence from the service area (where the Member is enrolled in the plan of six (6) months or less.

Members are covered while temporarily out of the service area for emergent, urgent, post-stabilization, and out-of- area dialysis services. If a member permanently moves out of our service area or is absent for more than six (6) months, the Member will be disenrolled from the Aetna Assure Premier Plus (HMO D-SNP) plan.

Coverage of Renal Dialysis – Out of Area

We pay for renal dialysis services obtained by a Aetna Assure Premier Plus (HMO D-SNP) plan member from a contracted or non-contracted certified Provider or health care professional while the Member is temporarily out of our service area (up to six months).

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 (flu), 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. Please see the "Healthchek" section under Benefits.

Mental Health / Substance Abuse

For information about Provider responsibilities surrounding MH/SA services, please see Chapter 10 of this Manual.

Educating Members on their own Health Care

Aetna Assure Premier Plus (HMO D-SNP) 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.
- The Member's right to participate in decisions regarding his or her MH/SA health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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, we 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 a PCP includes, but is not limited to:

- Providing primary and preventive care and acting as the Member's advocate
- Initiating and supervising for specialty care and inpatient services, maintaining continuity of Member care
- 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, flu/immunizations and health screening services.

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. Members do not need to have a referral to see any in-network provider, however, Primary Care Providers (PCP) should attempt to coordinate
quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Directing Members to MH/SA Providers, Providers or hospitals within our network, as appropriate, and if necessary;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for Members;
- Conducting follow-up (including maintaining records of services provided) for 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 Members are 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;
- Assurance that care rendered by specialty Providers is appropriate and consistent with each Member's health care needs.

After a member has been discharged from an acute inpatient setting to a home setting, the PCP must follow up with the Member. During the meeting, the PCP must make certain that all services for the Member have been ordered, they address any new concerns and/or the Member needs, provide direction to appropriate specialty services, and resume any ongoing care for the Member.

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.

Primary Care Providers (PCPs) may not close their panels immediately upon contracting with us. Aetna Assure Premier Plus (HMO D-SNP) manages each PCP's panel to automatically stop accepting new Members after the agreed limit. If the PCP site employs Certified Registered Nurse Practitioners/Provider Assistants, then the Provider site will be permitted to add an additional agreed upon number of Members to the panel. Please contact our Provider Experience Team for additional information.

Specialty Providers

Specialty Providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists are required to coordinate with the PCP when Members need to see another specialist. The specialist is responsible for verifying Member eligibility prior to providing services.

Physician Specialists shall have admitting privileges in at least one participating hospital in the county in which the specialist will be seeing enrollees. In the case of medical and dental surgical specialists, the specialists must have admitting privileges in a participating hospital in New Jersey 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 Assure Premier Plus (HMO D-SNP) network specialists. If the Member requires specialized care from a Provider outside of our network, a prior authorization is required.

Hospitals and nursing homes are prohibited from imposing a requirement for a three
(3) day hospital stay prior to covering a nursing home stay. If you have question regarding this requirement, please contact the Member's Care Manager. It is important to remember that only covered services will be reimbursed by Aetna Assure Premier Plus (HMO D-SNP) for approved facilities and/or contracted Providers. However, Members are permitted to see the following Provider types
even though they may not be contracted with Aetna Assure Premier Plus (HMO D-SNP):

- Emergency Services

- Urgent Care (for urgent needed services)
- Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)
- Qualified Family Planning Provider (QFPP)
- An Aetna Assure Premier Plus (HMO D-SNP) approved out-of-network Provider
- Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP)

Members are assured access to these Provider types. If a contracting Provider is available, Members must see the contracting Provider. If a member cannot locate a contracted Provider, they can contact Aetna Assure Premier Plus (HMO D-SNP) for assistance.

Please contact the Provider Experience Team for further clarification on how Members access these services at **1-844-362-2087.**

For a list of current behavior health contracted Providers, please search our web directory located on our **website.**

Specialty Providers Acting as PCPs

In limited situations, a member may select a Provider 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 non-specialist 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.

Our Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as a 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 the beginning of Chapter 3. This includes arranging for coverage 24-hours-a-day, 7-days-a-week.

Nursing Home Providers

Nursing homes provide services to Members that need consistent care, but do not need to be hospitalized or require daily care from a Provider. Many nursing homes provide additional services, or other levels of care, to meet the special needs of Members.

Home and Community-Based Services (HCBS)

Home and Community-Based Services (HCBS) Providers should work closely with our Care Managers. Care Managers will complete face-to-face assessments with our Members in their residence as frequent as the state requires, or as the Member's condition warrants. Based on the assessment, Care Managers will then identify the appropriate services that meet the Member's functional needs, including determining which network Provider may be available to provide services to the Member in a timely manner. Upon completion, our Care Managers will then create authorizations for the selected Provider and communicate these authorizations accordingly. Care Managers will also follow up with the Member the day after services are to start, confirming that the selected Provider has 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 bill for any days that fall between the admission date and the discharge fraudulent billing.

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

The Member is admitted into the hospital on January 1, 2021 and is discharged from the hospital on January 3, 2021. There should be no billable hours for January
2, 2018, 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 in the example above, since no services could be performed on January 2, 2021. This is also true for any in-home service.

Personal Assistants and Community Agencies are responsible for following this process: Claims may not be submitted when the Member has been admitted to a hospital or nursing home for the full twenty-four (24) hours. The day of admission or discharge is allowed, but the days in between are not. Personal Assistants and Community Agencies submitting claims for the days in between will be required to pay back any monies paid by Aetna Assure Premier Plus (HMO D-SNP). Periodic audits will be conducted to verify compliance. For additional HCBS waiver information, please review the HCBS Waiver Reference Manual located on the website within the "Kit Content" PDF.

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
- The room and board agreement is initially completed by the Aetna Assure Premier Plus (HMO D-SNP) Care Manager at the time of placement; and
- The Room and Board agreement form is completed at least once a year, or more often if there are changes in income; and
- The room and board amount may periodically change based on a member's 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 a Corrective Action Plan (CAP).

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 a 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 any 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 to be terminated:

1. The Provider must send a letter informing the Member of the termination and the reason(s) for the termination. The letter must be provided to the Member at least thirty (30) days prior to the removal.
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 will 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 Assure Premier Plus (HMO D-SNP) will work with the Member to inform him/her on how to select another Primary Care Provider (PCP).

Medical Records Review

Our standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our Provider network. Below is a list of our medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of our Quality Management 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 Assure Premier Plus (HMO D-SNP) Members, immediately and
completely available for review and copying by the DMAHS and/or federal officials at the Provider's place of business, or forward copies of records to the DMAHS 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. Medical records should include documentation of Cultural Competency.
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 or the DMAHS Identification Number).
- Documentation of identifying demographics including the Member's name, address, telephone number, employer, Medicaid and or the DMAHS 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.
- 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 should 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.
- Recommendations for specialty, MH/SA, 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.
- Current medications (Therapies, medications and other prescribed regimens- Drugs prescribed as part of the treatment, including quantities and dosages, should be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record should 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 Assure Premier Plus (HMO D-SNP) and (2) prior admissions as necessary.)
- Mental Health/Substance Abuse (MH/SA) health history and MH/SA health referrals and services provided, if applicable, including notification of MH/SA Providers, if known, when a member's health status changes or new medications are prescribed.
- Documentation as to whether or not an adult Member has completed advance directives and location of the document (advance directives include Living Will, 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 MH/SA Providers, as appropriate to promote continuity of care and quality management of the Member's healthcare.
- Entries - Entries will be signed and dated by the responsible licensed Provider. The responsible licensed Provider should countersign care rendered by ancillary staff. 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 Provider reviewer.

Medical Record Audits

Aetna Assure Premier Plus (HMO D-SNP) 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. Medical records must be made available to the DMAHS and CMS for quality review upon request and free of charge. Medical records should include documentation of Cultural Competency.

Access to Facilities and Records

Medicare laws, rules, and regulations require that network Providers retain and make available all records pertaining to any aspect of services furnished to a member or their Provider Agreement with Aetna Assure Premier Plus (HMO D-SNP) for inspection, evaluation, and audit for the longer of:

- A period of ten (10) years from the end of the Provider Agreement with Aetna Assure Premier Plus (HMO D-SNP)
- The date the DMAHS or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

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 our Member Services Department at **1-844-362-0934.**

Missed or Cancelled Appointments

Providers must:

- Document in the Member's medical record, and follow-up on missed or canceled appointments.
- Conducting affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the Member. Notify our Member Services Department when a member continually misses appointments.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and make certain the accuracy of any information that identifies an Aetna Assure Premier Plus (HMO D-SNP) 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 make certain timely access by Members to their medical records and other health information.
- Abide by all state and federal laws and our contracts with CMS and DMAHS 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 HIPAA privacy statute and regulations **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, Managed Care Organizations (MCOs), and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) has 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 provision of health care to the individual.
- The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe 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).
- 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 Assure Premier Plus (HMO D-SNP).
- Release of data to third parties requires advance written approval from the DMAHS, 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.

Breach of PHI[1]

If a Provider and or the Provider’s staff discovers a breach (i.e., when the incident that involves the impermissible use or disclosure of PHI becomes first known), a notification will need to be sent to affected patients without unreasonable delay and in no case later than sixty (60) calendar days after the date of the breach (unless requested by law enforcement). The sixty (60) day time period should be seen as an outer

limit. So, if the risk analysis and the necessary information to provide notification is completed earlier, waiting until the day sixty
(60) would be seen as an unreasonable delay. However, if during the sixty (60) day period a prompt risk analysis and investigation is conducted and it is concluded that no breach occurred, then no notification is necessary.

The breach notification should be sent to patients in written form by first-class mail at the last known address. If a patient agrees to receive a notification via e-mail and this agreement has not been rescinded, then the written notification can be sent electronically. In the case of minors or patients who lack legal capacity due to a mental
or physical condition, the parent or personal representative should be notified. If the Provider knows that a patient is deceased, the notification should be sent to the
patient's next of kin or personal representative (i.e., a person who has the authority to act on behalf of the decedent or the decedent's estate), if the address is known. In urgent situations where there is a possibility for imminent misuse of the unsecured PHI, additional notice by telephone or other means may be made. However, direct written notice must still be provided.

Substitute notice must be provided if contact information is not available for some or all of the affected patients or if some notifications that were sent are returned as undeliverable. The form of the substitute notice is based on the number of patients for whom contact information was unavailable or out-of-date. If the number of patients is fewer than ten (10), the Provider should choose a form that can be reasonably calculated to reach the individual who should be notified. Possible forms may be an e-mail message, a phone call (keeping in mind that sensitive information should not be left on voicemail or in messages to other household members), or possibly a web posting if no other contact information is available and this is reasonably calculated to reach the patient. If the number of patients is ten (10) or more, the Provider should place a conspicuous notice that includes a toll-free number: one (1) on its homepage or a hyperlink that conveys the nature and important of the information to the actual notice, or two (2) in major print or broadcast media in geographic areas where the affected individuals of the breach likely live. If the Provider can update the contact information and provide written notice to one or more patients so as to bring the total number of patients for whom contact information is unavailable or out-of-date to less than ten (10), then the conspicuous notice requirement can be avoided.

For additional details surrounding media coverage and notification to the Secretary of the Department of Health and Human Services, please visit the following site at: **https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html**

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

Providers must notify Aetna Assure Premier Plus (HMO D-SNP) if a breach occurs regardless of the number of patients impacted.

[1]U.S. Department of Health and Human Services, "Breach Notification Rule "available here:
www.hhs.gov/hipaa/for-professionals/breach-notification

Member Privacy Rights

Our 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. 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) and with other applicable federal and state privacy laws.
Our policy also assists our staff 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 Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) in writing.

Advance Directives

Providers are required to comply with state and federal 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. Each one includes written instructions relating to the provision of health care when the individual is incapacitated or otherwise unable to communicate preferences.

Provider Marketing

Providers must adhere to all applicable Medicare and Medicaid laws, rules, and regulations relating to marketing guidelines. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting the Aetna Assure Premier Plus (HMO D-SNP) plan, informing Members that they may enroll or remain enrolled in the Aetna Assure Premier Plus (HMO D-SNP) plan, explaining the benefits of enrollment in the Aetna Assure Premier Plus (HMO D-SNP) plan or rules that apply to Members, or explaining how services are covered under the Aetna Assure Premier Plus (HMO D SNP) plan. Regulations prevent us from conducting sales activities in healthcare settings.
Providers may discuss, in response to an individual patient's inquiry, the various benefits of the Aetna Assure Premier Plus (HMO D-SNP) plan. Providers are encouraged to display approved plan member materials for all plans with which they participate. Providers can also refer their patients to **1-800-MEDICARE**, Enrollment Broker, or CMS's website at **www.medicare.gov** for additional information.

Providers cannot accept Aetna Assure Premier Plus (HMO D-SNP) plan enrollment forms. We follow the Federal Anti-Kickback Statute and CMS marketing requirements associated with Aetna Assure Premier Plus (HMO D-SNP) plan-marketing activities conducted by Providers and related to program. Payments that we make to Providers for covered items and/or services will be fair market value, consistent with an arm's length transaction, for bona fide and necessary services, and otherwise will comply with relevant laws and requirements, including the Federal Anti- Kickback Statue.

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to the Aetna Assure Premier Plus (HMO D-SNP) plan marketing activities conducted by Providers, please refer to Chapter 3 of the Medicare Managed Care Manual, which can be found on CMS's **website .**

Please note that Providers may engage in discussions with potential Member should a potential Member seek advice. However, Providers must remain neutral when assisting with enrollment decisions:

- Providers May Not:
- Offer scope of appointment forms.
- Accept Aetna Assure Premier Plus (HMO D-SNP) plan enrollment applications.
- Make phone calls or direct, urge or attempt to persuade potential Members to enroll in a specific plan based on financial or any other interests of the Provider.
- Mail marketing materials on behalf of Aetna Assure Premier Plus (HMO D-SNP).
- Offer anything of value to induce plan members to select them as their Provider.
- Offer inducements to persuade potential Members to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for potential Member enrollment activities; and
- Distribute materials/applications within an exam room setting. (Following Section 1140 of the Social Security Act Under Section 1140 of the Social Security Act, 42 U.S.C. 1320b–10, it is forbidden for any

person to use words or symbols, including “Medicare,” “Centers for Medicare & Medicaid Services,” “Department of Health and Human Services,” or “Health & Human Services” in a manner that would convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government agency, including indicating that it’s approved by DMAHS.

- Providers May:
- Advise potential Members that they are contracted with Aetna Assure Premier Plus (HMO D-SNP).
- Make available and/or distribute Aetna Assure Premier Plus (HMO D-SNP) marketing materials (Provider must include other Managed Care Organizations material when distributing Aetna Assure Premier Plus (HMO D-SNP) materials).
- Refer their patients to other sources of information, such as Aetna Assure Premier Plus (HMO D-SNP) Member Services Department, CMS’s website, or to 1-800- MEDICARE.
- Share information with potential Members from CMS’s website, including the “Medicare and You” Handbook or “Medicare Options Compare” (from **http://www.medicare.gov**), or other documents that were written by or previously approved by CMS.
- Providers may announce their affiliation with Aetna Assure Premier Plus (HMO D SNP) through general advertising, (e.g., radio, television, and websites). Providers may make the affiliation announcements within the first thirty (30) days of the new Provider Agreement. Provider may announce to patients once, through direct mail, e- mail, or phone, a new affiliation, which names only one Managed Care Organization. The Provider and or PCP must contact our Provider Experience Team to review the guidelines surrounding this process. Requirements are outlined in Chapter 3, Section 70.12.1 of the Medicare Managed Care Manual.
- Providers may distribute printed information provided by Aetna Assure Premier Plus (HMO D-SNP) to potential Members comparing the benefits of all of the different plans with which they contract as long as it is completed by a third party. Materials may not “rank order” or highlight specific plans and should include only objective information.

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. We expect our Providers to treat all Members with dignity and respect as required by federal law. 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. We have 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 acknowledged 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 Aetna Assure Premier Plus (HMO D-SNP) will conduct initial cultural competency training during Provider orientation meetings. Our Quality Interactions® course series is available to Providers who wish to learn more about cultural competency. This course 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.hrsa.gov/culturalcompetence**

Interpretation and Translation Requirements

Providers participating in Aetna Assure Premier Plus (HMO D-SNP) network 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 Assure Premier Plus (HMO D-SNP) makes its telephone language interpretation services and sign language interpretation services available to Provider to facilitate Member interaction. These services are free to the Member and to the Provider. However, if the Provider chooses to use another resource for interpretation services, the Provider is financially responsible for the associated costs.

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 Assure Premier Plus (HMO D-SNP) is required to make certain 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 LEP or reading skills
- Those that require culturally-linguistically, or disability competent care
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities
- Those who are deaf or hard of hearing

- Those who have cognitive limitations

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, we make our 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 for associated costs.

The New Jersey Relay number is available for Members by calling 7-1-1. Our Member Services staff is trained and available to take TTY phone calls from Members. Our language interpreter vendor provides interpreter services at no cost to Providers and Members.

Language interpretation services are available to medical, MH/SA, community-based and facility-based LTSS, and pharmacy Providers for use in the following scenarios: If a Member requests interpretation services, our Member Services Representatives will assist the Member via a three-way call to communicate in the Member's native language.

- For outgoing calls, our Member Services Staff dials the language interpretation service and uses an interactive voice response system to conference with the Member and the interpreter.
- For face-to-face meetings, our staff (e.g., Care 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 Assure Premier Plus (HMO D-SNP) to link with an interpreter.

We provide alternative methods of communication for Members who are visually impaired, including large print and/or other formats. If a member has a question about alternative formats, please have them contact our Member Services Department at **1 844-362-0934.**

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

Alternative Formats

Aetna Assure Premier Plus (HMO D-SNP) 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. The following vendors are used when offering Limited English Proficient (LEP) services to our Members:

- Voiance: Telephonic interpretation services
- Akorbi: In person sign language interpretation services

Please call our Member Service Staff at **1-844-362-0934** for further assistance/questions surrounding these vendors.

Americans with Disabilities Act (ADA) Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a Provider'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 must comply with the physical accessibility's requirements defined in accordance with the physical accessibility requirements defined in accordance with the U.S. Department of Justice ADA guidance and Civil Rights Act, which include but are not limited to:

- The Providers obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities (e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, large doorways, and diagnostic equipment must be accessible)
- Utilizing waiting room and exam room furniture that meets needs of all Members, including those with physical and non-physical disabilities.
- Accessibility along public transportation routes and/or provides enough parting.
- Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities.
- Provide appropriate accommodations such as large print materials etc.

Providers must comply with requirements to accommodate access to care to those Members with special needs, which includes but is not limited to offering extend office hours to include night and weekend appointments, offering extended hours and adopting a flexible appointment scheduling system. Regular Provider office/site visits will be conducted by our Aetna Assure Premier Plus (HMO D-SNP) staff to make certain that network Providers are compliant with ADA requirements. Providers who fail Provider office/site visits may receive a CAP until the issue discovered has been resolved. Failure to resolve may warrant termination from the Program.

Additional Resources:

- **http://www.ada.gov/civilrights.htm**
- **http://www.ada.gov/**

Cognitive Impairment

A person that has certain limitations in mental functioning and in skills such as communication, self-help, and social skills. The following resources have been identified as providing useful information and resources to care givers and providers.

Additional Resources:
https://www.nia.nih.gov/health/assessing-cognitive-impairment-older-patients

https://www.alz.org/alzheimers-dementia/what-is-dementia/related_conditions/mild-cognitive- impairment

https://www.parentcenterhub.org/intellectual/

Olmstead[2] Decision

In Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176 (1999) ("the Olmstead decision"), the Supreme Court construed Title II of the ADA to require states to place qualified individuals with mental disabilities in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonable accommodate the placement, taking into account the resources available to the state and the needs of

others with disabilities. The Department of Justice regulations implementing Title II of the ADA require public entities to administer their services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
In Olmstead, the Supreme Court stated that institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. The Supreme Court state that "recognition and unjustified institutional isolation of person with disabilities is a form of discrimination reflect[ed] two evident judgments":

1. "Institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and
2. "confinement in an institution severely diminishes everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Olmstead, 119 S. Ct. 2176, 2179, 2187 [emphasis added]. This decision effects not only all persons in institutions and segregated settings, but also people with disabilities who are at risk of institutionalization, including people with disabilities on waiting lists to receive community-based services and supports.

The Court indicated that one-way states can show they are meeting their obligations under the ADA and the Olmstead decisions is to develop a "comprehensive, effectively working plan for placing qualified people with mental disabilities in less restrictive settings". Olmstead at 2179. Based on this, almost all states are in the process of developing, or have already developed such plans.

2 The Virginia Commonwealth University, Work Support "The Olmstead Act? What is it?, available at: http://www.worksupport.com/resources/printView.cfm/376

Aetna Assure Premier Plus (HMO D-SNP) complies with the Olmstead decision, and we require our Providers to provide care in accordance with the specified Olmstead decision for all Members under the Aetna Assure Premier Plus (HMO D-SNP) plan.

Additional resources:

- **http://www.worksupport.com/resources/printView.cfm/376**
- **http://www.ada.gov/olmstead/**

Filing an Olmstead Complaint

You can file an ADA complaint, including any complaint alleging Olmstead violations, alleging disability discrimination against a state or local government or a public accommodation by mail or email. To learn more about filing an ADA complaint, visit **www.ada.gov/fact_on_complaint.htm**

To file an ADA complaint, you may fill out this form and mail or fax the form to:
US Department of Justice
950 Pennsylvania Avenue, NW Civil Rights Division
Disability Rights Section – 1425 NYAV
Washington, D.C. 20530

Fax: (202) 307-1197
You may also file a complaint by E-mail at **ADA.complaint@usdoj.gov**.

If you have questions about filing an ADA complaint, please call: ADA Information Line: **800-514-0301** (voice) or **800-514-0383** (TTY).

Clinical Guidelines

Aetna Assure Premier Plus (HMO D-SNP) 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**

Shared Decision-Making Aids

Shared Decision-making aids offer healthcare providers the opportunity to leverage best practice tools tailored to their specific medical specialties. These tools serve as valuable resources, aiding physicians and other healthcare providers to engage in comprehensive discussions with their patients regarding a spectrum of treatment options. The resources offer options ranging from conservative approaches to more invasive interventions. These decision-making aids encompass detailed information on associated risks and potential outcomes, facilitating a more informed dialogue between healthcare professionals and patients.
These aids cover a diverse array of medical scenarios, providing specialized information on topics such as diabetes, cardiovascular, wellness screening, flu prevention and more. By incorporating these decision aids into their practice, healthcare providers can enhance the collaborative decision-making process, ensuring that patients are well-informed and actively involved in determining the most suitable course of action for their individual healthcare needs.
Below are evidence-based aids that provide information about treatment options, lifestyle changes and outcomes. You can access the aids under “Materials Resources” on our website.

- Diabetes
- Flu Prevention
- Statin Choice Decision Aid
- Depression Medicare Choice
- Cardiovascular primary prevention choice

Office Administration Changes and Training

Providers are responsible to notify our Provider Experience Team on any changes in professional staff at their offices (Providers, Provider assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Team to schedule staff training.

Providers are also responsible for notifying Aetna Assure Premier Plus (HMO D-SNP) of address, phone number, acceptance of new patients and office hour changes. Please notify Aetna Assure Premier Plus (HMO D-SNP) within 2 weeks of these changes.

Additions or Provider Terminations

In order to meet contractual obligations and state and federal regulations, Providers who are in good standing, are required to report any terminations or additions to their agreement at least sixty (60) days prior to the change in order for Aetna Assure Premier Plus (HMO D-SNP) to comply with CMS requirements. Providers are required to continue providing services to Members throughout the termination period.
The Centers of Medicare and Medicaid (CMS) require that Aetna Assure Premier Plus (HMO D-SNP) make a good faith effort to provide written notice of termination of a network Provider at least sixty days before the termination effective date to all Members who are patients seen on a regular basis by the Provider whose Provider Agreement is terminating. However, please note that all Members who are patients of that PCP must be notified when a Provider termination occurs.

Continuity of Care

Provider must 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. We are not responsible for payment of services rendered to Members who are not eligible. You may also contact our Trans- disciplinary Care Management Team (TCMT) for assistance if you have further questions surrounding continuity of care.

Credentialing/Re-Credentialing

Overview

Aetna Assure Premier Plus (HMO D-SNP) uses current National Committee for Quality Assurance (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 practitioners 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 practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Practitioners 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 practitioners nationwide.

Practitioners may not treat Members until they become credentialed.

Initial Credentialing Individual Practitioners

Initial Credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners, (with the exception of hospital-based Providers) including practitioners joining an existing participating practice with Aetna Assure Premier Plus (HMO D-SNP), must complete the credentialing process and be approved by the Credentialing Committee.

Recredentialing Individual Practitioners

Aetna Assure Premier Plus (HMO D-SNP) re-credentials practitioners on a regular basis (every thirty- six (36) months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA & URAC) requirements (as applicable to the health plan).

Termination of the Provider contract can occur if a Provider misses the thirty-six (36) month timeframe for recredentialing.

Facilities (Re)Credentialing

As a pre-requisite for participation or continued participation in our network, all applicants must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network, and every three years thereafter, Aetna Assure Premier Plus (HMO D-SNP) Credentialing (or entity to which Aetna Assure Premier Plus (HMO D-SNP) has formally delegated credentialing to) will confirm that each Organizational Provider meets assessment requirements.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or Provider sanctions, or loss of license to help manage potential risk of sub-standard care to our Members.

Licensure and Accreditation

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

Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination

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 C.F.R. part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act (including Olmstead Decision);
- 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 C.F.R. parts 160, 162, and164.
- In addition, our network Providers must comply with all applicable Medicare laws, rules and regulations for the Aetna Assure Premier Plus (HMO D-SNP) plan, 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

Balance billing Members is prohibited under the Aetna Assure Premier Plus (HMO D SNP) plan. 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 Assure Premier Plus (HMO D-SNP) or for any covered services under this plan. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part.

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 Assure Premier Plus (HMO D-SNP), and must indemnify the Member for payment of any fees that are the legal obligation of Aetna Assure Premier Plus (HMO D-SNP) for services furnished by Providers that have been authorized by Aetna Assure Premier Plus (HMO D-SNP) to service such Members, as long as the Member follows Aetna Assure Premier Plus (HMO D-SNP) rules for accessing services described in the approved Member Evidence of Coverage (EOC) and or their 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, Provider must make certain that the Member is aware of his or her obligation to pay in full for such non-covered services.

Out of Network Providers – Transition of Care

We will authorize service through an Out-of-Network Provider Agreement when a member with a special need or service is not able to be served through a contracted Provider. 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 Network Manager 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.

Risk Arrangements

The results of our risk arrangements are made available, upon request, to specified groups and to interested stakeholders.

Urgent/Emergent Results

Members must be notified with 24 hours of receipt of results in a urgent or emergent cases.

Non-Urgent or Non-Emergent Results

Members must be notified with 10 business days of receipt of results for non-urgent and non-emergent lab and radiology results.

Hospital Acquired Conditions and Provider–Preventable Conditions

All Network hospitals agrees to comply with the Contractors no payment policy and quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions according to federal regulations at CFR 434,438, and 447. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: **https://www.cms.gov/Medicare/Medicare-Fee-for- Service Payment/HospitalAcqCond/icd10_hacs.html.**

Chapter 5: Covered Services

Aetna Assure Premier Plus (HMO D-SNP) is responsible for administering medically necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver items and services to covered Members.

The following Benefits Chart is a general list of services the plan covers. It lists preventive services and categories of other services in alphabetical order. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact our Provider Experience Department.

Covered Services

Prior authorization may be required for some services listed.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Acupuncture	Not covered. Only available as an optional supplemental benefit under Medicare Advantage plans. (Medicare Managed Care Manual, 30.3)	Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability	Covered by MCO.
Blood and Blood Products	Covered. Parts A (inpatient) & B (outpatient). Members pay either the Provider customary charge for the first 3 units of blood in a calendar year, or must arrange to have the blood replaced (donated by member or someone else) if the Provider has to buy the blood used by the member. Generally, if the Provider doesn't have to pay a blood bank for blood, there is no obligation for the member to pay for or replace it. This deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood. (42 CFR § 409.87) Medicare Advantage plans may	Covered by MCO. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood. Covered for services rendered beyond Medicare Part A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*Medicaid secondary coverage. Covers whole blood and derivatives, as well as necessary processing and administration costs, with certain limitations. (N.J.A.C. §10:52-2.2)

	waive the 3-pint deductible in outpatient settings. (Medicare Managed Care Manual, 30.2)		
Blood and Blood Products Continued	Inpatient Hospital: Covered. Part A. Covers whole blood and derivatives, as well as necessary processing and administration costs, with certain limitations. (N.J.A.C. §10:52-2.2) Outpatient: Covered. Part B	Inpatient Hospital: Covered in outpatient hospital and Nursing Facility settings. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability Outpatient: Covered for mandatory services in home health and outpatient hospital settings. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability	Inpatient Hospital: Covered in outpatient hospital and Nursing Facility settings. Outpatient: Covered for services in home health and outpatient hospital settings.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)

Bone Mass Measurement	Covered. Part B. Covered for those who meet certain criteria. Covers one measurement every 24 months (more often if medically necessary).	Covered by MCO. Covers one measurement every 24 months (more often if medically necessary), as well as Provider's interpretation of results. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (SSA §1905(a)13) (N.J.A.C. § 10:74 3.3(a)8)
Cardiovascular Screenings	Covered. Part B. Covers screenings for cholesterol, lipid, and triglyceride levels once every 5 years	Covered by MCO. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers (for all persons 20 and older) annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol levels (low-density lipoprotein (LDL) and high-density lipoprotein (HDL) levels). (N.J.S.A.§26:2J-4.6(a)1) (SSA §1905(a)13)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Chiropractic Services	*Covered. Part B. * Covers manipulation of the spine to correct subluxation when deemed medically necessary. --Does not cover x-rays or any other diagnostic or therapeutic services furnished or ordered by a chiropractor.	Covered by MCO. Covers manipulation of the spine. Also covers certain services as outlined in N.J.A.C. 10:68-2, such as clinical laboratory services; certain medical supplies; durable medical equipment; pre fabricated orthoses; physical therapy services; and diagnostic radiological services, when they are prescribed by a chiropractor within their scope of practice. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. Covers manipulation of the spine which the chiropractor is legally authorized by the State to perform. The chiropractor may prescribe certain services as outlined in N.J.A.C. §10:68-2. (N.J.A.C. §10:49-5.2(a)2) For the Medically Needy, only available to pregnant women (Group A), as per N.J.A.C. §10:49-5.3(a)1. (N.J.A.C. §10:68 1.2) (N.J.A.C. §10:68-2)
Clinical Trials	Covered. Part A and Part B. Covers some costs, such as Provider visits and tests in qualifying research studies. Members pay as they ordinarily would for any covered services. The Part B deductible may apply.	Covered by MCO. Covered, including coverage for services rendered beyond Medicare Part A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Colorectal Screening	Covered. Part B. Covered for people 50 years old or older, or those at high risk of colon cancer. Covers fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, and other tests. Frequency of test coverage varies by specific procedure. Part B deductible does not apply if lesions or growths are removed, but coinsurance or copayments may apply. (42 CFR §410.37)	Covered by MCO. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer. Unlimited coverage available for medically necessary services beyond Part A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for those age 50 and over, and for those of any age who are considered to be at high risk for colorectal cancer. The method and frequency of screening is to be in accordance with the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the beneficiary's Provider. (N.J.S.A.§26:2J 4.24(8)) (SSA §1905(a)13)
Barium Enema	When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months for those 50 or older, and once every 24 months for those at high risk for colorectal cancer. Ordinarily: -In a hospital outpatient setting, the member also pays a copayment. -If the test results in the biopsy of a lesion or growth the same day, members may have to pay coinsurance or a copayment. Part B deductible does not apply.	When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months for those 50 or older. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.S.A.§26:2J 4.24(8))

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Colonoscopy	Covered once every 24 months for those at high risk for colorectal cancer. Otherwise covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. No minimum age. No coinsurance or copayment. Ordinarily: It the test results in the biopsy of a lesion or growth during the same visit, members may have to pay coinsurance or a copayment. Part B deductible does not apply.	Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.S.A.§26:2J 4.24(8))
Fecal Occult Blood Test	Covered once every 12 months for those 50 or older. No coinsurance or copayment for the test itself. Ordinarily:	Covered once every 12 months for those 50 or older. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.S.A.§26:2J 4.24(8))
Flexible Sigmoidoscopy	Covered once every 48 months for most people 50 or older. For those not at high risk, covered 120 months after a previous screening colonoscopy. No coinsurance or copayment. Ordinarily: It the test results in the biopsy of a lesion or growth during the same visit, members may have to pay coinsurance or a copayment. Part B deductible does not apply.	Covered once every 48 months for those 50 or older. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.S.A.§26:2J 4.24(8))

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Dental Services	*Not covered. *Part A may sometimes cover inpatient hospital services in connection with certain dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status, or due to the severity of the dental procedures. (42 CFR §411.15(i))	Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); x-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling and root planning; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary x-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity.	Covered by MCO. *Does not cover procedures which are primarily for cosmetic purposes, or for which dental necessity cannot be demonstrated. Categorically Needy. (N.J.A.C. §10:49 5.2) (N.J.A.C. §10:56) (SSA §1905(a)10)
	Inpatient Hospital: *See above.	Inpatient Hospital: Covered. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Diabetes Screenings	Covered. Part B. Covered for members with certain risk factors. Those not previously tested (or those tested and not diagnosed with diabetes or pre-diabetes) are eligible for one screening per year. Those diagnosed with pre diabetes are covered for two screenings per calendar year. No copayment or coinsurance for the tests themselves. Part B deductible does not apply. (42 CFR §410.18) (42 CFR §410.23) *See also Vision Care Services.	Covered by MCO. This screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Covered for services rendered beyond Medicare Part B limits. *See also Vision Care Services. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (SSA §1905(a)2) (SSA §1905(a)13)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Diabetes Testing and Monitoring	Covered. Part B. --Covers yearly eye exams for diabetic retinopathy. --Covers foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Members pay 20% of the Medicare-approved amount. In a hospital outpatient setting, members pay a copayment. (42 CFR §410.18)	Covered by MCO. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Covered beyond Medicare Part B limits. *See also Vision Care Services. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered. (SSA §1905(a)13)
	Hospital Outpatient: In a hospital outpatient setting, the member pays a copayment.	**Hospital Outpatient:** Covered. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability	

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Therapeutic Radiology and Laboratory Services	Covers CT scans, MRIs, EKGs, and X-rays when ordered as components of treatment for a specific medical problem. Certain tests may also be covered for the purpose of diagnostic or preventative testing. No copayment for Medicare-covered clinical diagnostic laboratory services. Part B deductible does not apply.	(but not limited to) CT scans, MRIs, EKGs, and X- rays. Covered for services rendered beyond Medicare Part A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	(N.J.S.A.§26:2J. 3(a)4) (SSA §1905(a)3) (SSA §1905(a)13)(State Plan, Addendum to Attachment 3.1A, Page 3(a), TN 94-18) (State Plan, Addendum to Attachment 3.1A, Page 13(a), TN 92-19A) (State Plan, Addendum to Attachment 3.1A, Page 13(b), TN 92-19A)
	Provider's Office or Independent Testing Facility : Ordinarily: Members pay 20% of Medicare-approved amounts for covered tests and X-rays done in a Provider's office or independent testing facility.	Provider's Office or Independent Testing Facility : Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	
	Other Outpatient Settings: Members pay a copayment for tests and X-rays in an outpatient setting.	Outpatient Settings: Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Outpatient Settings: Covered by MCO. Covers X-ray and diagnostic tests, as detailed in N.J.S.A.§26:2J .3(a)4

Doula	The Contractor shall provide access to doula care to all pregnant, birthing, and postpartum individuals regardless of their medical complexity. The Contractor shall not require prior authorization for doula care. Doula care is available from conception until 180 days after the birth event. Doula care can be provided in the community, in clinical offices, or in the hospital. Doula care does not include reimbursement for transportation. Prior to the initiation of visits, doula care must be recommended by a licensed practitioner. Doula care must be provided by a community doula, defined as a doula with trainings in doula core competency and community-based/cultural competency that are among those approved by the New Jersey Department of Human Services in consultation with NJ Department of Health. All in-network and out-of-network doulas must be enrolled as fee-for-service providers and have the ability to serve fee-for-service members; the Contractor shall not accept registration as a 21st Century Cures Act Provider. The Contractor shall allow doulas to contract as individual providers and/or as providers affiliated with groups with the following specialties: doula-only agency, physician practices, midwifery practices, advanced nurse practitioner practices, and independent clinics. The Contractor must give DMAHS 90 days notice prior to proposing rates that deviate from the current fee-for-service fee schedule for doula care.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Durable Medical Equipment (DME)	*Covered. Part B. *Covers the rental or purchase of iron lungs, oxygen tents, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home. Must be Provider-prescribed, and must meet specific criteria. The supplier of the DME must be enrolled in Medicare. Member pays for 20% of Medicare- approved amount. The Part B deductible applies. --Excludes hearing aids. (42 CFR §410.38)	Covered by MCO. Covered for services rendered beyond Medicare Part B limits. *see Hearing Services. *see Prosthetics and Orthotics. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. Medical supplies, routinely used DME and other therapeutic equipment/supplies essential to furnish the services offered by a Nursing Facility for the care and treatment of its residents are considered part of the per diem for the facility and are therefore not covered. A list of covered DME and accompanying HCPCS information can be found in N.J.A.C. §10.59-2.3. Hearing aids are covered. (N.J.S.A. §26:2J 4.31a) (N.J.A.C. §10.49 5.2(a)13) (N.J.A.C. §10.59-2.3) *see Hearing Services. *see Prosthetics and Orthotics.
Emergency Care	Covered. Part B. Covers emergency department and Provider services. Members pay a copayment per visit and per each hospital service, as well as 20% of the Medicare-approved amount for the Provider's services. The Part B deductible applies.	Covered by MCO, including coverage for services rendered beyond Medicare Part A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability	Covered by MCO. Categorically Needy. (N.J.A.C. §10:49-5.2(a)26)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	No closely analogous services (as they apply to the demographic in question) exist within Medicare.	Covered by MCO. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, dental, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. Coverage extends beyond Medicare coverage limits for analogous services. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered for those under 21. Covered by MCO. Categorically Needy. (Not available to any Medically Needy group.) (N.J.A.C. §10:49 5.2(a)) (SSA §1905(r))
Federally Qualified Health Centers (FQHC)	Covered. Part B. Includes outpatient and primary care services from community-based organizations. Member generally pays 20% of the Medicare-approved amount. Part B deduction does not apply. --Also includes some telehealth services (such as office visits and consultations) for certain members. Member pays 20% of the Medicare- approved amount for the Provider's services.	Covered by MCO. Includes outpatient and primary care services from community-based organizations. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. (N.J.A.C. §10:49 5.2(a)3)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Family Planning Services and Supplies	Part B. Medicare generally does not cover services associated with family planning.	Covered by MCO (except as noted in this entry). Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Services furnished by out of-network Providers are covered via Medicaid Fee-for-Service. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered.	Covered by MCO. Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. (N.J.A.C. §10:52-2.5) Categorically Needy. *Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered. (State Plan, Addendum to Attachment 3.1A, Page 4(c), TN 11-15) (N.J.A.C. §10:49 5.2(a)9) (N.J.A.C. § 10:74 3.3(a)10)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Health/Wellness Education (including preventive healthcare and counseling, health promotion)	Covered. Part B. Covers medical nutrition therapy for members with diabetes or kidney disease, diabetes education for those with diabetes, tobacco use cessation counseling, alcohol misuse counseling, depression screenings, and yearly "Wellness" visits.	Covered by MCO. Coverage includes (but is not limited to) medical nutrition therapy for members with diabetes or kidney disease, diabetes education, tobacco use cessation counseling, alcohol misuse counseling, and depression screenings. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.A.C. §11:24-5.5(a)) (N.J.S.A. §26:2J-4.6(a))
Hearing Services	*Covered. Part B. *Limited to medically necessary tests, including diagnostic hearing and balance exams. Routine hearing exams, hearing aids, and exams to fit hearing aids not covered. Member pays 20% of Medicare-approved amount for covered services. In hospital outpatient settings, members pay a copayment. In all cases, the Part B deductible applies.	Covered by MCO. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow- up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered. Covered for services rendered beyond Medicare Part B limits. *see EPSDT. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow- up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered. Categorically Needy. (N.J.A.C. §10:64-2.1) (N.J.A.C. §10:64-2.3(b)) (N.J.A.C. §10:64-2.6) (N.J.A.C. §10:49 5.2(a)7) (N.J.A.C. §10:49 5.2(a)24) *see EPSDT.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Home Health	*Covered. Parts A & B. *Limited to medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology, or a continuing need for occupational therapy. May include medical social services, home health aide services, durable medical equipment, and certain medical supplies. Members must meet a specific set of criteria to be eligible. Members pay 20% of the Medicare-approved amount for covered medical equipment.	Covered by MCO. Coverage includes nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment, and appliances suitable for use in the home; audiology services; physical therapy; speech- language pathology; and occupational therapy. Home Health Agency Services must be provided by a home health agency that is licensed through the Department of Health as a home health agency and meets Medicare participation requirements. Covered for services rendered beyond Medicare Parts A & B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (Except for ABD population. Medicaid secondary coverage for the Aged, Blind, and Disabled). Covers a minimum of 60 home care visits during any contract year. (N.J.A.C. §10:49- 5.2(a)8) FFS for the ABD population. (N.J.A.C. §10:49-5.2(b)14). Categorically Needy. (N.J.A.C. §11:24 5.2(a)19)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Hospice Care Services	Covered. Part A. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; certain durable medical equipment and other services, including respite care, and spiritual and grief counseling. - Does not pay for facility room and board for hospice care in a member's home or in another facility that is one's normal residence (such as a nursing home). - Room and board is covered if hospice staff determines a need for short-term inpatient care in a hospice facility, hospital, or nursing home, or in the case of respite care. Members may pay a copayment for outpatient prescription drugs for symptom control or pain relief. If a member's attending Provider is not employed by the hospice, the member pays the Part B deductible and copayment for his/her services.	Covered by MCO. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. - Covered in the community as well as in institutional settings. - Room and board services included only when services are delivered in institutional (non-residence) settings. Hospice care for Members under 21 years of age shall cover both palliative and curative care. NOTE: Any care unrelated to the Member's terminal condition is covered in the same manner as it would be under other circumstances. Covered for services rendered beyond Medicare Part A & B limits. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*	Covered by MCO. Covered in the community as well as in institutional settings. Covers hospice services from a Medicare certified hospice agency. Categorically Needy. (N.J.A.C. §11:24-5.2(a)20) (N.J.A.C. 10:49-5.2(a)9) (State Plan, Addendum to Attachment 3.1-A, Page 18(c), TN 11-10)
	Institutional/Hospital: Covered if hospice staff determines that the member needs short-term inpatient care in a hospice facility, hospital or nursing home, or respite care. Room and board are covered.	**Institutional/Hospital:** Room and board are covered. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Institutional/Hospital: Covered, including room and board, for the dually eligible. (N.J.A.C. 10:49 5.2(a)(9)) Member may elect coverage for hospice care occurring in a skilled nursing or intermediate care facility, in which case the State will only pay for hospice

			care itself. (SSA §1905(o)(1)(A)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Hospice Care Services continued	**Home/Community:** Covered. Room and board for hospice care are not covered in a member's home or in a facility that serves as the member's normal residence (such as a nursing home).	**Home/Community:** Covered. Room and board are not covered in a member's home, or in a facility (such as a nursing home) that serves as the member's normal private residence. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Home/Community: Covered. Room and board are not covered in private residences. (SSA §1861(dd)(1)
· **Respite Care**	Covered. Part A. The member pays 5% of the Medicare- approved amount.	Covered via the Medicare component of FIDE SNP coverage. For respite care, Medicare is the sole payer, and the benefit conforms to Medicare Part A standards unless the Member is receiving MLTSS. Members have $0 cost sharing liability.	Only covered for MLTSS members. Please refer to the MLTSS Benefits Dictionary in Appendix B.9.0.

Immunizations	Covered. Part B. Covers flu shots once per season in the fall or winter. Hepatitis B shots are covered under certain conditions. Covers pneumococcal shots to prevent certain types of pneumococcal infections. Part B deductible does not apply.	Covered by MCO. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT. Covered for services rendered beyond Medicare Part B limits. *See also EPSDT. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers pediatric immunizations. (N.J.A.C. §11:24-5.2(a)4) Covers recommended immunizations for adults. (N.J.S.A.§26:2J 4.6(a)7) Cost of vaccine administration is always the MCO's responsibility, except for vaccinations that fall under the Vaccines For Children (VFC) program, in which the cost of vaccines themselves are not the MCO's responsibility, insofar as they are covered by the program. Categorically Needy.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Inpatient Hospital Care	Covered. Part A. Includes stay in critical access hospitals, inpatient rehabilitation facilities, inpatient mental health care, and long-term care hospitals other than State- or County- operated psychiatric facilities. Does not cover private duty nursing. Includes a semi-private room (private rooms are only covered when deemed medically necessary), meals, general nursing, drugs (as part of inpatient treatment), and other hospital services and supplies. Part B covers Provider's services while members are hospitalized.	Covered by MCO. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; Providers' and surgeons' services; anesthesia; lab, x- ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital. Covered for services rendered beyond Medicare Part A & B limits. *For Behavioral Health or Substance Use Disorder, see Inpatient Mental Health. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered (General Acute Care, Special hospitals, and Rehabilitation hospitals). MCO: Covers semi-private room accommodations; Providers' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; and other services and supplies that are usually provided by the hospital. (N.J.A.C. §11:24-5.2(a)14) FFS: Covers those inpatient services ordinarily furnished by an approved hospital for any beneficiary whose condition warrants an appropriate hospital level of care. Covers accommodations in semi- private rooms. (N.J.A.C. 10:52-1.6) (N.J.A.C. 10:49-5.2(a) 10 Categorically Needy. (For Medically Needy, only available to pregnant women, as per N.J.A.C. §10:49-5.3(a).) *For Behavioral Health or Substance Use Disorder Treatment, see Inpatient Mental Health.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Acute Care	Covered. Part A. Includes bed and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). 42 CFR §409.10(a)	Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO (except for psychiatric care, which is *Medicaid secondary coverage). (N.J.A.C. 10:49-5.2(a)9) *See Inpatient Mental Health.
Substance Use Disorder Treatment	*Covered. Part A. *Covered as a part of Inpatient Mental Health treatment. *See Inpatient Mental Health.	*See Inpatient Mental Health. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*See Inpatient Mental Health.
Psychiatric	*See Inpatient Mental Health.	*See Inpatient Mental Health. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*See Inpatient Mental Health.
Rehabilitation	*Covered. Part A. *See Skilled Nursing Facility.	Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered. (N.J.A.C. 10:49-5.2(a)9)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
• **Respite Care**	*Covered. Part A. *See Hospice Care Services.	Covered via the Medicare component of FIDE SNP coverage. For respite care, Medicare is the sole payer, and the benefit conforms to Medicare Part A standards unless the beneficiary is receiving MLTSS benefits. *See Hospice Care Services. Members have $0 cost sharing liability.	Covered by MCO. Only covered for MLTSS members. *See Hospice Care Services.
Inpatient Mental Health	*Covered. Part A. Covers services in a psychiatric hospital, distinct partial psychiatric unit of an acute care hospital, or critical access hospital other than State- or County-operated psychiatric facilities. Member liability for payment and coverage provided through Medicare are the same as other inpatient hospital care, with one exception: there is a 190 day lifetime limit on inpatient care in specialty psychiatric hospitals. Member liability is covered via Medicaid after Medicare benefit days are exhausted.	Covered by MCO. *Covers services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital. --Inpatient psychiatric services in State, private, or county hospitals are covered for those under age 21 or age 65 and older. --Inpatient psychiatric services in a general hospital are covered for patients of any age. --Inpatient mental health services are covered by the MCO for all SNP members. Inpatient mental health services rendered in a psychiatric hospital (including services rendered beyond 190 days) are covered by the MCO for all members. All inpatient acute hospitalizations in a general hospital are covered by the MCO for all members (including services rendered beyond 190 days), regardless of the admitting diagnosis or treatment. *Services provided in an inpatient psychiatric institution (other than an acute care hospital) to individuals under 65 years of age and over 21 years of age are not covered. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*Medicaid secondary coverage --Inpatient psychiatric services in State, private, or county hospitals are covered for those under age 21 or age 65 and older. (N.J.A.C. 10:49-5.2(b)19) --Inpatient psychiatric services in a general hospital are covered for patients of any age. (N.J.A.C. §10:52-51.6(a)1) Categorically Needy. --Inpatient mental health services are covered by the MCO for all members. --Inpatient mental health services rendered in a psychiatric hospital (including services rendered beyond 190 days) are covered by the MCO for all members. --All inpatient acute hospitalizations in a general hospital (including services rendered beyond 190 days) are covered by the MCO for all members, regardless of the admitting diagnosis or treatment.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Inpatient Mental Health Continued		Inpatient Psychiatric Services (Acute Hospital Based): Covered by the MCO for all members.	Inpatient Psychiatric Services (Acute Hospital Based): Covered by the MCO for all members.
		Inpatient Psychiatric Provider Services (Acute Hospital Based): Covered by the MCO for all members.	Inpatient Psychiatric Provider Services (Acute Hospital Based): Covered by the MCO for all members.
		Psychiatric Hospital – Inpatient (stand-alone): Covered by the MCO for all members.	Psychiatric Hospital – Inpatient (stand-alone): Covered by the MCO for all members.
		Institutional: Inpatient psychiatric hospital services in a State, private, or county hospital, and nursing facility services for individuals under age 21 or age 65 or older in an institution for mental diseases. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Institutional: Inpatient psychiatric hospital services in a State, private, or county hospital, and nursing facility services for individuals under age 21 or age 65 or older in an institution for mental diseases. (SSA §1905(a)(14)) *See also Nursing Facility Services.
		General Hospital: Inpatient psychiatric services in a general hospital covered for patients of any age. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	General Hospital: Inpatient psychiatric services in a general hospital covered for patients of any age. (N.J.A.C. §10:52-51.6(a)1)
		Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital- based): Detoxification in a medical acute care inpatient setting is covered by the MCO for all members. ASAM 4 – WM Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital based): Detoxification in a medical acute care inpatient setting is covered by the MCO for all members. ASAM 4 – WM

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Mammograms	Covered. Part B. Covers one visit every 12 months for all women over the age of 40. Also covers a baseline mammogram between the ages of 35-39. Part B deductible does not apply. Diagnostic mammograms are covered when deemed medically necessary. In such cases, the member pays 20% of the Medicare-approved amount.	Covered by MCO. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary. Covered for services rendered beyond Medicare Part B limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers one baseline exam for women at least 35 (but less than 40) years of age; an exam every year for women 40 and over; and in the case of a woman under 40 years of age with a family history of breast cancer or other breast cancer risk factors, an exam at the ages and intervals deemed medically necessary by her health care Provider. (N.J.A.C.§11:24-5.2(a)(8)ii) (N.J.S.A.§26:2J-4.6(a)6) (SSA §1905(a)13)

Medical Day Care	Not covered.	Covered by MCO. Provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. Covers a minimum of five hours of services per day, excluding transportation time between the ADHS facility and the adult beneficiary's home. ADHS facilities shall provide beneficiaries' transportation to and from the facility and rehabilitation services appointments as needed if the rehabilitation service is not provided at the facility. An ADHS facility may provide transportation to an adult beneficiary's medical appointment(s) as a service that can be applied toward meeting the minimum service hour requirement. If a facility provides this service, the facility shall provide transportation to and from the facility and the location of the adult beneficiary's medical appointment. The facility shall accommodate the special transportation needs of the beneficiary and medical equipment used by the beneficiary. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. Provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. No licensed facility in the adult Medical Day Care Program may serve or receive daily reimbursement for fee for service or managed care unless limited to licensed capacity or for no more than 200 participants, whichever is lower. (N.J.A.C. § 11:24-5.2(b)4) For Medically Needy, only available to pregnant women, the aged, the blind and the disabled (Groups A and C). (N.J.A.C.§11:24-5.3(a)5) (N.J.A.C.§10:164) (N.J.A.C. § 10:74-3.4(a)2)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by setting/Facility Where Applicable)
Medical Supplies	Part B. Covered for approved procedures and services.	Covered by MCO. Covers for services rendered beyond Medicare Part B limits for approved procedures and services. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered.
Managed Long Term Services and Supports (MLTSS)	No closely analogous program exists under Medicare.	Covered by MCO. Covered for those who meet the associated financial and clinical eligibility requirements. For coverage details, refer to Appendix B.9.0, the MLTSS Services Dictionary, and to Appendix B.4.4., the MLTSS Behavioral Health Services Dictionary	Covered by MCO. Covered for those who meet the associated financial and clinical eligibility requirements. For details, refer to Appendix B.9.0, the MLTSS Services Dictionary, and to Appendix B.4.4., the MLTSS Behavioral Health Services Dictionary
Non-Physician Services	Part B. Services provided by physician's assistants, nurse practitioners, social workers, physical therapists, and psychologists.	Covered MCO. Covers for services rendered beyond Medicare Part B limits (within the scope of practice and in accordance with state certification/licensure requirements, standards, and practices) by certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants, social workers, physical therapists, and psychologists.	Covered.
Nurse Midwife Services	Not covered. (SSA, §1832(a)(2)(B)(iii))	Covered by MCO. Any Applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. (N.J.A.C. 10:49-5.2 (a)21)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Nursing Facility Services	*Covered. Part A. *Covered under certain circumstances in a Skilled Nursing Facility, for a limited time. This must follow a qualifying inpatient hospital stay (see Skilled Nursing Facility entry for this and other details). Includes room and board for skilled nursing and rehabilitative services. Days 1- 100 covered by Medicare. *See Skilled Nursing Facility.	Covered by MCO for all members. Covered beyond Medicare Part A benefits limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO for all members who require nursing facility services. (N.J.A.C. 10:49-5.2.(b)7) MCO. Categorically Needy and Medically Needy. Member may have patient pay liability.
Nursing Facility (Hospice)	*Covered. See Hospice Care Services.	Covered by MCO. *See Hospice Care Services.	* Covered. * See Hospice Care Services.
Nursing Facility (Skilled)	*Covered. Part A. *Covered in a Medicare-certified skilled nursing facility. *See Skilled Nursing Facility.	*Covered by MCO. *Covered in a Medicare- certified skilled nursing facility. *See Skilled Nursing Facility. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*Covered. *See Skilled Nursing Facility.
Nursing Facility (Special Care	*See Nursing Facility.	Covered by MCO. Coverage beyond Medicare covered limits in accordance with N.J.A.C. 8:85-2.21. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Nursing Facility (Long Term/Custodial Care)	Not covered (Social Security Act (§1862(a)(9)).	Covered by MCO. Covered for those who meet Nursing Facility Level of Care. Member may have patient pay liability. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered via MCO upon enrollment in NJFC. Covered via MLTSS for those who meet Nursing Facility Level of Care. (N.J.A.C. 10:49 5.2.(b)7) Member may have patient pay liability.
Organ Transplants	Part B. Includes Provider services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and from a Medicare-certified facility. Also covers certain bone marrow and corneal transplants.	Covered by MCO. Covers medical necessary organ transplants including liver, lung, heart, heart- lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Covered for services rendered beyond Medicare Part B benefit limits. Includes donor and recipient costs for Medicaid-covered transplants. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers medically necessary organ transplants including, liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine, and bone marrow including autologous bone marrow transplants. Categorically Needy. (N.J.A.C. 10:49 5.2(a)25)
Outpatient Hospital Service/Surgery	Part B. Included for approved procedures. Also includes Ambulatory Surgery Center services.	Covered by MCO. Covers for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO.
·**Outpatient Critical Access Hospital Services**	Covered. Part B. (SSA §1832(a)(2)h)	Covered by MCO. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost	

		sharing liability.	

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Outpatient Mental Health/Substance Use Disorder Treatment	Covered. Part B. Covers clinical services from a psychiatrist, clinical psychologist, nurse practitioner, Provider's assistant, clinical nurse specialist or clinical social worker; Substance Use Disorder services; lab tests. Members pay 20% of the Medicare- approved amount for visits to a health care Provider for diagnostic or monitoring purposes. The Part B deductible applies.	Covers outpatient mental health and substance use disorder treatment services, including psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages. Methadone cost, administration, and maintenance covered for all FIDE SNP members by the MCO. The contractor shall furnish MH/SUD services in hospital-based and community- based settings. The contractor shall retain responsibility for MH/SUD screening, referrals, prescription drugs, and for treatment of conditions. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*Medicaid secondary coverage Covers outpatient mental health and substance use disorder treatment services, including psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages. Methadone cost, administration, and maintenance covered under Medicaid Fee- For-Service, except for MLTSS, DDD and FIDE SNP members, for whom it is covered by the MCO. (N.J.A.C. 10:52-1.6(d)1) See Appendix B.4.4.
	Provider's Office: Members pay 20% of the Medicare-approved amount for treatment of the condition (such as counseling or psychotherapy) in a Provider's office setting.	Private Psychiatric Hospital: Outpatient psychiatric services covered for patients of all ages. Covered for all SNP members by the MCO. (N.J.A.C. 10:52-1.6(d)1) Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Private Psychiatric Hospital: Outpatient psychiatric services covered for patients of all ages. *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Outpatient Mental Health/Substance Use Disorder Treatment Continued	Hospital Outpatient: In a hospital outpatient setting, the member pays a copayment.	General Hospital Outpatient: Covered for patients of all ages. Covered for all SNP members by the MCO. (N.J.A.C. 10:52-1.6(d)1) Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	General Hospital Outpatient: Covered for patients of all ages. *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)
		Acute Partial Hospitalization (Mental Health): Covered by the MCO for all members. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Limited to 6 months per individual admission. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Acute Partial Hospitalization (Mental Health): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Limited to 6 months per individual admission.

		Ambulatory Withdrawal Management with Extended On-Site Monitoring/Ambulatory Detoxification: Covered by the MCO for all members. ASAM 2 - WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring/Ambulatory Detoxification: *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 2 WM

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Outpatient Mental Health/Substance Use Disorder Treatment Continued		Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN): Covered by the MCO for all members.	Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO.
		Non-Medical Detoxification/Non- Hospital Based Withdrawal Management: Covered by the MCO for all members. ASAM 3.7 - WM	Non-Medical Detoxification/Non- Hospital Based Withdrawal Management: *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 3.7 WM
		Opioid Treatment Services (Methadone Medication Assisted Treatment): Covered by the MCO for all members.	Opioid Treatment Services (Methadone Medication Assisted Treatment): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO.

	Opioid Treatment Services (Non-Methadone Medication Assisted Treatment): Covered. Part B. Includes coverage for FDA- approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Opioid Treatment Services (Non- Methadone Medication Assisted Treatment): Covered by the MCO for all members. Coverage includes (but is not limited to) FDA- approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Opioid Treatment Services (Non-Methadone Medication Assisted Treatment): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Outpatient Mental Health/Substance Use Disorder Treatment Continued		Partial Care (Mental Health): Covered by the MCO for all members. 25 hour per week (5 hours per day, 5 days per week) limit. Prior authorization required.	Partial Care (Mental Health): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. 25 hour per week (5 hours per day, 5 days per week) limit. Prior authorization required.
		Substance Use Disorder Partial Care (PC): Covered by the MCO for all members. ASAM 2.5	Substance Use Disorder Partial Care (PC): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 2.5
		Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments): Covered by the MCO for all members.	Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments): *Medicaid secondary coverage (for Plan A and ABP members), except for MLTSS members or and DDD clients, who are the Not covered for Plan B, C, or D members by FFS or the MCO. responsibility of the MCO.

		Substance Use Disorder Outpatient: Covered by the MCO for all members. ASAM 1	Substance Use Disorder Outpatient: *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 1

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Outpatient Mental Health/Substance Use Disorder Treatment Continued		Substance Use Disorder Intensive Outpatient (IOP): Covered by the MCO for all members. ASAM 2.1	Substance Use Disorder Intensive Outpatient (IOP): *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 2.1
		Substance Use Disorder Short Term Residential (STR) Covered by the MCO for all members. ASAM 3.7	Substance Use Disorder Short Term Residential (STR) *Medicaid secondary coverage, except for MLTSS members and DDD clients, who are the responsibility of the MCO. ASAM 3.7
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology	Part B. Outpatient evaluation and treatment for occupational, speech language pathology, and physical therapy. Certain conditions and limitations apply.	Covered by MCO. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability. See also Appendix B.9.0.	Covered by MCO. Covers physical, occupational, and speech/language therapy. For FamilyCare B and C beneficiaries, limited to 60 days per therapy per calendar year (except for MLTSS members - refer to Appendix B.9.0). (N.J.A.C. § 10:74-3.4(a)3)

Partial Care / Partial Hospitalization	Covered. Part B.	Medicaid intensive and time-limited acute psychiatric service for beneficiaries of all ages, rendered as a wraparound service beyond Medicare- covered Part B limits. Covered for all SNP members by the MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	*Medicaid secondary coverage. Covered for patients of all ages. Limited to 5 hours per day, five days per week. For MLTSS members and DDD clients, covered by the MCO.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Pap Smears and Pelvic Exams	Covered. Part B. Covers Pap tests, pelvic exams, and clinical breast exams for all women once every 24 months. Pap tests are covered once every 12 months for women at high risk for cervical or vaginal cancer, or for those of childbearing age who have had an abnormal Pap test in the past 36 months. These tests may be covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes (as opposed to routine screening purposes). No coinsurance or copayment. Part B deductible does not apply.	Covered by MCO. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Includes initial Pap smears, as well as any medically necessary confirmatory test. Includes all laboratory costs associated with the aforementioned tests. (N.J.A.C.§11:24-5.2(a)(8)i) (SSA §1905(a)13)

Personal Care Assistance	Covered with certain limitations for homebound members.	Covered by MCO. Covers health- related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a Provider in accordance with a beneficiary's written plan of care. Covered for services rendered beyond Medicare Part B benefit limits. For MLTSS members, the MCO may approve more than 40 hours per week of PCA services. See Appendix B.9.0. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a Provider in accordance with a beneficiary's written plan of care. Services limited to 40 hours per week (not covered for NJ FamilyCare B, C, or D Members). For MLTSS members, the MCO may approve more than 40 hours per week of PCA services. See Appendix B.9.0.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Podiatry	Covered. Part B. --Covers podiatric services deemed medically necessary for the treatment of foot injuries and diseases (such as hammer toe, bunion deformities, or heel spurs). Services considered to be part of routine foot care are not covered. The member pays 20% of the Medicare-approved amount for any medically necessary treatment provided by a Provider. The Part B deductible applies. In a hospital outpatient setting, the member pays a copayment. --Covers foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Members pay 20% of the Medicare- approved amount. In a hospital outpatient setting, members pay a copayment. --*Part B covers therapeutic shoes or inserts under certain circumstances. (*see “Diabetes Supplies” entry for details)	Covered by MCO. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers routine exams and medically necessary podiatric services. Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition. Categorically Needy. (N.J.A.C. 10:49-5.2(a)20) For the Medically Needy population, only available to pregnant women and the aged, blind, and disabled (Groups A and C), as per N.J.A.C. 10:49- 5.3(a)7. (N.J.A.C. §10:57-1.2)

	Hospital Outpatient: In a hospital outpatient setting, the member pays a copayment for medically necessary treatment provided by a Provider. Members also pay a copayment for foot exams related to diabetic peripheral neuropathy rendered in a hospital outpatient setting.	Hospital Outpatient: Covered by MCO. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (By Setting/Facility Where Applicable)
Prostate Cancer Screening	Covered. Part B. Covers digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for men over the age of 50. ■ There is no copayment or coinsurance for the PSA test, and the Part B deductible. ■ The Member pays 20% of the Medicare-approved amount for the digital rectal exam. And for the doctors services related to the exam. The Part B deductible applies. In a hospital outpatient setting, the	Covered by MCO. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer and other prostate cancer risk factors. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost share liability.	Covered by MCO. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer and other prostate cancer risk factors. (N.J.S.A §26:2J-4. 13) (SAA §1905(a)13)

	member pays a copayment.		
	Hospital Outpatient: The member pays a copayment for digital rectal exams in a hospital outpatient setting.	Hospital Outpatient: Covered by MCO Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost share liability.	
Prosthetics and Orthotics	Covered. Part B. Includes arm, leg, back and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Excludes dentures, hearing aids, and exams for fitting hearing aids.	Covered by MCO. Coverage includes (but is not limited to) arm, leg, back and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost share liability.	Covered. (SSA §1905(a)13)(State Plan, Addendum to attachment 3.1-A, Page 12(c), TN 95-41)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Renal Dialysis	Part B. Covered for members with End-Stage Renal Disease (ESRD). Certain restrictions and options apply to coverage under SNP. See 42 CFR 422.50(a)(2)(ii); 42 CFR 422.52(c).	Covered by MCO. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered.
Routine Annual Physical Exams	Covered. Part B.	Covered by MCO. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered.
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility	Part A. Includes skilled nursing and rehabilitative services, and other medically necessary services and supplies after a 3-day minimum inpatient hospital stay for a related illness or injury. The 3- day qualifying stay does not apply to health plans that waived the 3-day requirement with Medicare. Medicare will cover up to 100 days per benefit period.	Covered by MCO. *Covered for services rendered beyond Medicare Part A benefit limits. *See Nursing Facility (Long Term/Custodial Care). Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability	Covered.
·**Rehabilitative Services**	Covered. Part A.	Covered by MCO. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Categorically Needy. (N.J.A.C. 10:49 5.2(a)(10)iii)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Urgent Care	Covered. Part B. Covers care to treat a sudden illness or injury that isn't a medical emergency. The member pays 20% of the Medicare-approved amount. The Part B deductible applies.	Covered by MCO. Covers care to treat a sudden illness or injury that is not a medical emergency. Covered for services rendered beyond Medicare Part A and B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered.
Vision Care Services	*Limited coverage. Part B. *Routine eye exams are not covered. Coverage is provided for some preventative and diagnostic exams. (42 CFR §410.23)	Covered by MCO. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Replacement lenses and frames (or contact lenses) are covered once every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covered for services rendered beyond Medicare Part B benefit limits. *see EPSDT. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Optometric services and optical appliances are covered, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Replacement lenses and frames (or contact lenses) are covered once every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Categorically Needy. (N.J.A.C. 11:24-5.2(a)13) (N.J.A.C. 10:49-5.2(a)13) (N.J.A.C. 10:49-

			5.2(a)16) (N.J.A.C. 10:49-5.2(a)17) *see EPSDT.

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Corrective Lenses	Following cataract surgery with an implanted intraocular lens, Part B helps pay for corrective lenses (eyeglasses or contact lenses). The member pays 20% of the Medicare-approved amount for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. The Part B deductible applies. The member pays any additional cost for upgraded frames.	Covered by MCO. Covers 1 pair of lenses/frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. (N.J.A.C. 11:24-5.2(a)13)
Diabetic Retinopathy Screening	Covers yearly exams for diabetic retinopathy for those with diabetes. In these cases, the member pays 20% of the Medicare-approved amount for the Provider's services.	Covered by MCO. Covers yearly exams for diabetic retinopathy for those with diabetes. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered. (N.J.A.C. 11:24-5.2(a)13)
Glaucoma Screening	Covers a glaucoma test every 12 months for those at high risk for glaucoma. In these cases, the member pays 20% of the Medicare-approved amount for the Provider's services. The Part B deductible applies. (42 CFR §410.23)	Covered by MCO. Covers a glaucoma eye test every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered by MCO. Covers a glaucoma eye test every five years for those 35 or older. (N.J.S.A.§26:2J-4.6(8.a)2)

Service	Medicare Covered (by Setting/Facility Where Applicable)	FIDE SNP Wrap	Medicaid State Plan Service (by Setting/Facility Where Applicable)
Macular Degeneration Screening	Covers certain diagnostic tests for some members with age-related macular degeneration. In these cases, the member pays 20% of the Medicare-approved amount for the Provider's Services.	Covered by MCO. Covers certain diagnostic tests for members with age- related macular degeneration. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	Covered. (N.J.A.C. 11:24-5.2(a)13)
	Hospital Outpatient: In a hospital outpatient setting, the member pays a copayment for the following: - yearly exams for diabetic retinopathy; - glaucoma tests; - diagnostic tests involving age-related macular degeneration	Hospital Outpatient: Covered by MCO. Covered for services rendered beyond Medicare Part B benefit limits. Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.	

Additions Benefits

Service	Medicare Benefits in Network	Medicare Benefits Out of Network	All FIDE Benefits (+ Medicaid)
Cardiac Rehabilitation	Covered	N/A	Covered beyond Medicare limits
Intensive Cardiac Rehabilitation	Covered	N/A	Covered beyond Medicare limits
Pulmonary Rehabilitation	Covered	N/A	Covered beyond Medicare limits
Supervised Exercise Therapy (SET) for PAD	Covered	N/A	Covered beyond Medicare

Services			limits

Service	Medicare Benefits in Network	Medicare Benefits Out of Network	All FIDE Benefits (+ Medicaid)
Emergency/Post-Stabilization Services	Covered	N/A	Covered beyond Medicare limits
Urgently Needed Care	Covered	N/A	Covered beyond Medicare limits
***Worldwide Emergency Services**	Covered	Covered	Covered
***Worldwide Urgently Needed Services**	Covered	Covered	Covered
***Worldwide Emergency Transportation**	Covered	Covered	Covered
Provider Specialist Services	Covered	N/A	Covered beyond Medicare limits
Mental Health-Individual Sessions	Covered	N/A	Covered beyond Medicare limits
Mental Health-Group Sessions	Covered	N/A	Covered beyond Medicare limits
Psychiatric Services Group Sessions	Covered	N/A	Covered beyond Medicare limits
Psychiatric Services Individual Sessions	Covered	N/A	Covered beyond Medicare limits
Chiropractic Services	Covered	N/A	"Includes related lab services and diagnostic services"
Podiatry	Covered	N/A	"Includes routine exams and therapeutic shoes or inserts for those with severe diabetic foot disease"
Other Health Care Professional	Covered	N/A	**Covered beyond Medicare limits**

***Additional Telehealth Services**	Covered	N/A	**Covered beyond Medicare limits "MinuteClinic® Video Visits give you access to general medical care for nonurgent illnesses and conditions, such as allergies, minor injuries or the flu. These visits are available 24 hours a day, 7 days a week."**

Service	Medicare Benefits in Network	Medicare Benefits Out of Network	All FIDE Benefits (+ Medicaid)
Opioid Treatment Program Services	Covered	N/A	Covered beyond Medicare limits
Diagnostic Procedures/Tests	Covered	N/A	Covered beyond Medicare limits
Lab Services	Covered	N/A	Covered beyond Medicare limits
Diagnostic Radiology-CT Scan	Covered	N/A	Covered beyond Medicare limits
Diagnostic Radiology-Other than CT Scan	Covered	N/A	Covered beyond Medicare limits
Therapeutic Radiology	Covered	N/A	Covered beyond Medicare limits
X-Ray	Covered	N/A	Covered beyond Medicare limits
Outpatient Hospital Services	Covered	N/A	Covered beyond Medicare limits
Outpatient Hospital Observation Services	Covered	N/A	Covered beyond Medicare limits
ASC Services	Covered	N/A	Covered beyond Medicare limits
Outpatient Substance Abuse - Individual Sessions	Covered	N/A	Covered beyond Medicare limits
Outpatient Substance Abuse - Group Sessions	Covered	N/A	Covered beyond Medicare limits

Outpatient Blood Services (three pints deductible waived)	Covered	N/A	Covered beyond Medicare limits
***Transportation (Non-Emergent)**	*Covered under Medicaid	N/A	"Includes rides to and from approved locations arranged through New Jersey's transportation vendor, LogistiCare"
DME	Covered	N/A	Covered beyond Medicare limits

Service	Medicare Benefits in Network	Medicare Benefits Out of Network	All FIDE Benefits (+ Medicaid)
Medical Supplies	Covered	N/A	Covered beyond Medicare limits
Prosthetic Devices	Covered	N/A	Covered beyond Medicare limits
Diabetic Supplies	Covered	N/A	Covered beyond Medicare limits
Diabetic Therapeutic Shoes or Inserts	Covered	N/A	Covered beyond Medicare limits
Dialysis	Covered	N/A	Covered beyond Medicare limits
Medicare Part B Chemotherapy/Radiation Drugs (subject to Step Therapy)	Covered	N/A	Covered beyond Medicare limits
Other Medicare Part B Drugs (subject to Step Therapy)	Covered	N/A	Covered beyond Medicare limits
Medicare-Covered Dental	Covered	N/A	Covered beyond Medicare limits "Includes routine and comprehensive coverage, including exams, x-rays, cleanings, fluoride treatments, dentures, periodontal services, filings, crown and more. "
Medicare-Covered Eyewear	Covered	N/A	Covered beyond Medicare limits "Includes routine and diagnostic exams, eyeglasses and contact lenses"
Medicare-Covered Eye Exams	Covered	N/A	Covered beyond Medicare limits "Includes routine and diagnostic exams, eyeglasses and contact lenses"
Medicare-Covered Hearing Exams	Covered	N/A	Covered beyond Medicare limits "Includes routine and diagnostic exams, hearing aids, fittings and accessories"

Non-Participating Providers

All members must use a participating provider in the Aetna Assure Premier Plus (HMO D SNP) network.
Exceptions:

- The plan covers emergency care or urgently needed services from an out-of-network provider.
- If a member needs to seek medical care and there are no providers in the network that can provide care, members can see a non-participating provider with a prior authorization.
- The plan covers kidney dialysis services that are at a Medicare Certified dialysis facility when the member is temporarily outside the plan's service area with a prior authorization.

Outside Service Area

Aetna Assure Premier Plan covers emergencies and urgent services only. If the Member is out of the services area and they are having an emergency, they need to call 911, or go to the closest emergency room. The hospital must contact our Member Services Department to inform them that the Member is being admitted.

For urgent care, please instruct the Member to go to the nearest urgent care Provider. Routine care out of the service area or out of the country is not covered.

Post-Stabilization Services

We cover post-stabilization services provided by a contracted or non-contracted Provider in any of the following situations:

- When Aetna Assure Premier Plan authorized the services
- Such services were administered to maintain the Member has stabilized condition within one (1) hour after a request to Aetna Assure Premier Plan for authorization of further post- stabilization services.
- When Aetna Assure Premier Plan does not respond to a request to authorize further post- stabilization services within one 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.)

Emergency Services

We cover emergency services without requiring prior authorization for Members, whether the emergency services are provided by a contracted or non-contracted Provider. We 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 Members departure from the contracting area.
- Education of the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and plan before accessing emergency services. Aetna Assure Premier Plus (HMO D-SNP) Member Services and Care Management will also assist in educating members regarding emergency services.
- 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 hospitalization due to complications of pregnancy are covered. We abide by the determination of the Provider regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Dental Emergency Services

Members shall have access to treatment for dental emergencies in a dental office/clinical setting or in a hospital emergency department as needed on a twenty-four (24) hour seven (7) day a week basis. Members are able to seek treatment for dental emergencies from any licensed dental provider without the need for prior authorization while outside the Service Area (including out of state services covered by the Medicaid program).

Billing:

- Dental in nature claims, billing with a dental diagnosis code, will be sent to Liberty Dental for Par and Non-Par providers for emergency treatment.

Claims Billing:

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

Website: **www.libertydentalplan.com**

- Medical in nature claims, billing with a medical diagnosis code, for emergency treatment for Par and Non-Par Providers will be sent to the following address: Submitter (Payer ID#**46320**)

Paper Claims:

Aetna Assure Premier Plus (HMO D- SNP)
PO Box 61925
Phoenix, AZ 85082

Through Electronic Clearinghouse

www.echohealthinc.com

Website:

https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/file submit-claims.html

Laboratory Services

We provide services through several Laboratories, please visit our **website** .

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Services EPSDT is the name for the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service, which is required for children under age 21 enrolled in New Jersey Medicaid. EPSDT Program provides comprehensive preventive health care, diagnosis, and treatment to children under 21.

According to federal law, any Medicaid service that a child needs must be covered if determined medically necessary by New Jersey rules and laws. Therefore, New Jersey covers more services for children than for adults. These services help New Jersey 's children get the care they need before a treatable illness becomes serious. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) also covers complete medical, vision, dental, hearing, nutritional, developmental, and mental health exams, in addition to other care to treat physical, mental, or other problems or conditions found by an exam.

Aetna Assure Premier Plus (HMO D-SNP) will monitor its Providers to provide follow up or missed appointments and referrals for problems identified through the EPSDT exams.

For additional information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT), please visit the following website:
https://www.state.nj.us/dcf/policy_manuals/CPP-V-A-3-800_issuance.shtml

See the benefit grid for additional details.

Vision Services

Routine vision services are provided through 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 Assure Premier Plus (HMO D-SNP). 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 Assure Premier Plus (HMO D-SNP). 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 Assure Premier Plus (HMO D-SNP).

Aetna Assure Premier Plus (HMO D-SNP) covers vision services for all Members. Benefits included:

- Routine eye exams

Eyeglasses or contact lenses when medically necessary See the benefit grid for additional details.

Direct-Access Immunizations

Members may receive influenza and pneumococcal vaccines from any network Provider without a referral, and there is no cost to the Member if it is the only service provided at that visit.

Out of Area Benefits

When Members are out of the area (example: on vacation), Aetna Assure Premier Plan covers emergencies only.

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 our Member Services Department at **1-844-362-0934**.

Cost Sharing

Our Members have no cost sharing as part of the Aetna Assure Premier Plan. Providers are not allowed to balance bill, nor can they bill for any cost sharing, including deductibles, coinsurance or copay.
As provided at 42 U.S.C. 1395w-22(a)(7), (42 CFR 438.206(b)(5), the Contractor shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Member under title XIX if the individual were not enrolled in such plan.
All Medicare-covered services must be medically necessary, and except for emergency or urgently needed care, or otherwise authorized by Aetna Assure Premier Plus (HMO D SNP), must be provided by a participating PCP or other qualified participating Providers.

Benefit limits apply.

Providers are required to administer covered services to Members in accordance with the terms of their Provider Agreement and Member's Evidence of Coverage (EOC).
The full array of benefits and supportive services under the Aetna Assure Premier Plan include, Medicare (including inpatient, outpatient, hospice, durable medical equipment, nursing homes, home health, and pharmacy) and Medicaid (including behavioral health and MLTSS for those who qualify).

Annual Notice of Change

Benefits are subject to change annually. Members are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period begins on October 15th each year for Members and ends on December 7th.
Providers can access our website on or around October 15th for information on the individual plan and benefits that will be available for the following calendar year.

Medicare Coverage Overview

- Part A Hospital Insurance pays for inpatient care, nursing home care, hospice, and home health care.
- Part B – Medical Insurance pays for Provider's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- Part C – Medicare Advantage Plans (MA) combine Parts A and B health benefits through managed care organizations; most plans include Part D (MAPD plans).
- Part D – Medicare Prescription Drug Plan helps pay for prescription drugs, certain vaccines, and certain medical supplies (e.g. needles and syringes for insulin); Part D coverage is available as a standalone Prescription Drug Plan (PDP) or integrated with medical benefit coverage (MAPD).

Chapter 6: Dental Benefits

Dental Services

Aetna Assure Premier Plus (HMO D-SNP) has a comprehensive dental benefit that covers all medically necessary dental treatment. All NJFC Members have the same comprehensive dental benefits which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral surgical and other adjunctive general services. Some procedures may require prior authorization with documentation of medical services. Orthodontic services are age restricted and only approved with adequate documentation of handicapping malocclusion or medical necessity.

Dental Services Covered under the Medical Benefit

Dental services provided to Aetna Assure Premier Plus (HMO D-SNP) members are comprehensive and include reparative, restorative and reconstructive procedures involving the upper or lower jaws and dental structures as appropriate to Provider specialty.
Medical and surgical services that are performed by either dentists or Providers are covered, regardless of whether the Provider is a medical or a dental specialist. Examples of such services include management of facial trauma, maxillofacial prosthetics, management of tumors or cysts of the oral/facial structures and craniofacial reconstruction, which might be treated by otolaryngologists, oral surgeons, other dental Providers or plastic surgeons. Whether the service is covered under the dental benefit or under the medical benefit will depend upon multiple factors, including the need for additional service Providers, such as anesthesia, or for specific places of service, such as a hospital. Both dental and medical Providers will be covered according to the circumstances.

Services that need prior authorization under the medical benefit should be requested through the UM process. When services are covered under the dental benefit, they should be requested through the dental vendor (see below). If there is a question about which benefit applies, please call Provider Relations at **1-844-362-0934.**

In addition, medically necessary dental services which are performed at a facility-based setting, such as dental care under general anesthesia, are covered under the medical benefit. Providers who perform these procedures at hospitals must have admitting privileges at a participating NJ hospital. They should submit requests for the dental service to Liberty Dental Plan for authorization. Upon receiving authorization from Liberty Dental Plan, the Provider should contact Aetna Assure Premier Plus (HMO D-SNP)'s Prior Authorization Department for the facility authorization.

A prior authorization request may be submitted to the Aetna Assure Premier Plus (HMO D-SNP) Utilization Management Department by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Assure Premier Plus (HMO D-SNP) website at **http://www.AetnaBetterHealth.com/New-Jersey-hmosnp** or
- Fax the request form to **1-833-322-0034** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing; or
- Through our toll-free number **1-844-362-0934**

Definitions

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

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

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

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

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)--a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in Members under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

Dental Vendor

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

Liberty Dental Plan
340 Commerce, Suite 100,
Irvine, CA 92602

Liberty Dental Plan can be reached as follows:
Telephone: 1-855-225-1727
Website: **www.libertydentalplan.com**

Credentialing of Dentists

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

Dental Specialists and Specialty Care

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

Dental specialists are either board eligible or board certified. The listing of all dental Providers and dental specialists can be found on our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp**.

Requirements for Dental Providers using Mobile Dental Services

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

Definitions

Mobile Dental Practice -- Provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These Providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. Aetna Assure Premier Plus (HMO D-SNP) must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.
Mobile Dental Van -- a vehicle specifically equipped with stationary dental equipment and used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a “brick and mortar” facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van’s patients of record (Members). Patient records are to be maintained in the brick and mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements. When a mobile dental van’s use is associated with health fairs or other one time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. Aetna Assure Premier Plus (HMO D-SNP) must maintain documentation for all locations served to include schedule of time and days.

EPSDT Dental Services and Fluoride Varnish Program

The EPSDT benefit for children ages 0-20 includes oral health screenings provided by the primary care Provider as well as comprehensive dental services provided by dentists. Dental screenings include, at a minimum, observation of tooth eruption and occlusion pattern as well as examination for the presence of caries or oral infection. All children should be referred to a dentist before they reach one year of age and at least twice annually thereafter for oral evaluation and preventive services. All needed dental preventive and treatment services are covered. Dental Services may not be restricted to emergency services. There should be bidirectional communication between the dentist and the member's primary care Provider. Individuals eligible for EPSDT under New Jersey FIDE SNP program would need to be younger than Twenty-one (21) years of age.

Aetna Assure Premier Plus (HMO D-SNP) participates in the NJ Smiles Program. The program allows non- dental Providers to provide dental risk assessment, fluoride varnish and dental referral for children under the age of three (3) years old. Fluoride varnish to prevent caries can be applied up to four times a year by a PCP in addition to fluoride application performed by the primary care dentist (PCD). PCDs and PCPs should provide caries risk assessment at least once annually.

Information about training for primary care Providers in application of fluoride varnish can be found on our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp**.

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

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

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

Utilization Management for Dental Care

Dental services provided through the dental benefit are managed by Aetna Assure Premier Plus (HMO D-SNP) dental vendor, Liberty Dental Plan. Utilization management is among the services they provide. Criteria established for dental benefits are described in their Office Reference Manual and available on their website at: **www.libertydentalplan.com**.
Consideration for prior authorization of services considers the overall general health, patient compliance and dental history, condition of the oral cavity and a complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the Provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment. Proposed treatment plans are reviewed through the prior authorization process to assure that all services are medically necessary and within the benefit, with the considerations above. If documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the documentation. All final decisions regarding denials of referrals, PA's, treatment and treatment plans for non-emergency services shall be made by a licensed New Jersey dentist/dental specialist.

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

Second Dental Opinion

Any member may request and receive a second opinion from a different dentist or dental specialist within the network. With prior authorization and when medically

necessary, requests may also be approved to obtain a second opinion outside the network.

Continuity of Care for Dental Services

Treatment plans established in another plan before a member joins Aetna Assure Premier Plus (HMO D-SNP) are honored for up to 183 days or as long as the member is in active treatment, whichever is longer. The time frame begins on the first day of their active eligibility in Aetna Assure Premier Plus (HMO D-SNP).
The same time frame of 183 days or as long as the member is in active treatment, whichever is longer, also applies if the dentist treating the member started care as a participating Provider but subsequently leaves the network, either voluntarily or involuntarily.

Dental Care for Members with Special Needs

Aetna Assure Premier Plus (HMO D-SNP) has enhanced dental benefits for child and adult members with special needs, including intellectual/developmental disabilities, chronic medical conditions and behavioral health conditions. These members may need longer appointments, more frequents appointments or have other needs for modification of dental services. For members with special needs, preventive and other dental services are covered every three months or more often as needed to address their dental needs. There is no restriction in referral of these members to a dental specialist or Provider who has special skills in treating individuals with special needs Additional diagnostic, preventative and periodontal services shall be available beyond the frequency limitations of every six months and be allowed every three months to Members with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

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

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

Medically necessary dental services which are performed at a facility-based setting, such as dental care under general anesthesia, are covered under the medical benefit. Providers who perform these procedures at hospitals must have admitting privileges at a participating NJ hospital. They should submit requests for the dental service to Liberty Dental Plan for authorization. The information submitted should

include a narrative describing the medical necessity that includes the following information:
Report CDT procedure code D9999 to request prior authorization;

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

Providers shall be reimbursed for costs of pre-op and post-op costs related to OR services. Preauthorization is not required for the dentist for dental procedures performed for these members for dentally appropriate restorative, endodontic, periodontal or oral care provided under general anesthesia. Upon receiving authorization from Liberty Dental Plan, the Provider should contact Aetna Assure Premier Plus (HMO D-SNP) Prior Authorization Department at **1-844 362- 0934** for the facility authorization. Informed consent, signed by the member or authorized person, must be obtained prior to the operating room visit. In the event that normally preauthorized procedures are completed in the operating room, x-rays should be submitted with the claim supporting the procedures completed. For more information please visit the Liberty Dental Reference Guide at **www.libertydentalplan.com**.

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

ICD-10-CM DIAGNOSIS CODES FOR MEDICAL EXCEPTION REQUIREMENT

The ICD-10-CM diagnosis codes listed below meet the medical exception requirement for an operating room visit by a dentist to provide dental services. The medical exception diagnosis codes must be reported on outpatient hospital claims. A valid ICD-10-CM diagnosis code is composed of 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.

A three-character code is to be used only if it is not further subdivided.

E75 – E756 Disorders of Sphingolipid Metabolism and Other Lipid Storage Disorders

F03 – F0391 Unspecified Dementia

F06 – F068 Other Mental Disorders Due to Known Physiological Condition

F07 – F079 Personality and Behavioral Disorders Due to Known Physiological Condition

F09 Unspecified Mental Disorder Due to Known Physiological Condition

F48 – F489 Nonpsychotic Mental Disorders

F53 Puerperal Psychosis

F60 – F609 Specific Personality Disorders

F70 Mild Intellectual Disabilities (IQ 50-55 to ~70))

F71 Moderate Intellectual Disabilities (IQ 35-40 to 50-55)

F72 Severe Intellectual Disabilities (IQ 20-25 to 35-40)

F73 Profound Intellectual Disabilities (IQ level below 20-25)

F78 Other Intellectual Disabilities

F79 Unspecified Intellectual Disabilities

F84 – F849 Pervasive Developmental Disorders

F88 Other Disorders of Psychologica lDevelopment

F89 Unspecified Disorder of Psychological Development

F90 - F909 Attention-Deficit Hyperactivity Disorder

F91 - F919 Conduct Disorders

G10 Huntington's Disease

G25 – G259 Other Extrapyramidal and Movement Disorders

G31 – G319 Other Degenerative Diseases of Nervous System, Not Otherwise Classified

G40 – G409 Epilepsy and Recurrent Seizures

G71 – G719 Primary Disorders of Muscles

G72 – G729 Other and Unspecified Myopathies

G73 – G737 Disorders of Myoneural Junction and Muscle in Diseases Classified Elsewhere

G80 – G809 Cerebral Palsy

G93 – G939 Other Disorders of Brain

P04 – P049 Newborn (Suspected to be) Affected by Noxious Substances Transmitted via Placenta or Breast Milk (Does Not Include

P042 (Maternal Use of Tobacco))

Q86 Congenital Malformation Syndromes Due to Known Exogenous Causes, Not Elsewhere Classified

Q90 – Q99 Down Syndrome

R56 – R569 Convulsions, Not Otherwise Classified

S06 – S069X9 Intracranial Injury

F819 Developmental Disorder of Scholastic Skills, Unspecified

I6783 Posterior Reversible Encephalopathy Syndrome (PRES) P154 Birth Injury to Face (Facial Congestion Due to Birth Injury)

P158 Other Specified Birth Injuries

P159 Birth Injury, Unspecified

Additional information can be found in the Dental Provider Manual at **www.libertydentalplan.com**

Special Considerations for Orthodontia

Orthodontics are covered up to age 21 or until the time when NJ FamilyCare eligibility is lost. This includes limited, interceptive and comprehensive orthodontic treatment. There are special criteria for medical necessity for all orthodontic treatment as indicated in the form NJ Orthodontic Assessment Tool HLD (NJ Mod3). All orthodontic treatment requires prior authorization. Initial visits to evaluate (consultation and pre-orthodontic treatment visits) do not require authorization.

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

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

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

An orthodontic consultation (D9310) is a visual examination and may also include a complete HLD (NJ-Mod3) assessment tool by the attending Provider or a Provider in the same group who will be providing the service and which does not require prior

authorization. The consultation can be provided once a year; the member can have a second opinion with a different Provider.

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

The new HLD (NJ-Mod3) Assessment Tool

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

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

Minor Treatment to Control Harmful Habits

Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited, interceptive or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the Provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity. For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records. Upon completion of the case pre treatment and post-treatment photographs must be submitted.

Orthodontic Treatment Services

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

In cases where prior authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating Provider an opportunity to discuss the case.
An approved case must be started within six (6) months of receiving the approval.

Limited orthodontic treatment

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

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

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the Provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member.

Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered with documentation of medical necessity.

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

Interceptive and Comprehensive Orthodontic Treatment

For prior authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction and dental diagnosis;

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

Interceptive orthodontics

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

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

Comprehensive Orthodontic

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

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

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

Requesting Prior Authorization

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

Beginning Treatment

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

Continuing treatment

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

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC Medicaid Program

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

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

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

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

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

Conclusion of Active Treatment

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

Documentation for Completion of Comprehensive Cases – Final Records

The following must be submitted to document the completion of comprehensive cases:

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

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

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

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

If it is determined that treatment is not progressing because the patient is exhibiting non- compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered. A letter must be sent to the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the discontinuation of treatment with de-banding.
If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. A copy of the signed form and the patient treatment records must be sent to the NJFC MCO of enrollment. The reimbursement for appliance placement includes their removal, however, prior authorization to allow reimbursement can be considered when removal is performed by a Provider that did not start the case.

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

Grievances and Appeals for Dental Services or Issues

Member complaints, grievances and appeals regarding dental care, dental services and dental Providers should be submitted to the Aetna Assure Premier Plus (HMO D-SNP) Grievance and Appeals process (see Chapter 17: Grievance System), orally or in writing, similarly to all other types of complaints, grievances and appeals.

Aetna Assure Premier Plus (HMO D-SNP) reviews every complaint and grievance to assure that each is handled within the required timeframes and is handled as is appropriate to our members. If a member is not satisfied with the outcome of a first level appeal, all other levels of appeal are managed the same way as for other types of services.

Member complaints, grievances and appeals can be submitted to Aetna Assure Premier Plus (HMO D-SNP) at:
Aetna Assure Premier Plus (HMO D-SNP) Attn: Grievance and Appeals
P.O. Box 818070
5801 Postal Road
Cleveland, OH 44181
Fax Number: 1-860-607-7819
Provider claim appeals and other non-utilization management appeals should be submitted to Liberty Dental Plan at:
Liberty Dental Plan Grievance and Appeals Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Telephone: 1-888-703-6999
Website: **https://www.libertydentalplan.com**

Dental Forms

The forms referenced in this Chapter are available on our Website at **https://www.aetnabetterhealth.com/new-jersey_hmosnp/providers/forms.html**

Chapter 7: Member Rights & Responsibilities

Aetna Assure Premier Plus (HMO D-SNP) 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 Provider Agreement with us requires compliance with Member rights and responsibilities, especially treating Members with respect and dignity. Understanding Members' rights and responsibilities is important because you can help Members to better understand their role in and improve their compliance with treatment plans.

It is our 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 we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Oversight Committee (QMOC) and further action may be necessary.

In the event that we are made aware of an issue when the Member is not demonstrating the responsibilities as outlined above, we 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 Assure Premier Plus members have the following rights:

- To receive understandable information about Aetna Assure Premier Plan, its services, its practitioners and Providers and Member rights and responsibilities.
- To receive all services that Aetna Assure Premier Plan is required to provide pursuant to the terms of the three-way contract, Provider agreement, and CMS requirements.
- To receive understandable information about covered benefits and services as well as any Member cost-sharing.
- To be treated with respect and recognition of their dignity and their right to privacy.
- To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.
- To be provided information about their health. Such information should also be made available to the individual legally authorized by the Member to have

such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.

- To participate with practitioners in making decisions about their health care and be encouraged to involve caregivers or family Members in discussions and decision.
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. This information will be presented in a manner appropriate to the Member's condition, functional status, and language needs.
- To be assured of auditory and visual privacy during all health care examinations or treatment visits.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- To be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- To be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation will be entered into the medical record accordingly.
- To voice complaints or appeals about the organization or the care it provides.
- To be assured that all written Member information provided by Aetna Assure Premier Plus (HMO D-SNP) is available:
    - At no cost to the Member,
    - In the prevalent non-English languages of Members in Aetna Assure Premier's service area, and
    - In alternative formats and in an appropriate manner that takes into consideration the special needs of Members including but not limited to visually limited and limited reading proficiency (LRP)Members.
    - To be assured that oral interpretation and oral translation services are available at no cost to Members.
    - To be assured that the services of sign language assistance are available to hearing impaired Members.
- To be informed of specific student practitioner roles and the right to refuse student care.
- To refuse to participate in experimental research.
- To have advance directives explained to them, formulate advance directives and to file any complaints concerning noncompliance with advance directives with the New Jersey Department of Health.

- To change PCPs no less often than monthly. Aetna Assure Premier Plan mails written confirmation to the Member of their new PCP selection prior to or on the effective date of the change.
- To reasonable accommodations for disabilities
- To be protected from discrimination including on the basis of race, ethnicity, color, religion, gender, sexual orientation, age, national origin, ancestry, veteran's status, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, source of payment or disability.
- To appeal to or file directly with the United States Department of Health and Human Services Office of Civil Rights any complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.
- To appeal to or file directly with the DMAHS of Bureau Civil Rights any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.
- To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way Aetna Assure Premier Plan or its practitioners/ Providers, or State of New Jersey Division of Medical Assistance & Health Services (DMAHS) treats the Member.
- To be assured that Aetna Assure Premier Plan must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- To choose his or her health professional to the extent possible and appropriate.
- To have access to emergency care when and where it is needed.
- To be assured that female Members have direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCP if the PCP is not a woman's health specialist.
- To be provided a second opinion from a qualified health care professional within Aetna Assure Premier Plus (HMO D-SNP)'s panel. If such a qualified health care professional is not available within Aetna Assure Premier Plan's panel, Aetna Assure Premier Plan must arrange for a second opinion outside the network, at no cost to the Member.
- A right to make recommendations regarding Aetna Assure Premier Plan's Member rights and responsibilities policy.
- The right not to be balanced billed by any network Provider for any reason for covered services, including cost sharing.
- To receive information about a denial of health care payment, coverage of services or prescription drug coverage.

- To access an adequate network of primary and specialty Providers who are capable of meeting the Member's needs with respect to physical access, communication and scheduling needs and are subject to ongoing assessment of clinical quality including required reporting.
- To choose another Aetna Assure Premier Plan health plan at any time including a Medicare plan outside of the Aetna Assure Premier Plan program and have that choice be effective the first calendar day of the following month.
- Receive an in-person Comprehensive Assessment upon enrollment and to participate in the development and implementation of an Individualized Care Plan.
- Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
- To receive reasonable advance written notice of any transfer to another treatment setting and the justification for the transfer.
- To receive medical and non-medical care from a team that meets the Member's needs, in a manner that is sensitive to the Member's language and culture, and in an appropriate care setting, including the home and community.
- To receive timely information about plan changes. This includes the right to request and obtain the information in the Welcome Packet at least once per year, and the right to receive notice of any significant changes in the information provided in the Welcome Packet at least thirty 30 days prior to the intended effective date of the change.
- To choose or refuse health care in lieu of services of settings that the plan must provide, as long as the choices are medically appropriate and cost-effective.
- Members in MLTSS also have certain rights. These include:
    - To request and receive information on choice of services available;
    - Have access to and choice of qualified service providers;
    - Be informed of their rights prior to receiving chosen and approved services;
    - Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability;
    - Have access to appropriate services that support their health and welfare;
    - Choose between nursing facility and Home and Community Based Services if the member qualifies for nursing facility care and if the member's needs can be safely and cost effectively met in the community
- To assume risk after being fully informed and able to understand the risks and consequences of the decisions made;

- To make decisions concerning their care needs;
- Participate in the development of and changes to the Plan of Care;
- Request changes in services at any time, including to add, increase, decrease or discontinue;
- Request and receive from their Care Manager a list of names and duties of any person(s) assigned to provide services to them under the Plan of Care;
- Receive support and direction from their Care Manager to resolve concerns about their care needs and/or grievances about services or providers;
- Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings;
- Be informed of all the covered/required services they are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility;
- Not to be transferred or discharged out of a facility except for medical necessity; to protect their physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment.
- Have their health plan protect and promote their ability to exercise all rights identified in this document. Have all rights and responsibilities outlined here forwarded to their authorized representative or court appointed legal guardian
- Appeal or request Medicaid Fair Hearing through DMAHS regarding eligibility for MLTSS or participation in the participant direction program
- Members have the right, as a resident of an MLTSS community:
    - Have a key to lock/unlock the home and bedroom doors.
    - Have visitors of your choosing
    - Make and Receive phone calls
    - Make an independent schedule
    - Have access to food at any time unless otherwise determined in a documented, person centered process
    - Have access to appropriate services that support your health and welfare

Member Responsibilities

Aetna Assure Premier Plus (HMO D-SNP) Members, their families or guardians are responsible for:

- Knowing the name of the assigned PCP and/or Care 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 the Aetna Assure Premier Plus Plan
- To supply information (to the extent possible) that Aetna Assure Premier Plus (HMO D-SNP) and its practitioners and Providers need in order to provide care
- To follow plans and instructions for care that they have agreed to with their practitioners
- To understand their health problems and participate in developing mutually agreed- upon treatment goals, to the degree possible
- Reporting changes such as; address, telephone number and/or assets, and other matters that could affect the Member's eligibility to the office where the Member applied for Medicare-Medicaid services
- Protecting their Member identification card and providing it each time they receive services
- Disclosing other insurance, they may have and/or applying for other benefits they may be eligible for
- 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
- Bringing immunization records to all appointments for children under eighteen (18) years of age

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: 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 in the Integrated Care Program may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

Chapter 8: Eligibility & Enrollment

Aetna Assure Premier Plus (HMO D-SNP) arranges medically necessary covered services for individuals who are enrolled in the plan. This chapter describes eligibility categories and the enrollment and disenrollment processes.

Eligibility 10.5.2

Individuals who meet the following plan eligibility requirements may enroll:

- Eligible for Medicare; entitled to Medicare Parts A and B;
- Eligible for NJ FamilyCare (Medicaid);
- Have QMB+ or FBDE (Full Benefit Dual Eligible) status; and
- Live in the state of New Jersey

If a Member loses their Medicaid eligibility, our plan will continue to cover the Member's Medicare benefits for a period of deemed eligibility for three (3) months. The plan will also continue to cover Medicare cost-sharing during this time, however, during this period, Medicaid- only benefits may not be covered by our plan. To find out if a benefit is Medicaid only, or to find out if it will be covered, you can call **1-844-362-0934**. This period of deemed eligibility begins the first day of the month after we learn of the loss of eligibility. If at the end of the three (3) month period of deemed eligibility, the Member's Medicaid eligibility has not been regained and the member has not enrolled in a different plan, we will disenroll the member from our plan and they will be enrolled back in Original Medicare.

Non-Eligible Populations 10.5.2B

The following populations are not eligible for the Aetna Assure Premier Plus (HMO D-SNP) plan:

- Individuals in Medicare Beneficiary categories not eligible for NJ Medical Assistance.
- Individuals only eligible for Specified Low-Income Medicare Beneficiary, Qualified, Disabled and Working Individuals, the Qualified Individual or the Qualified Indivual-2 and are not otherwise legible for Medical Assistance.
- Individuals who are residents of State-operated psychiatric facilities.
- Individuals considered out of the Contractor's service area by Medicare, including incarcerated individuals.
- Newborns. Newborns to Members will be transferred automatically to the NJFC plan associated with the mother's FIDE SNP. The transfer will be effective as of the date of birth.
- Individuals enrolled in PACE

Verifying Eligibility

Providers can verify Member eligibility by calling our Member Service at 1-844-362-0934, or online through our Secure Web Portal at **http://www.AetnaBetterHealth.com/New-Jersey-hmosnp**

Enrollment Effective Dates

Aetna Assure Premier Plus (HMO D-SNP) members also have Special Enrollment Periods (SEP) which allow them to enroll, disenroll or switch plans throughout the month, year-round. Enrollment changes become effective the first day of the following month. Members can also make a plan change during the 4th quarter of the year during Medicare Open Enrolment.

Welcome Packet

Welcome packets are issued to Members prior to the first day of the month in which the Member's enrollment starts. If there is more than one Member in one household, every Member will receive their own welcome packet.

At a minimum, the welcome packet contains the following:

- Welcome Letter
- Transition of Care form
- Member Handbook/Evidence of Coverage (will also be mailed annually)
- Annual Notice of Change (after Aetna Better Health's first year offering the Plan)
- Summary of Benefits
- Multi-Language Insert
- HIPAA Notice of Privacy Practices
- "How to request a Provider and Pharmacy Directory and List of Covered Drugs (Formulary)" tear out card

We provide translated materials, interpretive services, and/or information available in alternative formats (i.e. braille, large print, CD etc.) as needed or requested by Members or potential Members.

PCP Changes

A member may change their PCP at any time and for any other reason. The Member may choose a new PCP at any time by calling our Member Services Department at **1-844-362 0934** We will promptly grant the request and process the PCP change in a timely manner. Members will receive a new ID card indicating the new PCP's name. In cases where a PCP has been terminated for reasons other than cause, we will promptly inform Members assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a member fails to select a new PCP, the Member is reassigned to another compatible PCP prior to the PCP's termination date, informing the Member of the change in writing.

Sample ID Cards

Medical Plan ID Card:

Front:

Back:

Members should present their Aetna Assure Premier Plus (HMO D-SNP) ID card at the time of service. Providers should always confirm eligibility prior to rendering services. The Member ID card contains the following information:

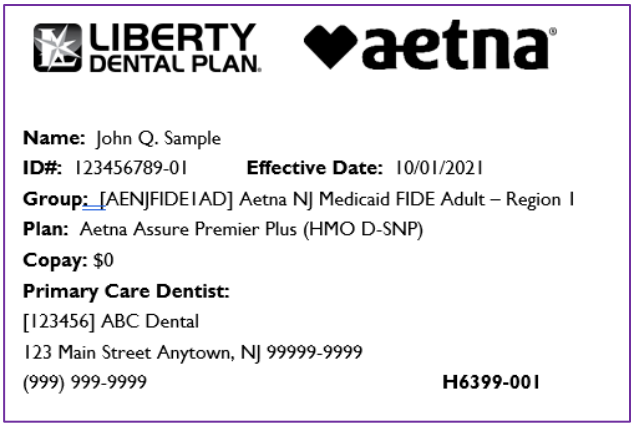
- Member Name, MMIS ID Number
- Health Plan ID Number
- PCP Name, PCP Phone Number
- Claims address
- Emergency Contact Information for Member
- Health Plan Name: Aetna Assure Premier Plus (HMO D-SNP) Logo, Aetna Assure Premier Plus (HMO D-SNP) Website
- RX Bin Number, RX PCN Number, RX GroupNumber

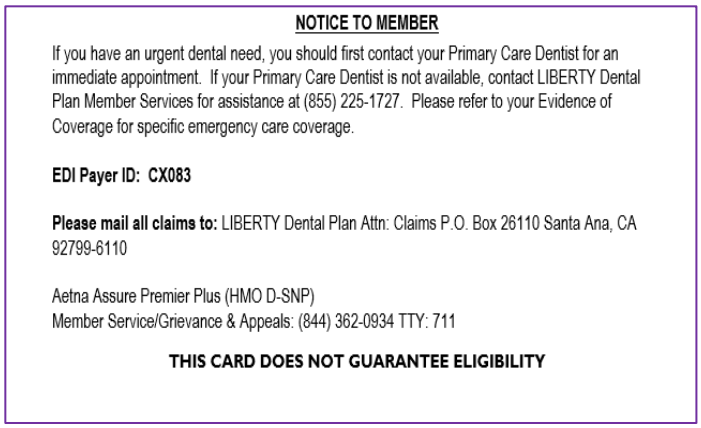
Dental Plan ID card:

For those plans which utilize PCD assignment, information regarding their separate dental identification card which is issued to members shall be included in the provider manual, which shall contain an image (front and back) of the enrollee identification card to be issued by the Contractor along with an explanation as to its use in assisting members in obtaining services in accordance with Section 5.8.5.

Front:

Back:





Chapter 9: Quality Management

Overview

Our Quality Assessment Performance Improvement (QAPI) program is a comprehensive program design that supports the delivery of safe and high-quality care and services to the served membership and network Providers. Our QAPI program provides an integrated operational framework for continuous quality improvement utilizing standardized performance indicators across the healthcare continuum and uses the Model of Care as a fundamental framework which focuses on member-driven needs.

Our QAPI Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities allow for proactive and ongoing review of 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, measure and modify interventions on an ongoing basis to drive sustainability and diffusion of improvement strategies.

The use of meaningful data and standardized indicators in the monitoring, measurement, and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our QAPI Program uses an integrated and collaborative approach, involving our senior management team, external stakeholders, functional areas within the organization, and committees. This structure allows members, member advocates and Providers to offer input into our quality improvement activities. The primary goal of the program is to improve the health and quality of life for our members or maintain current health status when the member's condition is not amendable to improvement. Our Chief Medical Officer (CMO) oversees the QAPI program. The CMO 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 our 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 experience, and quality and utilization management.

Additional committees such as Service Improvement, Credentialing and Performance, Delegation Oversight, Appeals and Grievance, Provider Advisory, Member Advisory, MLTSS Consumer Advisory and Utilization Management further support our QAPI Program. We encourage Provider participation on key medical committees. For a full listing of all the committees and their responsibilities please refer to the QAPI program description by contacting your Provider experience representative.

Providers may contact the Chief Medical Officer (CMO) or inform their Provider Experience Representative if they wish to participate.
Our 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.

Our 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, recommend and promote improvements in the delivery of care and services to our members. Our QM and Medical Management (MM) and managers (CM) departments maintain ongoing coordination and collaboration regarding quality initiatives, care management, and disease management activities involving the care of our members.

Aetna Assure Premier Plus (HMO D-SNP)'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 Assure Premier Plus (HMO D-SNP), 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 Assure Premier Plus (HMO D-SNP)'s QAPI and Utilization Management program standards.

Note: *Providers must also participate in the Centers of Medicare and Medicaid (CMS) and the State of New Jersey Division of Medical Assistance & Health Service's (DMAHS) quality improvement initiatives. Any information provided must be reliable and complete.*

Identifying Opportunities for Improvement

We identify and evaluate opportunities for quality improvement and determine the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data from various sources. The types of data Aetna Assure Premier Plus (HMO D-SNP) monitors to identify opportunities for quality improvements include:

- Formal Feedback from External Stakeholder Groups: Aetna Assure Premier Plus (HMO D-SNP) takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, various member and Provider experience surveys, or focus groups with individuals, such as members, member advocates 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 Assure Premier Plus (HMO D-SNP) 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, member representatives, Providers, and other external sources, Aetna Assure Premier Plus (HMO D-SNP) proactively identifies potential quality of care, quality of service, access to care issues, practitioner's office site issues or billing and financial issues for review through daily operations (i.e. member services, medical management, quality management, and care management). Through an established and 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 and timeliness of decision making), Aetna Assure Premier Plus (HMO D-SNP) is able to identify specific opportunities for improving care and services delivered to individual members.
- Findings from Internal Program Assessments: Aetna Assure Premier Plus (HMO D-SNP) conducts a number of formal assessments/reviews of program operations and Providers that are used to identify opportunities for improvement. These include but are 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 and network adequacy based on national standards.
- Clinical and Non-Clinical Performance Measure Results: Aetna Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) is able to identify opportunities for improvement in clinical and operational functions. These measures include but not limited to:

- Adherence to nationally recognized best practice guidelines and protocols
- Prior authorization, Concurrent reviews or post-service reviews (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 Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) 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 internally selected performance measures. Aspects of care that Aetna Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) has a process for identifying 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 Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) 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)/Chronic Condition Improvement Program(s)

Performance improvement projects (PIPs)/Chronic condition improvement program(s) are key component of our QAPI Program and are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs/CCIPs follow CMS's/DMAHS's protocols. Aetna Assure Premier Plus (HMO D-SNP) participates in state and CMS-mandated PIPs/CCIPs and selects topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of Members' care and services overtime
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Assure Premier Plus (HMO D-SNP) enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM Department prepares PIP/CCIP proposals that are reviewed and approved by our Chief Medical Officer (CMO), Utilization Management Committee, Quality Management Oversight Committee (QMOC) and the DSNP Oversight Committee prior to submission to the 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 Assure Premier Plus (HMO D-SNP), as well as from network Providers.

The QM Department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP/CCIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement, or even a decline in performance, we immediately conduct additional analyses to identify root cause of the decline and consequently modify the interventions to drive the desired effect. This cycle continues until we achieve real and sustained improvement.

Peer Review

Peer review activities are evaluated by the Health Plan's Credentialing Committee and Aetna's Credentialing and Performance Committee. These committees may take action if a quality of care issue is identified. Such actions may include, but are not limited to, development of a corrective action plan 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 QM department, they may require the participation of MM, CM, Provider Experience, or other departments. Aetna Assure Premier Plus (HMO D-SNP) may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The health plans peer review process adheres to the Aetna Assure Premier Plus (HMO D-SNP) policies, and is conducted under applicable state and federal laws, and is protected by the immunity and confidentiality provisions of those laws.

The right to appeal is available to Providers whose participation in the Aetna Assure Premier Plus (HMO D-SNP) 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.

Member Safety

Member safety is addressed through various collaborative activities such as prescription utilization review, prior authorization of pharmacy claims to verify medical appropriateness or prevent unsafe prescribing, education and reporting on critical incidents, review and adaptation of medical necessity criteria representative of healthcare needs of the served population, PQoC reviews, Hospital care-acquired conditions and other Provider-preventable condition reviews and assessments, evaluation of inpatient hospital mortality rates.

Performance Measures

We collect and report clinical and administrative performance measure data sets to the DMAHS and CMS. The data sets enable Aetna Assure Premier Plus (HMO D-SNP), the DMAHS and CMS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in member outcomes.

Satisfaction Surveys

We conduct Member and Provider satisfaction surveys to gain feedback regarding Member and Providers' experiences with quality of care, access to care, and service/operations. We use 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®) survey assesses patient satisfaction with the experience of and access to care. CAHPS® surveys are subsets of Healthcare

Effectiveness Data and Information Set® (HEDIS) reporting. Aetna Assure Premier Plus (HMO D-SNP) 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 We conduct an annual Provider survey to assess satisfaction with our operational processes. Topics include claims processing, Provider training and education, and Aetna Assure Premier Plus (HMO D-SNP)'s response to inquiries.
- Member Experience with Case Management Survey – On an ongoing basis we conduct a case management survey that allows us to evaluate the case management program design by evaluating the effectiveness of our interventions, our ability to help members reach or sustain their health goals, our ability to help them self- manage their conditions. Results of this survey are analyzed on an annual basis and drive program improvement interventions.
- Member Experience with Behavioral Healthcare Services – On an annual basis we conduct a member experience with behavioral healthcare services survey targeting members who have utilized behavioral healthcare services in the year prior. Through this assessment we evaluate behavioral healthcare access and timeliness to/of care, outcomes, communications with clinicians, patient rights, coordination of care and overall ratings of behavioral healthcare Providers. Results of this survey allow us to continually design and modify behavioral healthcare needs of the served membership.
- Health Outcomes Survey (HOS) – The health plan participates in a longitudinal outcomes survey administered through a CMS approved vendor. The HOS allows the health plan to gather valid and reliable clinically meaningful data that drive operational and clinical improvement strategies.

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. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members.

Aetna Assure Premier Plus (HMO D-SNP) 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 the DMAHS and CMS. Aetna Assure Premier Plus (HMO D-SNP) assists in the identification and collection of any data or records to be reviewed by the

independent evaluation team. We also provide complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Assure Premier Plus (HMO D-SNP)'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 high-quality care and services, we profile 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 Providers in an effort to improve clinical outcomes. Our 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 Assure Premier Plus (HMO D-SNP) includes several measures in the Provider profile, which include, but are not limited to:

- Frequency of individual patient visits to the PCP.
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma management linked with correct use of inhaled steroids).
- Use of and adherence to medications.
- ER utilization and inpatient service utilization.

We distribute 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.

Our Chief Medical Officer (CMO) regularly visits individual network Providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our Chief Medical Officer (CMO) investigates potential utilization or quality of care issues that may be identified through profiles. Aetna Assure Premier Plus (HMO D-

SNP)'s medical leadership is committed to collaborating with Providers to find ways to improve patientcare.

Clinical Practice Guidelines and Medical Necessity Criteria

The evidenced-based clinical practice guidelines used by Aetna Assure Premier Plus (HMO D-SNP) 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's 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 our website; Providers are informed of the availability of new guidelines and updates in the Periodic Provider Newsletter.
Medical necessity criteria are a set of nationally recognized, evidence-based criteria which are applied to medical necessity determination. Medical necessity criteria are reviewed at least annually for appropriateness to the Aetna Assure Premier Plan's population needs. Medical necessity criteria are reviewed by the Utilization Management Committee and the Provider Advisory Committee for recommendations and approval prior to being adopted. The availability of the annually reviewed and approved medical necessity criteria is communicated to Providers through various communication channels such as the Provider newsletter, health plan's website and Provider-health plan meetings. Providers may obtain a copy of the clinical practice guidelines but visiting the Plans website at **aetnabetterhealth.com/new-jersey-hmosnp/providers/quality-management**.

Chapter 10: Medical Management

Aetna Assure Premier Plus (HMO D-SNP) focuses on relationship building; promoting choice among Members and caregivers; and assisting in the coordination of the full continuum of physical, behavioral, LTSS and social care and services. The objective is to make certain that Members receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Members Needs

A licensed and experienced clinical professional will conduct an initial assessment upon enrollment and re-assessments within state required timeframes and if there is a change in the Member's condition or status.

The Member will be assigned to a Care Manager who will do a comprehensive assessment to gather Member information, concerns, and needs to initiate the member centered care planning process through collaboration with the Member, caregiver, and members of the Interdisciplinary Care Team (ICT). The Care Manager will also consult with the Member's Primary Care Provider (PCP), specialist Providers, and other relevant professionals involved in the Member's care. Aetna Assure Premier Plus (HMO D-SNP) assessment process is holistic, focusing on the individual's medical, psychological, cultural, financial, and environmental circumstances and long-term care needs.

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) is a team of individuals that will provide person- centered care coordination and care management to Members. The ICT is led by the assigned Care Manager and every Member will have a ICT of their choice. At any time, the Member may decline care management and the ICT process, unless they are enrolled in the LTSS program, where care management is a requirement. Each ICT will be comprised of the Member and/or the Member's authorized representative/designee, relevant health plan professionals, the PCP, behavioral health professional, the Member's home care aide, and other Providers either as requested by the Member or his/her representative/designee. Additional ICT members may be included as recommended by the Care Manager or PCP and approved by the Member and/or his/her representative/designee. The (ICT) will review the Member's care plan and service plan, coverage determinations and care coordination. The ICT will meet as warranted and regularly throughout the Member's care as care needs change.

Aetna Assure Premier Plus (HMO D-SNP) will be responsible for coordinating Members' care throughout the continuum of covered and non-covered services. The Plan will employ a number of strategies to accomplish this objective, including:

- Communicating with Members and their Informal Support Systems: The Care Manager will regularly communicate with Members and Members' families/caregivers telephonically, online, or and during in-person visits to discuss an array of issues relating to the Member's health and well-being,

including Provider visits, medications, therapies, nutrition, Member safety, etc. As needed, or per the request of anyone on the ICT, including the Member, the Care Manager will make certain referrals, schedule appointments, arrange transportation, and coordinate any other services needed for the Member. This process will include follow-up discussions with the Member to make certain the services put in place are appropriate and meet not only their needs, but the care planning requirements set forth by the Member's Providers.

- Communicating with Providers: The Care Manager will regularly confer with treating Providers and other professionals involved in the delivery of covered and non-covered services to support their prescribed course of treatment and make certain that authorized services and supports are consistent with the Member's health-related needs and preferences and follow the person-centered care and service plan approved by the ICT.

Documenting & Communicating Meetings

The participants of each ICT will communicate in-person or via teleconference. At every step-in care management, the Member is a partner in developing goals to improve health status and identifying root causes of poor health outcomes and barriers to care. If the Member is unable to be an active participant in this process, we will work with their identified family/representative and others to make sure they are included in the ICT process.

The care management and ICT activities/meetings will be documented in the Member's care management plan located in the Aetna Assure Premier Plus (HMO D SNP) business application system. The plan will be based on the assessed needs, and articulated preferences of the Member. If needed, we will transition Members to new Providers once the care plan is completed.

For care management services, please call our toll-free line to be connected to a Care Manager.

Chapter 11: Utilization Management

Primary Care Providers (PCPs), assigned Care Managers, Members of the Interdisciplinary Care Management Team (ICMTs), or treating practitioner and or Providers are responsible for initiating and coordinating a request for authorization. However, specialists and other practitioners, and/or Providers, may need to contact the Aetna Assure Premier Plus (HMO D-SNP)'s Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting Provider is responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. We will not prohibit, or otherwise restrict, practitioner and Providers from:

- Acting within the lawful scope of practice
- Advising or advocating on behalf of an individual who is a patient and Member of the Aetna Assure Premier Plus (HMO D-SNP) plan

UM decision making is based on appropriateness of care and service and existence of coverage. Aetna does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

For those services requiring pre-service authorization, participating and nonparticipating Providers must obtain pre-service authorization from us before providing clinical services, procedures, non-emergency or elective hospitalizations which require prior authorization. Noncompliance with pre-service authorization policies and procedures may result in denial or delay of reimbursement. A list of services that require prior authorization can be found on our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp**. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of- network services require authorization (see below for exceptions).

Emergency Services

There is no requirement to inform or contact Aetna Assure Premier Plus (HMO D-SNP) prior to the provision of emergency care, including emergency treatment or emergency admission.

Notification to Aetna Assure Premier Plus (HMO D-SNP) after an emergent admission is encouraged for the purpose of appropriate coordination of care and discharge planning. Our Prior Authorization Department or Concurrent Review Clinicians will document the notification in the Member's record.

Services Requiring Authorization

Primary care Providers (PCP) or treating practitioner/Providers must request authorization for certain medically necessary services.
A current list of services which require prior authorization can be found online at

www.AetnaBetterHealth.com/New-Jersey-hmosnp

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Exceptions to Prior Authorizations:

- Service authorization for emergency services including behavioral health care; urgent care; crisis stabilization, including mental health; or post-stabilization services whether provided by an in-network or out-of-network practitioner/Provider
- Access to family planning services
- Preventative services
- Well-woman services
- Communicable disease services, including STI and HIV testing
- Renal dialysis services

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Secure Provider Web Portal located on our website, or
- Fax the request form to **1-833-322-0034** (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 call us directly at **1-844-362-0934**.

All clinical information must be submitted with the original request. Medical management and behavioral health medical necessity criteria and clinical practice guidelines are disseminated to all affected practitioners and or Providers upon request. To request criteria, call **1-844- 362-0934**.

Timeliness of Decisions and Notifications

We make service authorization decisions and notify Providers and Members in a timely manner. We adhere to the following decision/notification time standards. Aetna Assure Premier Plus (HMO D-SNP) records all telephonic contacts or attempted telephonic contacts to inform Members and Providers of approvals and denials of service and requests for extensions of decision timelines in our electronic business system.

Departments that handle pre-service authorizations must meet the timeliness standards appropriate to the required services and as the Member's condition requires but no more than the following:

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre service approval	Within seventy-two (72) hours of receipt of request	Provider and Member	Oral and Written
Urgent Part B Drug Approval	Within twenty-four (24) hours of receipt of request	Provider and Member	Oral and Written
Urgent pre service denial	Within seventy-two (72) hours of receipt of request	Provider and Member	Oral and Written
Urgent Part B Drug denial	Within twenty-four (24) hours of receipt of request	Provider and Member	Oral and Written
Non-urgent pre service approval	Within fourteen (14) calendar Days of receipt of the request	Provider	Electronic/Written
Non-urgent Part B Drug approval	Within seventy-two (72) hours of receipt of request	Provider and Member	Electronic/Written
Non-urgent pre service denial	Within fourteen (14) Calendar Days of receipt of the request	Provider and Member	Electronic/Written
Non-urgent Part B Drug denial	Within seventy-two (72) hours of receipt of request	Provider and Member r	Electronic/Written
Urgent concurrent approval	Within seventy-two (72) hours of receipt of request	Provider	Oral and Written

Decision	Decision/notification timeframe	Notification to	Notification method
Non-urgent concurrent approval	Within seventy-two (72) hours of receipt of request	Provider and Member	Electronic/Written
Non-urgent concurrent denial	Within seventy-two (72) hours of receipt of request	Provider and Member	Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Provider and Member	Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Provider and Member	Electronic/Written

Out-of-Network Providers

We will communicate the approval or denial to the out-of-network Provider within the appropriate timeframes based on 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. Our Prior Authorization Department makes such decisions on a case-by-case basis in consultation with the Aetna Assure Premier Plus (HMO D-SNP)'s Chief Medical Officer (CMO).

Referrals

We do not require referrals from in network PCPs, or in network treating Providers.

Pharmacy Prior Authorization-Pharmacy

Aetna Assure Premier Plus (HMO D-SNP) will process coverage determinations and exception requests in accordance with Medicare Part D regulations and/or Medicaid regulations. Requests will be handled through the prior authorization review process. The prior authorization staff will adhere to approved criteria. The Aetna Assure Premier Plus (HMO D-SNP) Pharmacy and Therapeutic Committee establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit prior authorization requests by phone, fax, or through the Secure Web Portal. Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Coverage determination requests will be determined seventy-two (72) hours after receipt of complete information from the Provider for Standard determinations. Expedited reviews will be determined within twenty-four (24) hours after receipt of complete information from the Provider. Conditions meeting expedited review include an imminent or serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Determination notices will be faxed to the Provider's office once the decision is made and a letter will be mailed to the Member.

To submit a coverage determination or exception request, complete the Coverage Determination form and fax to **1-(844)-814-2260**.

Concurrent Review Overview

We conduct concurrent utilization management 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 content of the Member's medical record is used to evaluate the medical necessity for the admission. The appropriateness of the level of care is determined utilizing the appropriate criteria based on the Aetna Assure Premier Plus (HMO D-SNP) medical necessity criteria hierarchy.
Initial admission medical necessity review is conducted within seventy-two (72) hours of receiving notification.

Continued stay reviews are conducted by our Utilization Management Clinical staff. Providers will be notified of approval or denial of continued stay.

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. Hospital staff and the attending Provider are responsible for developing a discharge plan for the Member. The Member and their family should be involved when implementing the plan.

Our Concurrent Review Clinical staff works with the hospital discharge team, attending Providers, and assigned Care Managers to make certain 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 Provider with names of network Providers (i.e., home health agencies, DME/medical supply companies, other outpatient Providers).

- Informing hospital staff and attending Provider of covered benefits as indicated.

D-SNP Medicare Outpatient Observation Notice Requirement (MOON)

Developed by the Centers for Medicare & Medicaid (CMS), the Medicare Outpatient Observation Notice (MOON) serves as the standardized notice used by hospitals and critical access hospitals (CAH) to notify Medicare patients who receive more than 24 hours of observation services that their hospital stay is outpatient, not inpatient. You must provide the MOON to these patients no later than 36 hours after services begin.

How to comply

- Providers should have begun issuing the MOON effective March 8, 2017. Provider compliance with this notification requirement is mandatory.
- Deliver a hard copy of the MOON to beneficiaries and enrollees.
- Obtain the signature of the individual on the MOON or an individual acting on behalf of the patient.
- Retain a copy of the signed MOON. You may store the MOON electronically if you keep electronic medical records.
- Give the beneficiary a paper copy of the signed MOON, regardless of whether a paper or electronic version is issued, and whether the MOON is signed digitally or manually.

You may give the MOON by telephone in cases where the beneficiary has a representative who isn't physically present, as long as a hard copy is delivered to the representative. The standard language for the MOON notice and instructions can be accessed on the CMS website at **www.cms.gov/Medicare/Medicare-General Information/BNI/index.html.**

Chapter 12: Behavioral Health

Mental Health/Substance Abuse Services

In order to meet the behavioral health needs of our Members, Aetna Assure Premier Plus (HMO D-SNP) will provide a continuum of person-centered 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 New Jersey population.

Availability

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

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 endorse early identification of mental health issues so that timely intervention, including treatment and patient education, can occur. To that end, 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 PCP's scope of practice
- Inform Members how and where to obtain behavioral health services
- Understand that Members may self-refer to an Aetna Assure Premier Plus (HMO D-SNP) behavioral health care Provider without a referral from the Member's PCP.

Coordination of Mental Health and Physical Health Services

We coordinate physical and mental health care services for Members through our Trans- disciplinary Care Management Team (TCMT) that is led by each Member's assigned Care Manager. Coordination and care and services includes screening, evaluations, evidence- based treatment and/or referrals for physical health, behavioral health or substance use disorder, dual or multiple diagnoses, developmental disabilities and social needs. With the Member's permission, our Care

Management Staff can facilitate coordination of care 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 must be screened for co- existing medical issues. Behavioral Health Providers must 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 also 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.

Medical Records Standards

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

Specific Screening Tools

Whenever a PCP is concerned about a member who may have a Mental Health/Substance Abuse problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. This level of concern might be triggered by the PCP's clinical judgment and/or by responses on the "Well-Being Tool for Adolescents & Adults: Patient Problem Questionnaire". We strongly recommend the PCP use two screening tools, one for mental illness, and one for substance use disorders, when additional screening is indicated. We recognize a high proportion of Members with either disorder may have a co-occurring Mental Health or Substance Use disorder, which would require integrated dual diagnosis treatment to achieve optimal clinical outcomes. Aetna Assure Premier Plus (HMO D-SNP) uses the following standard screening tools to facilitate the identification of people with potential Mental Health/Substance Abuse conditions:

K-6 - The K-6 is a brief general screening instrument that is used to identify adults who are likely to have a serious mental illness. The tool is not diagnosis specific and a person with a positive result on the K-6 requires a clinical assessment to make a definitive diagnosis. The K-6 is now included in the core of the National Health Interview Survey as well as in the annual National Household Survey on Drug Abuse. A person with a positive result on the K- 6 should be screened for a substance use

disorder using the UNCOPE since these disorders frequently occur together, and people with co-occurring mental illness and substance use disorders require treatment for both types of disorders.

UNCOPE- The UNCOPE is a brief general screening instrument that identifies adults who are likely to have a Substance Abuse disorder. The UNCOPE consists of six questions found in existing instruments and assorted research reports. It is not diagnosis specific. A person with a positive result on the UNCOPE requires a clinical assessment to make a definitive diagnosis. In addition, a person with a positive result on the UNCOPE should be screened for a serious mental illness using the K-6 since these disorders frequently occur together.

Services

The following chart is an overview of behavioral health services that Aetna Assure Premier Plus (HMO D-SNP) standardly covers, or as a part of Behavioral Health Redesign.

Outpatient Behavioral Health Services
Evaluation and Management
Psych Diagnostic Evaluation
Individual and Group Psychotherapy
Psych/Dev/Neuro Testing
Crisis Intervention
Alcohol/Substance Abuse Screening
Services at Community Mental Health Centers
Assertive Community Treatment (prior to initiation of service)
Intensive Home-Based Treatment (prior to initiation of service)
Psychiatric Diagnostic Evaluation (once annual limit is reached)
Psychological Testing (once annual limit is reached)
SBIRT (once annual limit is reached)
Psychosocial Rehabilitation
Therapeutic Behavioral Services
Community Psychiatric Supportive Treatment
Psychotherapy/Mental Health Counseling Services
TBS Group Services
MH RN/LPN Services
Crisis Intervention Services
MH Peer Recovery Support (SRSP Members only)
IPS-Supported Employment Services (SRSP Members only)
Respite Services
100 hours of respite care per calendar year for members under 21 years of age

Behavioral Health Services Provided by Outpatient Hospitals
Evaluation and Management
Psychiatric Diagnostic Evaluation
Individual and Group Psychotherapy
Psych/Dev/Neuro Testing
Crisis Intervention
Alcohol/Substance Abuse Screening
SUD Intensive Outpatient, Partial Hospitalization, and Residential Treatment Services
TBS Group Services
Case Management
Community Psychiatric Support Treatment (CPST)
Alcohol and Drug Testing
LPN and RN Services

Substance Use Disorder Services - Community Mental Health Centers
SUD Assessment
SUD Individual Peer Recovery Support
SUD Group Peer Recovery Support
Individual Counseling
Group Counseling
SUD Case Management
Urine Drug Screening – collection, handling and point of service testing
Nursing Services – Individual
Nursing Services – Group
Group Counseling IOP Level of Care
Group Counseling PH Level of Care
Withdrawal Management Hourly ASAM 2 WM
Withdrawal Management Per Diem ASAM 2 WM
Substance Use Disorder – Residential Treatment
Withdrawal Management Per Diem ASAM 2 WM
Clinically Managed Low-Intensity Residential Treatment ASAM 3.1
Clinically Managed Withdrawal Management ASAM 3.2 WM
Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)
Clinically Managed High Intensity Residential Treatment ASAM 3.5
Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7
Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM

For pharmacy, dental and vision services please reference specific MCP requirements located on their websites.

Clinical information can be submitted as indicated below. If urgent or time-sensitive, please indicate at time of request.

Website Information	Phone
www.AetnaBetterHealth.com/New-Jersey-hmosnp	1-844-362-0934

Chapter 13: Pharmacy Management

Overview

Prescription drugs may be prescribed by any authorized prescriber, such as a Primary Care Provider (PCP), specialist, attending Provider, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The list of Covered Drugs (Formulary) identifies all of the prescription and over the counter drugs covered by the Aetna Assure Premier Plus (HMO D-SNP) plan. We also refer to this as a Drug List.

The Drug List has been approved by the Centers of Medicare and Medicaid Services (CMS) and/or the state and reviewed by the Pharmacy and Therapeutics Committee (P&T Committee) to make certain that they are clinically appropriate to meet the therapeutic needs of our Members in a cost effective manner.
All Drug List utilization management restrictions are approved by CMS and the P&T Committee.

Updating the List of Covered Drugs (Formulary)

Our Drug List is continuously reviewed by the P&T Committee and prescription drugs are added or removed based on objective, clinical, and scientific data and market changes. All updates to the Drug List must be approved by CMS and/or the state and adhere to all mandated guidance on changes. Considerations include safety, efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.
Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change drugs listed in the Drug List. Market share shifts, price increases, generic availability, and varied dosage regimens may affect the actual cost of therapy.
- The Drug List must adhere to CMS and state requirements.
- Products are not added to the Drug List if there are less expensive, similar products on the Drug List unless the new product provides superior outcomes or is mandated by CMS or the state.
- When a drug is added to the Drug List, other drugs in the same category maybe removed.
- We update the Formular Drug List posted to our website monthly or more frequently as applicable. Please visit our website for the most recent preferred formulary list updates and access our up to date formulary search tool.

Quantity Limits

We also limit coverage on the quantity of certain drugs. Quantity limits are established using medical guidelines and FDA-approved recommendations from drug manufacturers. The quantity limits include the following:

- Dose efficiency edits: limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing.
- Maximum daily dose: a message is sent to the pharmacy if a prescription is less than the minimum, or higher than the maximum, allowed dose.
- Quantity limits over time: limits coverage of prescriptions to a specific number of units in a defined amount of time.

Step Therapy

Some members may have a plan that includes step therapy. With step therapy, certain drugs are not covered unless members try one or more preferred alternatives first. Step therapy is based on:

- Current medical findings
- U.S. Department of Food and Drug Administration (FDA)-approved manufacturer labeling information
- FDA guidelines
- Cost and manufacturer rebate arrangements

If it is medically necessary, a member can get coverage of a step therapy drug without trying a preferred alternative first. In this case, a physician, patient or a person appointed to manage the patient's care must request coverage for a step therapy drug as a medical exception. The drugs requiring step therapy are subject to change.

Notification of List of Covered Drugs (Formulary) Updates

We must follow CMS and state policy regarding Drug List changes. Our Pharmacy and Therapeutics Committee may add drugs to the Drug List or delete utilization management requirements at any time during the year. After March 1st of each year, our Pharmacy Management Department may only make maintenance changes to the Drug List, such as replacing a brand name drug with a new generic, or modifications to quantity limits based on new drug safety information. The Centers of Medicare and Medicaid Services (CMS) limits non-maintenance Drug List changes and must be approved by CMS.

We will provide notice to affected Members at least thirty (30) days prior to removing a covered drug from the Drug List or provide the Member with a 30-day supply of the drug. If the Federal Drug Administration (FDA) deems a drug unsafe or it is removed from the market by its manufacturer, we will provide a retrospective notice as soon as possible. A list of Drug List changes is maintained on our website.

Federal Part D regulations require Aetna Assure Premier Plus (HMO D-SNP) to have a Drug List that contains at least two Part D prescription drugs in each approved category, and all drugs in the six special classes listed below:

- Antidepressants
- Antipsychotic
- Anticonvulsants

- Antiretroviral
- Antineoplastic
- Immunosuppressant

Certain OTCs are covered under the plan. Members will need to present their member ID card at the pharmacy to see if these medications are covered.

Both generic and brand name drugs are covered, but some drugs are statutorily excluded from coverage or are excluded for certain indications by Medicare and Medicaid. Excluded drugs include, but are not limited to:

- Drugs for anorexia, weight loss or weight gain
- Fertility drugs
- Erectile Dysfunction drugs
- Drugs for cosmetic purposes or hair growth

Pharmacy Transition of Care Process

The following applies to new members who are taking a Part D drug that is either:

- Not on the Aetna Assure Premier Plus (HMO D-SNP) Drug List
- Subject to a utilization management requirement or limitation (such as step therapy, prior authorization, or a quantity limit)

Aetna Assure Premier Plus (HMO D-SNP) Members are entitled to receive a 30-day supply of the Part D drug within the first 90 days of their enrollment. (The period of time in which Members are entitled to receive the transition supply is called the "transition period.")

The following applies to existing members who renew their Aetna Assure Premier Plus (HMO D SNP) coverage and are taking a Part D drug that is either:

- Removed from the Drug List
- Subject to a new utilization requirement or limitation at the beginning of the new plan year

Aetna Assure Premier Plus (HMO D-SNP)'s Members are entitled to receive the 30-day supply during their transition period. For existing members who renew their Aetna Assure Premier Plus (HMO D SNP) coverage from one year to the next, the transition period is the first 90 days of the new plan year. The 90-day transition of coverage period is also available to Members throughout the plan year if a drug is removed from the Drug List.

Members can get multiple fills up to the 30-day supply within their transition period if their first fill is less than a 30-day supply. This applies to both new and renewing Members.

In general, Aetna Assure Premier Plus (HMO D-SNP) will determine Members right to a 30-day fill at the pharmacy when they go to fill their prescription. However, in some situations, Aetna Assure Premier Plus (HMO D-SNP) will need to get additional

information before we can determine if Members are entitled to a transition 30- day fill.

LTC/ Nursing Facility

If Member is a resident of a long-term care facility, they can receive up to a 31-day supply of a Part D drug during their transition period.
Member may also be eligible to receive a transition fill outside of their 90-day transition period. For example, Members may be eligible to receive a temporary supply of a drug if they experience a change in their "level of care." (an instance of this would be if Member returned home from a stay in the hospital with a prescription for a drug that isn't on the Drug List).

There are other situations where Member may be entitled to receive a temporary supply of a prescription drug. If Members have questions about whether they are entitled to a temporary supply of a drug in a particular situation, they can call Member Services.

Members and their prescribing Provider will receive a letter instructing them to consult with their prescribing Provider to decide if they should switch to an equivalent drug that is on the Drug List or to request a Drug List exception in order to get coverage for the drug.

We will not pay for additional fills for the drug(s), unless the prescriber submits a request for a coverage determination or Drug List exception, and we approve. If a Drug List exception is approved, the approval will be valid through the remainder of the calendar year.

Please note that transition policy applies only to Part D drugs filled at a network pharmacy.

Part D Pharmacy Co-Payments

Member co-payments for covered prescription products will be $0.

Medical exception and precertification

You can ask for a medical exception for coverage of drugs on the Formulary Exclusions List or the Step Therapy List or request prior authorization or exceptions to quantity limits. Physicians, patients or a person appointed to manage the patient's care can contact the Aetna Assure Premier Plus (HMO D-SNP) Precertification Unit. To contact us, see the options below:

Phone: 1-844-362-0934
Fax: 1-844-814-2260

Prescribing providers can download the drug specific prior authorization form or general pharmacy prior authorization forms from the health plan website. To support

the timely review of the prior authorization request, prescribers are asked to supply the following information:

- Member's name, date of birth, and identification number
- Prescribing practitioner's/provider's name, and telephone and fax numbers
- Medication name, strength, frequency, quantity, and duration
- Diagnosis for which medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (e.g. non-formulary drug, age limit, QLL, or ST override, generic override, or vacation override.)

Chapter 14: Member Coverage Determinations, Exceptions, Appeals, Grievance for Part D Prescription Drugs

Medicare Part D Prescription Drug Coverage Determinations

Prescription drug coverage is included in the Aetna Assure Premier Plus (HMO D-SNP) plan. CVS Caremark is the Pharmacy Benefit Manager (PBM) that Aetna Assure Premier Plus (HMO D-SNP) has contracted with to administer the HMO D-SNP prescription drug benefit. Aetna Assure Premier Plus (HMO D-SNP) will review and process Medicare Part D Coverage Determinations and Exception requests initiated by our Members, their authorized representative and/or their prescribing Provider. While typically prescribing Providers submit requests to us to make a coverage determination, Members have the right to request a coverage determination concerning a prescription drug they believe they are entitled to receive under their plan, including:

- Basic prescription drug coverage
- The amount, if any, that the Member is required to pay for a drug

We will process coverage determinations under the standard timeframe of seventy-two (72) hours of receipt, unless the prescriber has indicated that the Member would be harmed if we apply the standard timeframe. In these cases, we will process the review under the expedited timeframe of twenty-four (24) hours, or as fast as the Member's health condition requires. If we fail to process the request within the required timeframe, we will submit the request to the Qualified Independent Contractor (QIC), C2C Innovative Solutions, Inc., within twenty-four (24) hours. Should this occur, we will notify both the Member, and the prescribing Provider, that C2C Innovative Solutions, Inc. will conduct the review. For all other redetermination upholds (denial of coverage), the Member or their representative must request a QIC review within sixty-five (65) days of the notification of denial from the health plan.

A member, their authorized representative, and/or their prescribing Providers may submit a request directly to us orally or in writing to make a coverage determination for a Drug List exception. Written requests may be on the Pharmacy Coverage Determination Request Form. The form is in this Manual and on our website. The request for a coverage determination Drug List exception must be filed directly with us. If a member or their authorized representative submits an exception request it must include the prescribing Provider's supporting statement before this request can be reviewed.

A Pharmacy Coverage Determination Request Form is located on our website for your convenience. Prescribing Providers may initiate a request by calling our Pharmacy Prior Authorization Department at **1-844-362-0934**, 24 hours a day, 7 days a week or fax your request to **1-844-814-2260**.

A coverage determination is any decision made by us regarding a request for Part D drug benefit or payment. There are two (2) types of coverage determinations:

- Formulary UM Requirements – A request for approval for a Drug List Utilization Management (UM) requirement such as prior authorization, step therapy and quantity limitations.
- Formulary Exceptions - Request for Part D prescription drug not listed on the Drug List or a request for an exception to the Drug List UM requirements.

Grievance and Redetermination Overview

Members can file a grievance or redetermination if they are not satisfied. A prescribing Provider, acting on behalf of a member, and with the Member's written consent, may file a grievance or redetermination, QIC, Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or Judicial Review as applicable.

Upon completion of the appeal process, if we do not make a decision timely, we will automatically forward the case to the QIC within twenty-four (24) hours. If the QIC decision is unfavorable to the Member, the Member or their representative may request an ALJ, MAC, or Judicial Review in successive order.

We will inform Members and Providers of the grievance and redetermination procedures. This information is contained in the Member's Evidence of Coverage (EOC) and within the Provider Manual including being available on our website. When requested, we give Members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, Provider interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Grievances

A grievance may be filed with us orally or in writing either by the Member or the Member's authorized representative, including prescribing Providers. In most cases, a decision on the outcome of the grievance is reached within thirty (30) calendar days of the date the grievance was filed. If we are unable to resolve a grievance within thirty (30) calendar days, we may ask to extend the grievance decision date by fourteen (14) calendar days. In these cases, we will provide information describing the reason for the delay in writing to the Member and, upon request, to the

Centers of Medicare and Medicaid Services (CMS) and as required to the State of New Jersey Division of Medical Assistance & Health Services (DMAHS).

Members are advised in writing of the outcome of the investigation of the grievance within two (2) calendar days of its resolution. 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 a member that their case was forwarded to the Independent Review Entity (IRE) if applicable.

Expedited Grievance Resolution

We resolve grievances effectively and efficiently, as the Member's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where we have:

- Taken an extension on prior authorization or appeal decision making time frame; or
- Determined that a member's request for expedited prior authorized or expedited appeal decision making does not meet criteria and has transferred the request to a standard request
- Waiting the standard timeframe could seriously jeopardize the life or health of the Member

Members and their authorized representative if designated are informed of their right to request an expedited grievance in their EOC and in the extension and denial of expedited processing prior authorization and appeal letters.

In these cases, a decision on the outcome of an expedited grievance is reached within twenty-four (24) hours of when the grievance was filed. Members are advised orally of the resolution within the twenty-four (24) hours followed by a written notification of resolution within two (2) calendar days of the oral notification. 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 a member how to obtain information on filing an external grievance.

Quality Improvement Organization - Quality of Care Grievances

A member may file a grievance regarding concerns of the quality of care received with Aetna Assure Premier Plus (HMO D-SNP). For items or services covered by Medicare, a member or their authorized representative may also file a quality of care concern with the CMS contracted Quality Improvement Organization (QIO). In New Jersey, the QIO, which is located at:
Livanta
Attn: Beneficiary Complaints
10820 Guilford Rd, Ste# 202
Annapolis Junction, MD 20701

Toll-Free Phone: **1-888-524-9900**
Toll-Free TTY: **1-888- 985-8775**
Telephone (toll free): **1-216-447-9604**
Fax: (216) 447-7925

Regulatory Complaints

Members or their designated representatives may submit complaints direct to a regulatory body through:

- Centers for Medicare and Medicaid Services (CMS) at **1-800- MEDICARE (1-800- 633- 4227).**
- State of New Jersey Ombudsman's office at **1-800-446-7467,** TTY 711.

Redeterminations

A member may file a redetermination, a formal request to appeal and reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action), with us. Authorized Member representatives, including prescribing Providers, may also file a redetermination on the Member's behalf with the written consent of the Member.

Redeterminations must be filed no later than sixty-five (650) calendar days from the postmark on the Aetna Assure Premier Plus (HMO D-SNP) Notice of Denial.

The Notice of Denial informs the Member of the following:

- Our decision and the reasons for our decision
- The requirement and timeframes for filing are determination
- The availability of assistance in the filing process
- The toll-free numbers that the Member can use to file a redetermination by phone
- That the Member may represent himself or designate a legal counsel, a relative, a friend, a prescribing Provider or other spokesperson to represent them
- The specific regulations that support, or the change in federal or state law that requires the action

Redeterminations may be filed either verbally by contacting our Member Services Department or by submitting a request in writing.

Members may appeal the decision and request a redetermination of Aetna Assure Premier Plus (HMO D-SNP)'s actions. Examples include:

- The denial or limited approval of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The denial of a member's request to obtain services outside of the contracting area when Aetna Assure Premier Plus (HMO D-SNP) is the only health plan servicing a rural area.

Members may file a redetermination by:

- Calling our Member Services Department at **1-844-362-0934** TTY/TTD Relay 711
- Faxing the request to us at **1-844-814-2260**

- Writing Aetna Assure Premier Plus (HMO D-SNP) at:

Aetna Assure Premier Plus (HMO D SNP) HMO D-SNP Part D Appeals
4750 S. 44th Place, Suite 150
Phoenix, AZ 85040-4015

We will also provide Members with access to necessary medical records and information to file their appeals.

A brief overview of the appeals process follows:

- Members are advised of their or their authorized representative's rights to provide more information and document for their redetermination either in person or in writing.
- Members are advised of their, or their authorized representative's, right to view their redetermination file.
- Members or their authorized representative may be present either onsite or via telephone when the Appeal Committee reviews their redetermination.
- Redeterminations will be resolved within seven (7) calendar days for standard requests, or seventy-two (72) hours for urgent requests.
- Aetna Assure Premier Plus (HMO D-SNP) makes reasonable effort to provide verbal notice and mails the decision letter within three (3) calendar days of the date of oral notification.
- For untimely decisions, the decision letter includes an explanation for the decision and notification that the appeal has been forwarded to the QIC for review.
- If the QIC does not agree with the Member's redetermination, the Member can ask for an ALJ hearing request to continue receiving benefits that were previously approved while the hearing is pending. If we reverse our original decision and grant the redetermination, services will begin immediately.

If a member or their authorized representative shows good cause in writing, we may extend the time frame for filing a redetermination. The Member or their authorized representative must request the redetermination in writing and include the reason for good cause. The circumstances considered when making the decision to extend the timeframe for redetermination include, but are not limited to:

- The Member did not personally receive the adverse organization determination notice, or he/she received it late;
- The Member was seriously ill, which prevented a timely appeal of the decision;
- There was a death or serious illness in the Member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The Member had incorrect or incomplete information concerning the reconsideration process; or

- The Member lacked capacity to understand the time frame for filing a request for redetermination.

Expedited Redeterminations

We resolve redeterminations effectively and efficiently, as the Member's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited redeterminations, 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. If the Member's ability to attain, maintain, or regain maximum function is not at risk, the request to process the redetermination in an expedited time frame may be denied, and the appeal processed within the normal seven (7) calendar day time frame. A member or their authorized representative, including Providers, may request an expedited redetermination, either verbally or in writing, within sixty-five (650) calendar days from the day of the decision or event in question. Written confirmation, or the Member's written consent, is not required to have the Provider act on the Member's behalf.

Upon receipt of an expedited redetermination, we begin the process immediately. We attempt to acknowledge expedited redeterminations by telephone and in writing on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited redetermination. If the issue fails to meet the definition of an expedited redetermination, the issue is transferred to the standard redetermination process. We make reasonable efforts to give the Member prompt verbal notice of the denial of expedited processing and follow up in writing within three (3) calendar days of receipt of the expedited redetermination request.

In cases where the health plan determines that a member's request meets expedited urgency or a Provider supports the Member's request, we will render a decision as expeditiously as the Member's health requires, but no later than seventy-two (72) hours from the receipt of the appeal. We will make reasonable efforts to give the Member prompt verbal notice of the redetermination decision within the seventy-two (72) hours and will follow up in writing within three (3) calendar days of the verbal notification.

If we reverse our original decision and approve the redetermination, services will begin immediately.

Qualified Independent Contractor (QIC)

If we do not issue a decision timely on a coverage determination or a redetermination, we will forward the case to the QIC for review within twenty-four (24) hours. We will notify the Member that we have forwarded the case to the QIC for review in the Notice of Case Status letter. The letter will include contact information

for the QIC office and the Member's right to submit additional evidence, that may be relevant to the case, direct to the QIC office.

For all other redetermination decisions, if we do not agree with the Member's request for redetermination and the coverage determination decision is upheld at redetermination in whole or in part, the Redetermination Decision letter will include contact information for the QIC office, the Member's right to request a QIC review, and their right to submit additional evidence that may be relevant to the case direct to the QIC office.

The QIC will conduct the review as expeditiously as the Member's health condition requires, not to exceed seven (7) calendar days for a standard request, or seventy-two (72) hours for an expedited request. The QIC will notify all parties of the determination and will include the right to an ALJ hearing, and the procedure to request one, if the total dollar amount of the items/services being appealed meets or exceeds the established AIS threshold. This amount is calculated annually and published in the Federal Register prior to the end of each calendar year.

Administrative Law Judge (ALJ)

If the QIC does not agree with the Member's request for redetermination, the Member or their authorized representative may file a request for an ALJ hearing in writing within sixty (60) calendar days of the QIC Notice of Denial. The request must be in writing to the ALJ hearing office specified in the QIC's denial notice. If we receive a written request for an ALJ hearing from the Member, we will forward the Member's request to the QIC. The QIC will compile the redetermination file and forward it to the specified ALJ hearing office.

The ALJ will conduct its review as expeditiously as the Member's health condition requires, not to exceed ninety (90) calendar days for a standard request, or ten (10) calendar days for an expedited request, and will notify all parties of the determination. The notification will include information about the right to a MAC review and the procedure to request one.

Medicare Appeals Council (MAC)

If the ALJ hearing does not agree with the Member's request for redetermination, the Member or their authorized representative may request a MAC review in writing, through a letter to the MAC, within sixty (60) calendar days of the ALJ decision. The request should be submitted directly to the MAC at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W. Cohen Building, Room G-644
Washington, DC 20201

The MAC will review the appeal and render a decision within ninety (90) calendar days for a standard request, and within ten (10) calendar days for an expedited

request, from the receipt of the request and will notify all parties of determination. If the decision is upheld in whole or in part, notification will include the right and the timeframes to request a Judicial Review.

Judicial Review

Any party, the Member, their representative (if designated), or Aetna Assure Premier Plus (HMO D-SNP), may request judicial review upon completion of the MAC review process when the total dollar amount of the items/services meets or exceeds the Amount in Controversy (AIC) threshold. This amount is calculated annually and published in the Federal Register prior to the end of each calendar year.

The party may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same Member;
- The MAC must have acted on all the claims;
- The Member must meet the sixty (60) day filing time limit for all claims; and
- The request must identify all claims.

To request a Judicial Review any party, must file a civil action in a district court of the United States. The action should be initiated in the judicial district in which the Member lives, or where the health plan has its principal place of business. If neither the organization nor the Member is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

Chapter 15: Advance Directives (The Patient Self-Determination Act)

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

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA) of 1990 requires health professionals and facilities, serving those covered by Medicare and Medicaid, to give adult patients written information about their rights to have an advance directive. An advance directive is a legal document through which a member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Advance directives are used when the patient is unable to make or communicate decisions about his or her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes the patient to be unable to actively make a decision about his or her medical care.

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

In New Jersey, "advance directives" is the term used to describe four types of legal documents a member can complete to express their wishes regarding their future health care:

- Durable Power of Attorney for health care (DPOA) – Lets a patient name someone, called an “agent”, to make decisions about their medical care including decisions about life-sustaining treatment if the patient can no longer speak for themselves. The durable power of attorney of health care is especially useful because it appoints someone to speak on behalf of the Member any time the patient is unable to make their own medical decisions, not only at the end of life. The durable power of attorney for health care becomes effective when the Provider determines that the patient has lost the capacity to make informed health care decisions.
- Declaration for Mental Health Treatment- If a patient has a mental illness or has been diagnosed with a mental illness in the past, they may already have a DPOA. The patient may also opt to have a mental health declaration to address issues that might arise and are not specifically covered by their health care DPOA. The mental health declaration lets health care professionals know the patient’s preferences regarding mental health treatment. It also allows the patient to name, in the declaration, their "agent" to advocate for their stated choices and make other decisions in their best interest if the patient has not stated any preferences.
- DNR (Do-Not-Resuscitate) Order – See below for a full description of aDNR.

- New Jersey Living Will Declaration- Lets patients state their wishes about their health care in the event that they become terminally ill, or permanently unconscious, and can no longer make their own health care decisions.

Practitioner Orders for Life-Sustaining Treatment (POLST)

The Practitioner Orders for Life Sustaining Treatment (POLST) form enables patients to indicate their preferences regarding life-sustaining treatment. This form, signed by a patient's attending Provider, advanced practice nurse or Provider's assistant, provides instructions for health care personnel to follow for a range of life-prolonging interventions. This form becomes part of a patient's medical records, following the patient from one healthcare setting to another, including hospital, nursing home or hospice. Pursuant to P.L. 2011, c. 145, the Institute for Quality & Patient Safety Organization was designated as the Lead Agency for Provider Orders for Life-Sustaining Treatment Act.

For more information please visit:
https://www.state.nj.us/health/advancedirective/polst/.

Do Not Resuscitate (DNR)

A person who does not wish to have Cardiopulmonary Resuscitation (CPR) performed may make this wish known through a Provider's order called a DNR order. A DNR order addresses the various methods used to revive people whose hearts have stopped functioning or who have stopped breathing. Examples of these treatments include chest compressions, electric heart shock, artificial breathing tubes, and special drugs. These standardized DNR orders allow patients to choose the extent of the treatment they wish to receive at the end of life. A patient may choose to be DNR Comfort Care (DNRCC) or a DNR Comfort Care – Arrest (DNRCC-Arrest).

- DNR Comfort Care (DNRCC) – a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life. This protocol is activated immediately when a valid DNR order is issued or when a living will requesting no CPR becomes effective.
- DNR Comfort Care – Arrest (DNRCC-Arrest) – a person receives standard medical care until the time he or she experiences a cardiac or respiratory arrest. Standard medical care may include cardiac monitoring or intubation prior to the occurrence of cardiac or respiratory arrest. This protocol is activated when the patient has a cardiac or respiratory arrest. "Cardiac arrest" means absence of a palpable pulse. "Respiratory arrest" means absence of spontaneous respirations or presence of agonal breathing.

The State of New Jersey approved DNR forms can be located:
https://nj.gov/health/advancedirective/ad/forums-faqs

Medical Records

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

- Providing written information to adult patient 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 patient 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.

For additional information about medical record requirements, please visit Chapter 3 of this Manual.

As a pre-requisite for participation or continued participation in our network, all Providers must maintain advance directive policies and make them available to Aetna Assure Premier Plus (HMO D-SNP) upon request.

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Assure Premier Plus (HMO D-SNP) as a grievance or complaint.

Chapter 16: Encounters, Billing, and Claims

Aetna Assure Premier Plus (HMO D-SNP) 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. We use our business application system to process and adjudicate claims. Both electronic and manual claim submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, we encourage Providers to submit claims electronically. To facilitate electronic claims submissions, we have developed a business relationship with ECHO, Health Inc. Aetna Assure Premier Plus (HMO D-SNP) 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 system each business day. Within twenty-four (24) hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Billing Encounters and Claims Overview

We are required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of CMS's Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and Providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

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 make certain the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to verify the accuracy of diagnosis codes submitted on randomly selected claims.

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 Provider data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Assure Premier Plus (HMO D-SNP) by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding Provider, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each Member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10CM 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 us, and payments made by us 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 Provider 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 Assure Premier Plus (HMO D-SNP). Medical records created and maintained by Providers must correspond to and support the hospital inpatient, outpatient, and Provider 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. CMS may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the CMS website at **http://csscoperations.com/internet/cssc3.nsf/docsCatHome/CSSC%20Operations**

Billing and Claims

When to Bill a member

All Providers must adhere to federal financial protection laws and are prohibited from billing any Member for any costs for covered services under the Aetna Assure Premier Plus (HMO D-SNP) plan.

A member may be billed only when the Member knowingly agrees in writing to receive non-covered services under the Aetna Assure Premier Plus (HMO D-SNP) plan

- 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:

- Participating Providers:
  - New Claim Submissions –Please consult your contract for your contractual timely filing limit for new claims. For hospital inpatient claims, date of service means the date of discharge of the Member.
  - Claim Disputes & Resubmissions – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the Member.
- Non-Participating Providers:
  - New Claim Submissions – Claim submissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the Member.
  - Claim Disputes & Resubmissions – Claim disputes & corrected claims must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital

inpatient claims, date of service means the date of discharge of the Member.

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.

Injuries Due to an Accident

Medicare law only permits subrogation in cases where there is a reasonable expectation of third party payment. In cases where legally required insurance (i.e. auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

Claims Submission

Claims Filing Formats

Providers can elect to file claims with us in either an electronic or a hard copy format. Claims must be submitted using either the CMS 1500 or UB-04/1450 formats, based on your Provider type as detailed below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, we encourage Providers to electronically submit claims, through ECHO Health, Inc. which can be found on our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp/providers/file-submit-claims.html**.
- Please use the following Submitter (Payer) ID when submitting claims to us for both CMS 1500 and UB-04/1450 forms. You can submit claims via ECHO Health, Inc by visiting the Claims Submission portal at www.echohealthinc.com www.echohealthinc.com. Before submitting a claim through your clearinghouse, please make certain that your clearinghouse is compatible with ECHO Health, Inc.
    - Submitter (Payer) ID# **46320**

Important Points to Remember

- We do not accept direct EDI submissions from our Providers.
- We do not perform any 837 testing directly with our Providers but perform such testing with ECHO Health, Inc.
- 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-04/1450 claims directly to us via mail at the following address:

Aetna Assure Premier Plus (HMO D-SNP)
PO Box 982967
El Paso, TX 79998-2967

Clean Claims

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

We process clean claims according to the following timeframes:

- 90% of HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) of receipt.
- 90% of manually submitted clean claims shall be processed within thirty (30) days of receipt.
- 99.5% of all claims, whether submitted electronically or manually, within forty-five (45) days of receipt

Behavioral Health claims will be subject to regular Contractor reporting, at the state's direction utilizing the state's reporting template and instructions. The state reserves the right to issue corrective action plans for issues with rates of first pass denials as needed.

A clean claim must include the following:

1. The claim is for a service or supply covered by the health benefits plan.
    I. If necessary, substantiates the medical necessity and appropriateness of the service provided.
    II. If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person.
3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service.
    I. Identifies the service rendered using a generally accepted system of procedure or service coding (ICD-10).
    II. Lists the date and place of service.
    III. Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and
5. The claim does not require special treatment. Special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly

approved medications. The circumstances requiring special treatment should be documented in the claim file.

Topic	Description	Medicaid, HMO DSNP, or Both
Claims Form Types	CMS 1500 or UB-04 (also known as CMS 1450)	Both
Clean Claim	A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or a third party.	Both
BH Medicaid Claims Processing Timeframes	• Electronically Submitted – within 15 calendar days of receipt • Manually Submitted – within 30 calendar days of receipt • All claims – with 45 days of receipt	Both
Corrected Claims	Claims must be submitted within 365 days from the date of service.	Both
Timely Filing	Claims must be submitted within 180 calendar days from the date of service.	Both
Common Claims Barriers	5010 Requirements (Rendering NPI and pay-to NPI; Both are required) • NDC Codes Missing or Incomplete for drugs • Lack of Prior Authorization	Both
Balanced Billing	Balance billing is strictly prohibited. You cannot bill members for any services that are covered by NJ Medicaid.	Both
Coordination of benefits non-integrated primary plan	Members must submit the primary insurance EOB along with claim for the secondary ABHNJ benefits to apply.	Medicaid
Coordination of benefits FIDE Primary Plan	Using the member's ID number from the plan ID card, you'll only need to submit one claim. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits. Medicare processing timeframes apply.	HMO-DSNP
Remittances	You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to resubmit a secondary claim to Aetna.	HMO -DSNP

Risk Pool Criteria

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

How to File a Claim

Instructions on how to fill out the claim forms can be found on our website.

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

Service	Claim Form
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, nursing home and emergency room services	CMS UB-04/1450 Form
General dental services	ADA 2006 Claim Form
Dental services that are considered medical services (oral surgery, anesthesiology)	CMS 1500 Form

2. Complete the claim form
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 Assure Premier Plus (HMO D-SNP) at the correct address.
   a. Electronic Clearing House- Providers who are contracted with us can use electronic billing software. Electronic billing allows 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.
      i. ECHO Health, Inc. is the EDI vendor we use
      ii. Contact your software vendor directly for further questions about your electronic billing
      iii. Contact our Provider Experience Team for more information about electronic billing. All electronic submission should be submitted in compliance with applicable law including HIPAA regulations and Aetna Assure Premier Plus (HMO D-SNP) policies and procedures.
4. Through the mail

Claims	Claim Form	Electronic Submission
Medical	Aetna Assure Premier Plus (HMO D-SNP) PO Box 982967 El Paso, TX 79998-2967	Through Electronic Clearinghouse **www.echohealthinc.com**

Correct Coding Initiative

We follow the same standards as Medicare's Correct Coding Initiative (CCI) policy and perform 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/ .**

We utilize ClaimCheck as our comprehensive code auditing solution that will assist payers 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 TM.

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 and 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
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect Coding

Examples of incorrect coding include:

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

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. We 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 Provider 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 the DMAHS 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 – Providers/Non Provider 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 Provider uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure.

Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.”

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

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website or by calling the Provider Experience Department.

Online Status through our Secure Web Portal

We encourage Providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims. To register, go to **www.AetnaBetterHealth.com/New-Jersey-hmosnp** to download our Secure Web Portal Agreement. Contact our Provider Experience Team for additional information or to schedule training.

Calling the Provider Experience Department

The Provider Experience Department is also available to:

- Answer questions about claims
- Assist in resolving problems or issues with a claim
- Provide an explanation of the claim adjudication process
- Help track the disposition of a particular claim
- Correct errors in claims processing:
    - Excludes corrections to prior authorization numbers (Providers must call the Prior Authorization Department directly).
    - Excludes rebilling a claim (the entire claim must be resubmitted with corrections). Please be prepared to give the service representative the following information:
- Provider name or 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

Payment of Claims

We process claims and notify Providers of outcomes using a Remittance Advice. Providers may choose to receive checks through the mail or electronically. We encourage Providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than Remittance Advice received through the mail, enabling you to post payments sooner. Please contact our Provider Experience Team for further information on how to receive ERA.

Through Electronic Funds Transfer (EFT), Providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment for the Aetna Assure Premier Plus (HMO D-SNP) plan will be made on separate checks, one check from Medicare, and one check from Medicaid. You may enroll in EFT by submitting

an EFT Enrollment Form, which is located on our website, or by contacting our Provider Experience Team. Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT to be established. Our Provider Experience Team can assist you with this process.

Claim Resubmission

Non-participating Providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating Providers should refer to their contract for timely filing and resubmission time frames. 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:

- 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 “Corrected Claim” 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.

Claim Reconsiderations

Conditions for payment are outlined in your Provider Agreement and fee schedule. Claim payments are adjudicated in accordance with your Provider Agreement. CMS prohibits HMO D-SNP plans from applying the mandated Medicare Member process to Providers.
Providers are encouraged to contact the Provider Experience Department with questions on how their claim paid. We will work with the Provider to resolve the issue if an error is discovered. In some situations, we may require the Provider to resubmit the claim for reprocessing. For additional information about claims disputes, please see the Grievance Systems Chapter in this Manual (Chapter 16).

Instruction for Specific Claims Types

General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your Provider Agreement. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Nursing Homes

Providers submitting claims for nursing homes should use the CMS UB-04 Form.

Providers must bill in accordance with standard Medicare Resource Utilization Groups (RUGs) billing requirement rules for Aetna Assure Premier Plus (HMO D-SNP), following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment**.

Home Health Claims

Providers must bill in accordance with their Provider Agreement. Non-participating health care Providers must bill according to CMS HHPPS requirement rules for Aetna Assure Premier Plus (HMO D-SNP). For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: **http://www.cms.gov/HomeHealthPPS/** .

Home Health Agencies

No payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each Member.

Dental Claims

- Claims for dental services should be submitted on the standard American Dental Association form, ADA 2006 Claim Form.
- Services provided by an anesthesiologist, or medically related oral surgery procedure, should be submitted on the CMS 1500Form.

Personal Emergency Response System

All bills for Personal Emergency Response Systems should contain a dated certification by the Provider that the care, services, and supplies itemized have in fact been furnished.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for DME Rental should use the 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 Medicaid and the Aetna Assure Premier Plus (HMO D-SNP) plan. Units billed for Aetna Assure Premier Plus (HMO D-SNP) 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 the 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 of discharge.

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

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

Hospice Claims

The only claims payable during a hospice election period by Aetna Assure Premier Plus (HMO D-SNP) are additional benefits covered under us that would not normally be covered under the FIDE D-SNP plan 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 Assure Premier Plus (HMO D-SNP). While most claims can be processed under both the FIDE D-SNP plan, and Medicaid, there may be instances where separate billing may be required.

Remittance Advice

Provider Remittance Advice

We generate 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 make certain 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 Experience Team if you are interested in receiving electronic remittance advices.

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

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Assure Premier Plus 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 Agreement.
- 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 Assure Premier Plus (HMO D-SNP) 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 Assure Premier Plus (HMO D-SNP) 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 EFT Reference # and EFT Amount are listed, along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the Provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. 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 obtained. In order to qualify for 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 Experience Team for assistance with this process.

Encounter Data Management (EDM) System

Aetna Assure Premier Plus (HMO D-SNP) uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to the DMAHS requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to the DMAHS. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to the DMAHS. Our EDM System processes CMS1500, UB04 (or UB92), 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 Agreements 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 DMAHS's requirements.

The EDM System has top-of-the-line functionality to accurately, and consistently tracks 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 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 the business application system claims data into EDM

System using a transfer validation report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Encounter Staging Area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third-party vendors (e.g., Pharmacy Benefit Management, dental or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain Encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and is populated with the 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 the DMAHS's 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 program. 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 the EDM System, to submission and acceptance by the DMAHS. Reports are run to make certain 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 DMAHS. 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 DMAHS 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 Encounter Data Management System (EDM) for resubmission to the DMAHS in accordance with the encounter correction protocol, which is tailored to the DMAHS'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 DMAHS'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 encounter 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 DMAHS and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

Chapter 17: Grievance & Appeal

Member Grievance and Appeal Overview

Aetna Assure Premier Plus (HMO D-SNP) takes grievances and appeals very seriously. We want to know what is wrong so we can make our services better. Members can file a complaint, grievance or appeal if they are not satisfied. A network Provider, acting on behalf of a member and with the Member's written consent, may file a grievance, appeal, State Fair Hearing, Independent Review Entity (IRE) review, Administrative Law Judge (ALJ) review, Medicare Appeals Council (MAC), or Judicial Review as applicable.

For Medicaid only covered items/services, a member or their authorized representative may request a State Fair Hearing through the State of New Jersey Division of Medical Assistance & Health Services (DMAHS) at the same time as, in lieu of, or after the appeal process.

For all other Medicare only covered items/services, if we uphold the coverage decision in whole or in part, we will automatically forward the case to the Independent Review Entity (IRE). If the IRE upholds the decision and the total of the item/services appealed, meets the Amount in Controversy (AIC) established dollar amount for the coverage year, the Member or their authorized representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review in successive order.

For items/services covered by both Medicaid and Medicare, upon completion of the appeal process, if we uphold the coverage decision in whole or in part, we will automatically forward the case to the Independent Review Entity (IRE), and the Member or their authorized representative may request a State Fair Hearing through the DMAHS. In instances where a case is reviewed both by the IRE and the State Fair Hearing officer, the decision that is most favorable to the Member will be the one that counts. If both decisions are unfavorable to the Member and the total of the item/services appealed meets the AIC established dollar amount for the coverage year, Members or their representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or Judicial Review in successive order.

We inform Members and Providers of the grievance, appeal, and State Fair Hearing procedures. This information is contained in the Member's Evidence of Coverage (EOC) within this Provider Manual, including being available on our website. When requested, we provide Members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, Provider interpreter services and toll- free numbers that have adequate TTY/TTD and interpreter capability.

Grievances

A grievance may be filed with us either orally, or in writing, by the Member or the Member's authorized representative, including Providers. We respond to grievances within the following timeframes:

- Two (2) business days when the grievance is about access to service
- Thirty (30) calendar days for all other grievances

Members are advised in writing of the outcome of the grievance investigation the same day as the decision, when the grievance involves disputed care or services, and for all other grievances, within two (2) business days of when we make our decision on your grievance and within the processing time described above. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the Member can speak with someone regarding the decision. The notice also tells a member how to obtain information on filing a State Fair Hearing as applicable.

Grievance Extension

If we are unable to resolve a standard grievance within the specified timeframe, we may ask to extend the grievance decision date by fourteen (14) calendar days. We will only take an extension if it is in the Member's best interest. In these cases, we will provide information describing the reason for the delay in writing to the Member and, upon request, to the Centers of Medicare and Medicaid Services (CMS) and as required by the DMAHS.

Expedited Grievance Resolution

We resolve grievances effectively and efficiently, as the Member's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where we have:

- Taken an extension on prior authorization or appeal decision making time frame; or
- Determined that a member's request for expedited prior authorized, or expedited appeal decision making, does not meet the criteria, has denied expedited processing time, and has transferred the request to a standard request.

Members and their representative, if designated, are informed of their right to request an expedited grievance in the EOC and in the extension and denial of expedited processing prior authorization and appeal letters. In most cases, a decision on the outcome of an expedited grievance is reached within twenty-four (24) hours of the date the grievance was filed. Members are advised orally of the resolution within twenty-four (24) hours, followed by a written notification of resolution within two (2) business days of the oral notification. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the Member can speak with someone regarding the decision. The

notice also tells a member how to obtain information on filing a State Fair Hearing as applicable.

Quality Improvement Organization - Quality of Care Grievances

A member may file a grievance regarding the quality of care they received. For items or services covered by Medicare, a member or their authorized representative may file a quality of care grievance direct with us, with CMS's contracted Quality Improvement Organization (QIO) or with both Aetna and the QIO. In New Jersey, the QIO is Livanta, which is located at:

Livanta Attention: Beneficiary Complaints
1820 Guilford Rd., Suite 202
Annapolis Junction, MD 20701

Toll-free Phone: **1-866-815-5640 -** Office hours: 8:00 a.m. to 4:30 p.m. (Monday-Friday)
TTY **1-866-868-2289**
Website: **http://www.livantaqio.com**

Regulatory Complaints

For items/services covered by Medicaid only, a member or their authorized representative may submit complaints direct to the State, primarily through the Ombudsman's office at **1-800-446-7467**.

For items/services covered by Medicare only, a member or their authorized representative may submit complaints direct to CMS through **1-800- MEDICARE (1-800-633-4227)**.

For items/services covered by both Medicaid and Medicare, a member or their authorized representative may submit complaints direct to the State, primarily through the Ombudsman's office at 1-800-446-7467, or to CMS through **1-800-MEDICARE (1-800-633- 4227)**.

Appeals

A member may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with us. Authorized Member representatives, including Providers, may also file an appeal on the Member's behalf with the written consent of the Member. Appeals must be filed no later than sixty-five (65) calendar days from the postmark on the Aetna Assure Premier Plus (HMO D-SNP) Notice of Action. 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
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the Member can use to file an appeal by phone

- That the Member may represent himself or designate legal counsel, a relative, a friend, a Provider or other spokesperson to represent them
- The specific regulations that support, or the change in Federal or State law, that requires the action
- The fact that, when requested by the Member, benefits will continue if the Member files an appeal or requests a State Fair Hearing within the timeframes specified for filing

Appeals may be filed either verbally, by contacting our Member Services Department, or by submitting a request in writing. Unless the Member is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written request.

Members may appeal the decision and request a further review of our actions. Examples of appeals include:

- The denial or limited approval of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to respond to an appeal in a timely manner
- The denial of a member's request to obtain services outside of the contracting area when Aetna Assure Premier Plus (HMO D-SNP) is the only health plan servicing a rural area.

Members may file an appeal by:

- Calling our Member Services Department at **1-844-362-0934** TTY/TTD NJ Relay Number 711
- Faxing Pre-Service Expedited request at **1-724-741-4958**

Participating providers can file an appeal for Medicaid Only covered services on behalf of the members.

- The request must be submitted in writing.
- The plan must render a decision and provide written notification to the provider within 30 calendar days of receipt of the request.
- Faxing Post Service Payment or coverage disputes 1-724-741-4953
- Writing at:

Aetna Assure Premier Plus (HMO D-SNP) Attn: Provide Disputes
PO Box 14579
Lexington, KY 40512-4579

Continuation of Benefits

For items/services that the Member is currently receiving that are being reduced, denied, termed or suspended, the Member may continue to receive the items/services at the current level during the appeal process if the Member requests services to continue while the appeal is reviewed and the Member filed the appeal no later than ten (10) calendar days from the date of our Notice of Action letter, or the effective date of our proposed termination, suspension or reduction of previously authorized services. We will also provide Members with access to necessary medical records and information to file their appeals.

Appeal Process

A brief overview of the appeals process follows:

- Verbal appeals must be put into writing and signed within ten (10) days.
- We notify Members of receipt of the appeal within three (3) business days via an acknowledgment letter.
- Members are advised of their, or their authorized representative's, rights to provide more information and document for their appeal either in person or in writing.
- Members are advised of their, or their authorized representative's right, to view their appeal file.
- Appeals will be resolved within (72) hours for expedited or (30) calendar days for standard. An extension can be granted by the Health plan or at the request of the member or Provider. The Health plan will provide a reason for the extension, or the Member or their authorized representative requests the extension, after Aetna Assure Premier Plus (HMO D-SNP) receives the appeal.
- We make reasonable effort to provide verbal notice and mail the decision letter, including an explanation for the decision, within two (2) business days of the Appeal decision.
- If we do not agree with the Member's appeal, the Member can ask for a State Fair Hearing and request to receive benefits while the hearing is pending. Members can also request that the appeal be reviewed by the DMAHS.
- If we, or the State Fair Hearing officer, reverses the original decision and approves the appeal, services will begin immediately.

Expedited Appeal Resolution

We resolve appeals effectively and efficiently, as the Member's health requires. 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. If the Member's ability to attain, maintain, or regain maximum function is not at risk, the request to process the appeal in an expedited time frame may be denied and the appeal processed within the normal thirty (30) calendar days' time frame. A member or their authorized representative, including

Providers, may request an expedited appeal either verbally, or in writing, within sixty (60) calendar days from the day of the decision or event in question. 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.

Upon receipt of an expedited appeal, we begin the appeal process immediately. We attempt to acknowledge expedited appeals by telephone and in writing on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the Member prompt verbal notice of the denial of expedited processing time within one (1) business day and follow up within two (2) calendar days with a written notice.

In cases where the health plan determines if a member's request meets expedited urgency, or a Provider supports the Member's request, our Medical Director will render a decision as expeditiously as the Member's health requires, but no later than seventy- two (72) hours from the receipt of the expedited appeal.

If Members wish for services to continue while their appeal is reviewed, they must request the appeal within fifteen (15) calendar days from the date of the Notice of Action letter or the intended effective date of the action. If we reverse our original decision and approve the appeal, services will begin immediately.

Appeal Extension

If we are unable to resolve a standard or an expedited appeal within the specified timeframe, we may extend the period by up to fourteen (14) calendar days. We will only take an extension if it is in the Member's best interest. In these cases, we will provide information describing the reason for the delay in writing to the Member and, upon request, to CMS and as required to the DMAHS.

Failure to Make a Timely Decision

Appeals must be resolved within stated timeframes and parties must be informed of our decision.

For items/services covered by Medicaid only: if a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

For items/services covered by Medicare only or by both Medicare and Medicaid: if a determination is not made by the above timeframes, the Member's request will be automatically forwarded to the Independent Review Entity (IRE) for review.

The State of New Jersey Division of Medical Assistance & Health Services (DMAHS) State Fair Hearing

For items/services covered by Medicaid only or by both Medicaid and Medicare, the Member and/or the Member's authorized representative acting on behalf of the Member may request a State Fair Hearing through the DMAHS within (120) calendar days from Aetna Better Health's Notice of Action (NOA) Letter or the Appeal Decision Letter.

If Members wish services to continue receiving services while their State Fair Hearing is reviewed, they must request a State Fair Hearing within fifteen (15) calendar days from the date of the Notice of Action Letter or the Appeal Decision Letter. At the State Fair Hearing, Members may represent themselves or be represented by a lawyer, their Provider or other authorized representative, with the Member's written permission. To request a State Fair Hearing, Members must:

- Submit a request for a State Fair Hearing to the DMAHS To submit a request in writing, Members should write to:

New Jersey Division of Medical Assistance and Health Services (DMAHS) Fair Hearing Unit
PO Box 712
Trenton, NJ 08625-0712

The State Fair Hearing officer will render a decision about services. If the hearing decision favors the Member, then we will commence the services immediately.

Independent Review Entity (IRE)

For Medicare Part D covered medications, if the decision is upheld at appeal in whole or in part, the Member or their authorized representative can request an Independent Review

Entity (IRE) review. If the IRE upholds the decision and the total of the medications appealed meets the Amount in Controversy (AIC) established dollar amount for the coverage year the Member or their authorized representative may request an Administrative Law Judge (ALJ), Medicare Appeals Council (MAC), or Judicial Review in successive order.

The IRE will conduct the review as expeditiously as the Member's health condition requires, notify all parties of the determination, and outline the procedure to request an ALJ Hearing if the total dollar amount of the items/services being appealed meets or exceeds the established AIC threshold. For the current AIC threshold amounts please visit **https://www.federalregister.gov/documents/2019/10/07/2019-21751/medicare-program_medicare-appeals-adjustment-to-the-amount-in-controversy-threshold-amounts-for** .

For all other items/services covered by Medicare only or by both Medicare and Medicaid, if the decision is upheld at appeal in whole or in part, we will submit a case summary to the Independent Review Entity (IRE). We will then notify the Member that we forwarded the case to the IRE for review in the Appeal Decision Letter. The notice will include contact information for the IRE and the Member's right to submit additional evidence that may be relevant to the case direct to the IRE.

The Independent Review Entity (IRE) will conduct the review as expeditiously as the Member's health condition requires, will notify all parties of the determination, and will include the right to an ALJ hearing and the procedure to request one if the total dollar amount of the items/services being appealed meets or exceeds the established AIC threshold. For the current AIC threshold amounts please visit **https://www.federalregister.gov/documents/2019/10/07/2019-21751/medicare program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold amounts-for** .

Administrative Law Judge (ALJ)

The Member or their authorized representative may file a request for an ALJ hearing in writing within sixty (60) calendar days of the IRE notice of determination, to the entity specified in the IRE's reconsideration notice. If we receive a written request for an ALJ hearing from the Member, we will forward the Member's request to the IRE. The IRE will compile the reconsideration file and forward it to the appropriate ALJ hearing office.

Medicare Appeals Council (MAC)

The Member or their authorized representative may request a MAC review in writing through a letter to the MAC within sixty (60) calendar days of the Administrative Law Judge (ALJ) decision. The request should be submitted directly to the MAC at the following:

Department of Health and Human Services Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W. Cohen Building, Room G-644
Washington, DC 20201

The MAC will review the appeal, render a decision, and notify all parties within ninety (90) calendar days of receipt of the request. If the appeal decision is upheld in whole or in part, notification will include the right and the timeframes to request a MAC review.

Judicial Review

Any party, the Member, their representative, if designated, or Aetna Assure Premier Plus (HMO D-SNP), may request judicial review upon completion of the MAC review process when the total dollar amount of the items/services meets or exceeds the Amount in Controversy (AIC). For the current AIC threshold amounts please visit **https://www.federalregister.gov/documents/2019/10/07/2019-21751/medicare**

program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold amounts-for .

The party may combine claims to meet the amount in controversy requirement. To meet the requirement:

- All claims must belong to the same Member;
- The MAC must have acted on all the claims;
- The Member must meet the 60-day filing time limit for all claims; and
- The request must identify all claims.

To request a Judicial Review any party, must file a civil action in a district court of the United States. The action should be initiated in the judicial district in which the Member lives, or where the health plan has its principal place of business. If neither the organization, nor the Member, is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

Claim Reconsiderations for PAR Providers (Dispute)

Is a claim for a PAR Provider in which the Provider is not correcting the claim in anyway, but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim.

Aetna Assure Premier Plus (HMO D-SNP) and our participating Providers are responsible for timely resolution of any disputes between both parties. Disputes, also known as reconsiderations, will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to Members as a result of disputes.

We will inform Providers through the Provider Manual and other methods including Provider Newsletters, training, Provider orientation, webinars, the website about the Provider claims dispute process. Our Provider Experience Team are available to

discuss a Provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

To have a claim reconsidered through our claim dispute process for par Providers, the contracted Provider may submit using one of two methods:

1. The Claim Reconsiderations for PAR Providers (Dispute) Form is accessible on our website under the "For Providers" link, under "Forms" and then PAR Provider Dispute Form. Complete and submit the PAR Provider Claims Dispute Form along with the claim and any appropriate supporting documentation (if applicable) to:

   Aetna Assure Premier Plus (HMO D-SNP)
   PO Box 61925
   Phoenix, AZ 85082

2. Log into the Secure Provider Web Portal located on our website under the 'For Providers' link at **www.AetnaBetterHealth.com/New-Jersey-hmosnp/providers/portal**. For instructions, please visit our website under the 'For Providers' link, and click on Resources, then Tools & Resources. Here, you will find a PDF document under Online Provider Dispute Instructions to walk you through the process. You will also be required to upload any supporting documentation required for the reconsideration of your claim related to your Dispute.

Claims Disputes for Participating are delegated to Claims Investigation / Claims Research Department for review, research and analysis. Providers will be notified of the decision for a Claim Dispute via remit (along with claim edits and descriptions) for reprocessed claim, or if the Claim Dispute was incomplete, a letter will be sent to the Provider indicating that the Dispute could not be processed and will need to be resubmitted.

Claim Reconsiderations for non-PAR Providers (Appeal)

Is a claim for a non-contracted Provider in which the Provider is not correcting the claim in anyway but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim.

Non-participating Providers do not have Dispute rights and will be required to submit an Appeal for any claim that the Provider would like to have reconsidered. Non-contracting Provider claim appeals must be submitted in writing accompanied by the Non-Participating Provider Claim Appeals form along with a completed Waiver of Liability (WOL) form within 365 days of the original submission. Both forms are available on our website at **www.AetnaBetterHealth.com/New-Jersey-hmosnp/providers/forms.**

Once complete, please mail the form, the Waiver of Liability, the claim and any supporting documentation to:

Aetna Assure Premier Plus (HMO D-SNP) ATTN: Appeals
PO Box 818070
5801 Postal Road
Cleveland OH 44181

Claim Resubmission (Corrected Claim)

A claim that is resubmitted to the plan via the same process of a new day claim (via Provider's claims tool, Aetna's claims portal, or mailed) but the claim itself has been corrected in some way and the claim is designated as 'Corrected' via Bill Type code. Paper claims should also have the word 'RESUBMISSION' written across the top of the claim.
Corrected claims that do not require a reconsideration do not require a Dispute or Appeal form. Both Participating and Non-Participating Providers should follow standard corrected claim billing requirements. These claims should be coded

correctly as a corrected claim and can either be submitted via our ECHO Health, Inc. the Provider's own clearing house, or mailed to:

Aetna Assure Premier Plus (HMO D-SNP)
PO Box 61925
Phoenix, AZ 85082

Please write "RESUBMISSION" at the top of any paper claims being mailed to the address indicated to help ensure the claim is handled appropriately.
Provider Payment Appeals must be submitted in writing with the supporting documentation that they should receive a different payment under original Medicare within sixty (60) calendar days of the remittance advice.
If the Provider remains in disagreement with the Non-Participating Provider Payment Appeal decision, the Provider can submit a request in writing for the Independent Review Entity (IRE) review within one-hundred-eighty (180) calendar days of the remittance advice. The IRE will process the request within sixty (60) calendar days of receipt and will notify all parties to the appeal of their decision. If the decision is overturned, we will effectuate the decision within thirty (30) calendar days of receipt of IRE's notification of decision.

Provider Grievances

Both, network and out-of-network Providers, may file a complaint verbally or in writing, directly with us in regard to our policies, procedures or any aspect of our administrative functions. Providers can file a verbal grievance with us by calling **1-855-364-0974**. To file a grievance in writing, Providers should write to:

Aetna Assure Premier Plus (HMO D-SNP) Grievance Team
PO Box 818070
5801 Postal Road
Cleveland OH 44181

The Grievance Team 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 Grievance System 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 Assure Premier Plus (HMO D-SNP)'s written policies and procedures, collecting pertinent facts from all parties.

Provider Disputes

A Provider may file a dispute, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, within sixty (60) calendar days from the postmark on the Aetna Assure Premier Plus (HMO D-SNP) Notice of Action. The expiration date to file a dispute is included in the Notice of Action. Providers can file a verbal dispute with us by calling **1-844-362-0934**. All verbal appeals must be followed up in writing. All written disputes should be sent to the following:

Aetna Assure Premier Plus (HMO D-SNP) Attn: Provider Disputes
P.O. Box 61925
Phoenix, AZ 85082

Management of the Process

The Appeal and Grievance Department is responsible for the management of appeals and grievances. All data collected is reported to the appropriate quality committees which includes representation from compliance.
The Grievance Team has overall responsibility for the management of the Member Grievance System process. Responsibilities include:

- Documenting individual grievances, appeals, State Fair Hearings, IRE reviews, ALJ reviews, MAC reviews and Judicial Reviews.
- Coordinating resolutions of grievances and appeals
- Tracking, trending and reporting data
- Identification of opportunities for improvement
- Ensuring complete appeal and grievance records
- Real time Quality Assurance (QA) Review

Our Member Services Department, in collaboration with the QM Department, are responsible for informing and educating Members and Providers about a member's right to file a grievance or appeal or request an DMAHS State Fair Hearing, and for assisting Members throughout the grievance or appeal process.
Members are advised of their grievance, appeal, the DMAHS State Fair Hearing Independent Review Entity (IRE), Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) or Judicial Review rights and processes, as applicable, at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual, during initial Provider orientation, within the Provider Agreement, and on our website.

DOBI Independent Utilization Review Process

A Provider can appeal Aetna's service decision through the DOBI Independent Utilization Review Organization (IURO) process. This is handled by the State of New Jersey Office of Banking & Insurance (DOBI) thru their Office of Managed Care (OMC). The OMC oversees the Independent Health Care Appeals Program (IHCAP). After a member or a Provider, with the member's consent, exhausts a carrier's internal UM appeal process, the member or Provider has a right to access the Stage 3 (external appeal) process through the IHCAP administered by the DOBI. DOBI

contracts with independent utilization review organizations (IURO) to conduct the Stage 3 reviews for the IHCAP. The IURO's determination is binding on the carrier. Provider complaints regarding carrier payment issues are also reviewed and investigated through DOBI's Provider Prompt Payment Unit (PPPU) in the OMC. The PPPU also oversees DOBI's Program for Independent Claims Payment Arbitration (PICPA).

For more information, please visit the DOBI website at:
https://www.nj.gov/dobi/division_insurance/managedcare/ihcap.htm

Chapter 18: Fraud, Waste, and Abuse

Fraud and Abuse

Aetna Assure Premier Plus (HMO D-SNP) of New Jersey maintains a comprehensive anti- fraud program dedicated to preventing detecting, investigating, correcting and reporting FWA. Our commitment to fraud prevention is long standing. Aetna implemented its first Anti- Fraud Plan in the1980s.

Aetna believes there are three critical elements that help us fight FWA.

1. Employing a diverse team of experienced and highly trained professionals.
2. Leveraging advanced data analytics, tools and technology.
3. Continuous training of employees on FWA prevention and detection.

Our program helps us protect the safety of our members, satisfy fiduciary responsibilities, and lead the industry in combatting FWA.

Aetna has extensive detection and prevention protocols to combat FWA and to ensure compliance with state and federal requirements.

These protocols include, but are not limited to:

- Fraud awareness training programs
- Data mining and data analytics
- Monitoring of hotlines and other reporting mechanisms
- Developing relationships with Law Enforcement and PBM
- Tracking industry information to FWA trends and indictments
- Promoting public awareness

Special Investigations Unit (SIU)

Aetna has a dedicated investigative unit that is responsible for preventing, detecting, and investigating, correcting and reporting FWA. The unit operates separately from claim and underwriting functions.

The Special Investigation Unit (SIU) is well-staffed and highly trained. The SIU employs approximately 150 colleagues and has both investigative and prepay teams. Approximately one third of the Aetna SIU is dedicated to fraud investigations. SIU has a diverse team that includes: a medical director, nurses, certified coders, former law enforcement, pharmacy technicians, attorneys, accredited healthcare fraud investigators, certified fraud examiners, IT specialists, and administrative staff.

Optimal staffing levels are determined based on a number of factors related to Aetna's vulnerability to health care fraud (e.g. claim volumes, number of insured lives, volume of plan benefits being administered, optimal caseloads, contract requirements, etc.). Staff and case assignments can be shifted, as necessary, to ensure there are manageable workloads. SIU investigators must meet specific

education, experience and training requirements. All investigators have knowledge, training and/or experience in:

- FWA laws, rules and regulations
- General claims practices
- The analysis of claims for patterns of fraud
- Current trends in insurance fraud
- Company systems
- Red flags, red flag events, and criteria indicating possible fraud

In addition, the Aetna's Health Plans have at least one investigator dedicated to fraud prevention efforts. These plan based investigator(s) focus on fraud prevention in the state they are located and supported by the SIU.

Many mechanisms are used to collect tips from internal and external stakeholders. Options include toll-free phone numbers, web forms, and email addresses. There are options for anonymous and confidential reporting. Each mechanism is available 24 hours a day, 7 days a week.

These reporting mechanisms are available to colleagues, Providers, pharmacies, members, and others. They are advertised to colleagues on the intranet and through training courses. Additionally, they are publicized on public websites and in member materials.

Reporting Suspected Fraud and Abuse

Participating Providers are required to report all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the HMO D-SNP plan, to Aetna Assure Premier Plus (HMO D-SNP).
Providers can report suspected fraud, waste or abuse in the following ways:

- By phone to the confidential Aetna Assure Premier Plus (HMO D-SNP) Compliance Hotline at **1- 855-282-8272**; or
- Online by completing the Fraud, Waste and Abuse web form located at **www.AetnaBetterHealth.com/New-Jersey-hmosnp/fraud-abuseform.html**.

You can also report fraud to the State of New Jersey Medicaid Fraud Division Office (MFD) at **1 888-937-2835**, or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services (HHS) at **1-800-HHS-TIPS (1-800-447-8477)**.

CMS requires us to have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. §422.503 (b) (4) (vi), and 42 C.F.R §423.504(b) (4) (vi).
CMS combats fraud by:

- Close coordination with contractors, Providers, and law enforcement agencies

- Developing Aetna Assure Premier Plus (HMO D-SNP) plan compliance requirements that protect stakeholders
- Early detection through medical review and data analysis
- Effective education of Providers, suppliers, and Members

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 – make certain coding reflects services provided
- Monitor medical records – make certain 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
- Understand that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Fraud, Waste and Abuse Defined

- Fraud: Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal and/or state law. Examples include but are not limited to the following schemes:
    - Billing for services that were never rendered.
    - Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation, and
    - Falsifying a patient's diagnosis to justify tests, surgeries or other procedures
- Waste: Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Examples include but are not limited to the following schemes:
    - Performing large number of laboratory tests on patients when the standard of care indicates that only a few tests should have been performed on each of them,
    - Medication and prescription refill errors, and
    - Failure to implement standard industry waste prevention measures.
- Abuse: Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to a health plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not

knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors. Examples include but are not limited to the following schemes:

- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered),
- Waiving patient co-pays or deductibles and over-billing, and
- Billing for items or services that should not be paid for by a health plan, such as never events.

Examples of Provider Fraud, Waste and Abuse can include:

- 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 Drug List 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 (e.g., by not referring a member to an appropriate Provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., 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 20 nursing home visits without furnishing any specific service to the Members.
- Double billing such as billing both the Member, or billing Aetna Assure Premier Plus (HMO D-SNP) 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.

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 Assure Premier Plus (HMO D-SNP)'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 address individuals or entities that are excluded from participating in the HMO D-SNP plan.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, Managers, directors, and Members of the compliance committee, as well as related entities.
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non- compliance, while maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Assure Premier Plus (HMO D-SNP).
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 that Apply to Fraud, Waste, and Abuse

Providers contracted with us must agree to be bound by, and comply with, all applicable state and federal laws and regulations. There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) 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 $13,508 to $27,018 per false claim. The amount of the false claim's penalty is to be adjusted periodically for inflation in accordance with a federal formula.
- The False Claims Act prohibits, among other things:
    - Knowingly presenting a false or fraudulent claim for payment or approval.

  - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government.
  - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.
  - "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.
  - Retaliatory Actions-Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action.
- Self-Referral Prohibition Statute (StarkLaw)
  - Prohibits Providers from referring Members to an entity with which the Provider or Provider's immediate family Member has a financial relationship, unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
  - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
- Health Insurance Portability and Accountability Act (HIPAA)requires:
  - Transaction standards.
  - Minimum security requirements.
  - Minimum privacy protections for protected health information.
  - National Provider Identification (NPIs) numbers.
  - The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $13,508 to $27,018 per 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 claim's 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 Assure Premier Plus (HMO D-SNP) services through the HMO D-SNP plan.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. 1396a(a)(68), Aetna Assure Premier Plus (HMO D-SNP) Providers must follow state and federal 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 Assure Premier Plus (HMO D-SNP) services through the NJ Medicaid/NJ FamilyCare.
- •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 $13,508 and $27,018 per false claim. Penalty amounts are subject to adjustment for inflation.
- Under the criminal provisions of the New Jersey Medical Assistance and Health Services Act (MAHSA), codified at N.J.S.A. §30:4D-17(a) - (d), providers with Aetna Assure Premier Plus (HMO D-SNP) shall refrain from engaging in fraud or other criminal violations relating to Title X|X (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 Assure Premier Plus (HMO D-SNP): (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 $13,508 to $27,018. Penalty amounts are subject to adjustment for inflation. Per false claim when violations of the

Medicaid statute are intentional or when there is a violation of the New Jersey False Claims Act. Providers engaging in civil violations may be excluded from participation in Medicaid and other health care program sunder N.J.S.A. § 30:4D-17.1(a)

- Under the 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 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 Assure Premier Plus (HMO D-SNP) services who (1) knowingly commit health care claims fraud in the course of providing professional services; (2) recklessly commit health care claims fraud in the course of providing services; or (3) commit acts of health care claims fraud as described in (1) and (2), if the commission of such acts would be performed by an individual other than the professional who provided services (e.g., claims processing staff), are guilty of a crime. Providers may lose his/her license as part of the penalties of this act.
- Under the New Jersey Consumer Fraud Act (CFA), codified at N.J.S.A. §§ 56:8-2, 56:8-3.1, 56:8-13, 56:8-14, and 56:8-15, provider agencies and the individuals working for them shall be prohibited from the unlawful use of “any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact”, with the intent that others rely upon it, in connection with the sale, rental or distribution of any product or service by the provider agency or its employees, or with the subsequent performance of that provider agency or its employees.
- Under the Conscientious Employee Protection Act (CEPA), codified at N.J.S.A. §34:19-1, et seq., provider agencies are prohibited from taking retaliatory action against employees who: (a) disclose or threaten to disclose to a supervisor or any public agency an activity, policy or practice of the provider agency or another business with which the provider agency shares a business relationship, that the employee reasonably believes to be illegal, fraudulent and/or criminal; (b) provides information or testimony to any public agency conducting an investigation, hearing or inquiry into any violation of law, rule or regulation by the provider agency or another business with which the provider agency shares a business relationship; or (c)objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes is illegal, fraudulent, criminal or incompatible with a clear mandate of public policy concerning the public health, safety or welfare, or protection of the environment.
- The New Jersey Insurance Fraud Prevention Act, N.J.S.A 17:33A-1 et seq, The purpose of this act is to confront aggressively the problem of insurance fraud

in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims. Any person who violates any provision of P.L.1983, c.320 (C.17:33A-1 et seq.) shall be liable, in a civil action brought by the commissioner in a court of competent jurisdiction, for a penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $15,000 for each subsequent violation. The penalty shall be paid to the commissioner to be used in accordance with subsection e. of this section. The court shall also award court costs and reasonable attorneys' fees to the commissioner. In addition to any other penalty, fine or charge imposed pursuant to law, a person who is found in any legal proceeding to have committed insurance fraud shall be subject to a surcharge in the amount of $1,000. If a person is charged with insurance fraud in a legal proceeding and the charge is resolved through a settlement requiring the person to pay a sum of money, the person shall be subject to a surcharge in an amount equal to 5 percent of the settlement payment. The amount of any surcharge under this section shall be payable to the Treasurer of the State of New Jersey for use by the Department of Banking and Insurance to fund the department's insurance fraud prevention programs and activities.

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 O|G List of Excluded |individuals/Entities database
- License suspension or revocation

Potential Civil and Criminal Penalties

- False Claims Act - For each false claim, the penalty could range from $13,508 to $27,018 per false claim. Penalty amounts are subject to adjustment for inflation. |f the government proves it suffered a loss, the Provider is liable for three times the loss.
- Anti-Kickback Statute - Up to five years in prison and fines of up to $25,000.00 for violations of the Anti-Kickback Statute. |f a member suffers bodily injury as a result of the scheme, the prison sentence may be 20+years.

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions

- Civil litigation and settlements
- Criminal prosecution
    - Automatic disbarment
    - Prison time

Reporting

If any provider or person discovers fraud and/or abuse occurring in any State or federally- funded health benefit program, they should report it to the Office of State Comptroller, Medicaid Fraud Division hotline at **1-888-937-2835** or web site at **https://www.nj.gov/ comptroller/about/work/medicaid/complaint.shtml**

Exclusion Lists

By law, we are required to check Providers against the Office of the Inspector General's (OIG) Exclusion Database, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any other such databases as the State of New Jersey Division of Medical Assistance & Health Services (DMAHS) may prescribe.

We do 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 Medicaid or any programs by the DMAHS for fraud, waste, or abuse. The Provider must agree to assist us 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.

Chapter 19: Abuse, Neglect, Exploitation and Misappropriation of Member Property

Mandated Reporters

Reporting requirements and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families and the Division of Disability Services including, but not limited to:

1. N.J.A.C. 8:39- 9.4
2. N.J.A.C. 8:36-5.10(a)
3. N.J.A.C. 8:43F-3.3
4. 7/2019 Accepted1/2020 Changes Article 9 – Page 56
5. N.J.A.C. 8:43J-3.4
6. N.J.S.A. 52:27D-409
7. N.J.A.C. 8:57

As mandated by New Jersey Revised Statute 52:27D-409 A health care professional, law enforcement officer, firefighter, paramedic or emergency medical technician who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation shall report the information to the county adult protective services Provider.

All alleged or suspected crimes which endanger the life or safety of residents or employees, which are also reportable to the police department, and which result in an immediate on-site investigation by the police.

In addition, the State Office of the Ombudsman for the Institutionalized Elderly (1-877 582- 6995) shall be immediately notified of any suspected or reported resident abuse, neglect, or exploitation of residents aged 60 or older, pursuant to P.L. 1983 c.43, N.J.S.A. 52:27G-7.1, and the Department shall be immediately notified for residents under the age of 60

A notification is to be sent for any suspected case of participant abuse or exploitation to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly, pursuant to N.J.S.A. 52:27G-7.1 et seq., if the participant is 60 years of age or older, and if less than 60 years of age, to the DHSS Complaint Program, Division of Long Term Care Systems

The facility shall notify the Department immediately by telephone at (609) 633-9034 or (609) 392-2020 after business hours, followed within 72 hours by written confirmation, for any suspected cases of resident abuse or exploitation, which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly.

The notification of any suspected case of child abuse or exploitation to the New Jersey Department of Human Services, Division of Youth and Family Services

CMS Guidance–Nursing Home / Long-Term Care Facilities

The Centers for Medicare and Medicaid Services (CMS) issued guidance on the reporting requirements for nursing homes when there are alleged violations related to mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property.

Federal regulations (42 C.F.R. 483.13 & 42 U.S.C. 1320b–25) and state regulations (New Jersey Revised Code Ann. § 5101.61(A) – (C)) require the reporting of alleged violations of abuse, mistreatment and neglect, including injuries of unknown origin, immediately to the facility administrator and in accordance with state law, to the Department of Health.
Additionally, Federal regulations require that alleged violations of misappropriation of resident property be reported immediately.

Reporting timeframes are as follows:

- Serious Bodily Injury – two (2) Hour Limit: If the incident and/or events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual must report the suspicion immediately, but not later than two (2) hours after forming the suspicion.
- All Others – Within twenty-four (24) Hours: If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual must report the suspicion not later than twenty-four (24) hours after forming the suspicion.

Information to Report

When reporting the incident, please be prepared to provide the following information if applicable:

- The identity of the person making the report and where he/she can be found
- The name and address of the health care facility
- The names of the operator and administrator of the facility, if known
- The name of the subject of the alleged physical abuse, mistreatment or neglect, if known
- The nature and extent of the physical abuse, mistreatment or neglect
- The date, time and specific location of the occurrence
- The names of next of kin or sponsors of the subject of the alleged physical abuse, mistreatment or neglect, if known
- Any other information which the person making the report believes would be helpful to further the purposes of this section

Reporting Agency	Suggested Reporting Timeframes	CMS Required Reporting Timeframes	New Jersey Attorney General's Office	DMAHS-Adult Protective Services
Seniors (Over Age 60) • Dependent Elder Adults • Nursing Homes • Hospice	Immediately and/or in writing within forty-eight (48) hours		New Jersey Attorney General Complaints Hotline Phone: 1-609-292-1272 Hours: 8 a.m. – 5 p.m. (Excluding holidays and weekends. Voice mail service will be available whenever the Hotline is closed} service will be available To report online: **https://www.nj.gov/oag/medicaidfraud/report.html**	DMAHS Adult Protective Services Complaints Hotline Phone: 1-888-937-2835 or view the link to find county specific information. **www.state.nj.us/humanservices/doas/services/aps/index.html** Hours: See link above for hours of operation
Adults (Under 60)	Immediately and/or in writing within forty-eight (48) hours		New Jersey Attorney General Complaints Hotline Phone: 1-609-292-1272 Hours: 8 a.m. – 5 p.m. (Excluding holidays and weekends. Voice mail service will be available whenever the Hotline is closed) To report online: **https://www.nj.gov/oag/medicaidfraud/**	

Nursing Home/ Long-Term Care Facilities		Serious Bodily Injury – immediately, But not later than Two (2) hours After forming The suspicion All Others – twenty- Four (24) After forming the suspicion	New Jersey Attorney General Complaints Hotline Phone: 1-609-292 1272Hours: 8 a.m. – 5 p.m. (Excluding holidays And weekends. Voice mail service will be available whenever the Hotline is closed) To report online: **https://www.nj.gov/oag/medicaidfraud/report.html**	DMAHS Adult Protective Services Complaints Hotline Phone: 1-888-937 2835or view the link to find County specific Information **https://www.state.nj.us/humanservices/doas/services/aps/index.html**

After reporting the incident, concern, issue, or complaint to the appropriate agency, the Provider office must notify Aetna Assure Premier Plus (HMO D-SNP)'s Compliance hotline at **1-855- 282-8272**.

Examinations to Determine Abuse or Neglect

When a State agency notifies us of a potential case of neglect and/or abuse of a member, our Care 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, we also notify the appropriate regulatory agency of the report.

Definitions

- Reasonable Cause means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury.
- Immediately means "right-away"; however, reporting may be delayed to prevent harm (e.g., for as long as it takes to call emergency responders and/or address the need to maintain supervision.)
- Discovery comes from witnessing the situation, or when the vulnerable person or another individual comes to you and the available information indicates reasonable cause.

Examples, Behaviors and Signs

Abuse and Examples of Abuse

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth.
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints

Behaviors of Abusers (Caregiver and /or Family Member)

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

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

Examples of Neglect

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

Financial Exploitation And 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.

Children

Providers must report suspected or known child abuse and/or neglect to the Division of Child Protection and Permanency (DCP&P) and, if relevant, the law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any

individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect. If the child is in immediate danger, call **911** as well as **1-877 NJ ABUSE (1-877-652-2873)** or the Division of Child Protection and Permanency (DCP&P) at **1-800-792-8610**. NJ 126 -22-01-23, update 2/2022

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 our Compliance Hotline at: **1-855-282-8272**. Our providers must fully cooperate with the investigating agency and must make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g)

Emergency Room Criteria

As mandated by New Jersey Administrative Code, emergency room providers are required to examine children for suspected physical abuse and/or neglect and also when placed in foster homes after normal agency business hours. These visits are covered by Aetna Assure Premier Plus. To remain in compliance with N.J.A.C. 8:43G-12.10(b), regularly assigned emergency department staff should attend training or educational programs related to the identification and reporting of child abuse and/or neglect in accordance with N.J.S.A. 9:6-1 et seq.; sexual abuse; domestic violence; and abuse of the elderly or disabled adult.

Chapter 20: Forms

Par Provider Dispute Form

Participating Providers may use this form to have a claim decision reconsidered.
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/PAR-PROV-DISPUTE.pdf

Non-Par Provider Appeals Form

Non-participating Providers who wish to appeal a claim decision must use this form.
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/NON-PAR_APPEAL.pdf

Waiver of Liability Form

To be completed by non-contracted Providers who file a claim appeal.
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/providers/pdf/WOL.pdf

Pharmacy Coverage Determination Request Form

Request for Medicare prescription drug coverage.
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/pdf/H6399%20CoverageDETERMINATION%20H6399_NR_3032_20800_2021_C_RMD.pdf

Consent to Sterilization

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

English:
https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf

Spanish:
https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-spanish-2025.pdf

Special Needs Form

Request to complete form per provider group/facility.
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-hmosnp/pdf/ abhnjdsnp_special_need_survey.pdf

Glossary

Claim Resubmission (Corrected Claim)--A claim that is resubmitted to ABHO via the same process of a new day claim (via Provider's claims tool, Aetna's claims portal, or mailed) but the claim itself has been corrected in some way and the claim is designated as 'Corrected' via Bill Type code. Paper claims should also have the word 'RESUBMISSION' written across the top of the claim.

Claim Reconsideration Par Provider (Dispute)--A claim for a PAR Provider in which the Provider is not correcting the claim in anyway but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim. This requires the Provider to fill out the PAR Provider Dispute Form.

Claim Reconsideration Non-Par Provider (Appeal)--A claim for a non-contracted Provider in which the Provider is not correcting the claim in anyway but disagrees with the original claim outcome and wishes to challenge the payment or denial of a claim. This requires the Provider to fill out the non-PAR Provider Appeal Form

Cost Sharing Protections for Dual Eligible--As provided at 42 U.S.C. 1395w-22(a)(7), (42 CFR 438.206(b)(5), the Contractor shall not impose cost-sharing that exceeds the amount of cost- sharing that would be permitted with respect to the Member under title XIX if the individual were not enrolled in such plan.

Durable Medical Equipment (DME)--Equipment, including assistive technology, which: a) can withstand repeated use; b) is used to service a health or functional purpose; c) is ordered by a qualified practitioner to address an illness, injury or disability; and d) is appropriate for use in the home or work place/school.

Emergency Medical Condition--A medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Medical Transportation-- A Basic Life Support ambulance is for patients who need medical assistance while in transit. Ambulance services for an emergency medical condition.

Emergency Services--Covered inpatient and outpatient services furnished by any qualified Provider that are necessary to evaluate or stabilize an emergency medical condition.

Emergency Room Care-- Emergency services in a hospital emergency room.

Habilitation Services and Devices--Health care services that help members keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Care--Health care services a person receives at home.

Hospice Services-- Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization--Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care; in a hospital outpatient care; Care in a hospital that usually doesn't require an overnight stay.

Network--The facilities, Providers and suppliers a health insurer or plan has contracted with to provide health care services.

Premium--The amount a member pays for their health insurance every month.

Prescription Drug Coverage--Health insurance or plan that helps pay for prescription drugs and medications. All Marketplace plans cover prescription drugs.

Prescription Drugs--Drugs and medications that, by law, require a prescription.

Pre-Service Authorization Member Appeals--Member appeal which can be filed on a member's behalf related to an authorization denial.

Primary Care Providers (PCP)--A Provider (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or Provider assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider--Any Provider, hospital, facility, health care professional or other Provider of Member services who is licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.

Provider Grievance--Both network and out-of-network Providers, may file a complaint verbally or in writing, directly with the plan in regard to our policies, procedures or any aspect of our administrative functions.

Rehabilitative Services--Health care services that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Specialist--A Provider specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-Provider specialist is a Provider who has more training in a specific area of health care.

Skilled Nursing Care Facility (SNF)--Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or Provider.