MLTSS Provider Training

Aetna Better Health of New Jersey

Presenter name

aetna®

06.30.2022

Agenda

About us

Utilization Management

Case Management / Care Coordination

Provider Services

Community Resources

Contacts

About Us

The Aetna Medicaid Difference

Nationally recognized – locally focused

30 years of Medicaid and MLTSS experience

Expertise in serving complex, high-risk populations

Integrated, member-centric care model

Local, community-based plan

Focus on quality outcome improvement

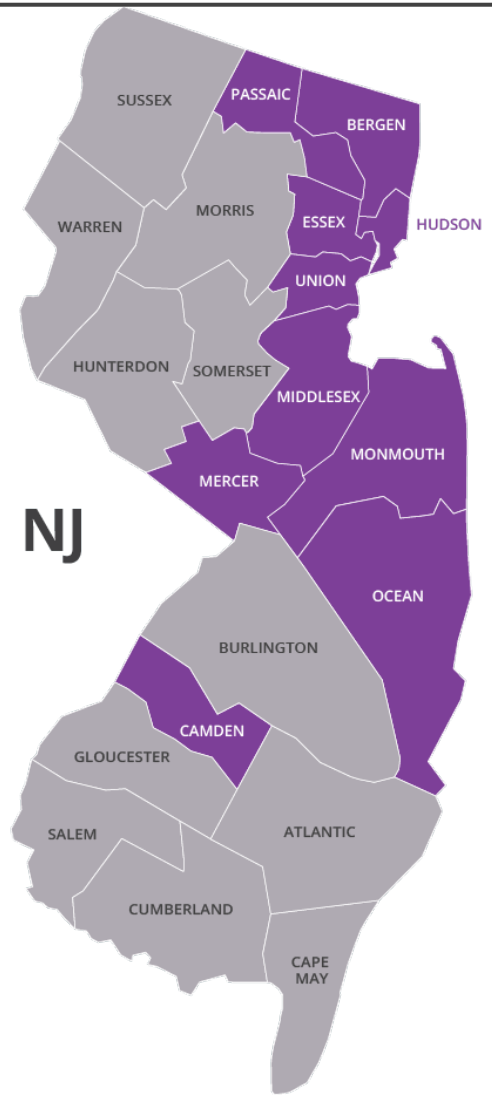
Value-based provider payment alignment

Commitment to health care transformation and technology

Aetna Better Health of New Jersey

- We are a statewide NJ FamilyCare plan.
- Our members are the center of what we do. We offer no-cost and low-cost health care for adults and children through the NJ FamilyCare program.

Aetna Assure Premier Plus (HMO D-SNP) Service Area

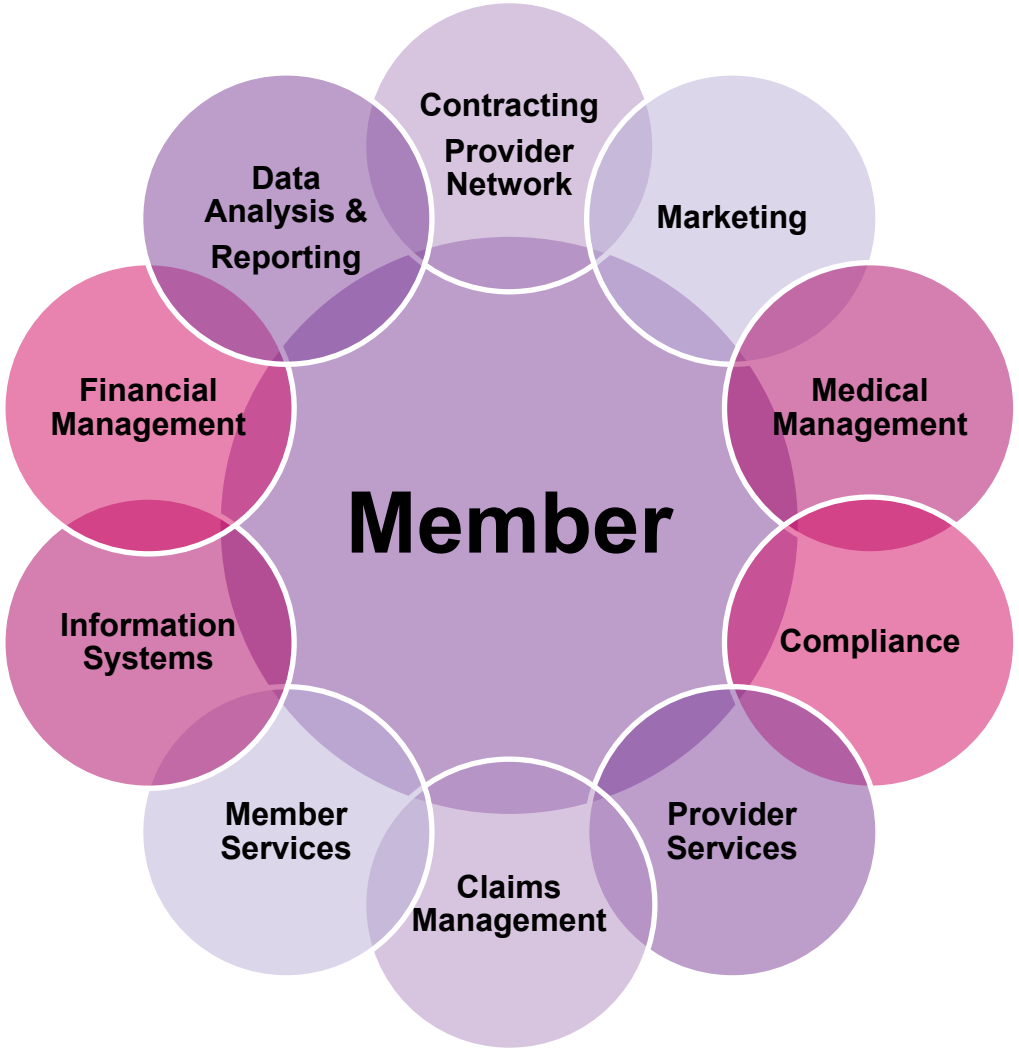


CURRENTLY OPERATIONAL IN:

- Bergen
- Camden
- Essex
- Hudson
- Mercer
- Middlesex
- Monmouth
- Ocean
- Passaic
- Union

“At Aetna Better Health of New Jersey, we believe in improving every life we touch as good stewards to those we serve.”

Overview



"We put the member at the center of everything we do"

aetna™

Covered Services

- The benefits grid in the Provider Manual shows what services Aetna Better Health of New Jersey and Medicaid Fee-for-Service (FFS) covers.
- Members under NJ FamilyCare C or D may have to pay a copayment during their visit.
- All services must be medically necessary, and the provider may have to ask for a prior approval before some services can be provided.

MLTSS Eligibility Exclusions

- Members with Division of Developmental Disabilities Community Care Waiver
- People with Pervasive Developmental Disabilities
- PACE Program beneficiaries
- Persons enrolled in Dual Eligible Special Needs Plans
- Fee-for-service Medicaid beneficiaries who are in a Nursing Facility on or before 7/1/14

MTLSS Covered Services

- Custodial care in a nursing facility
- Assisted living
- Respite
- Home/environmental modifications
- Special equipment not routinely covered under Medicaid
- Personal Emergency Response Systems (PERS)
- Private duty nursing (PDN) for adults and children

*Clinical criteria needs to be met for these services

Note: Some services already contained in the benefit package for all individuals are considered long term supports (medical day care, personal care, and PDN for children). Individuals who receive MLTSS services are also eligible to receive the full benefit array.

Assessments

- Member will be assessed for MLTSS using a state approved tool, called the NJ Choice
- The NJ Choice is utilized to assess the member's clinical need
- The assessment is then completed yearly and or with a change in condition

Utilization Management

Prior Authorization Requests

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:

- Fax 1-844-797-7601
- Phone 1-855-232-3596

Please submit the following with each authorization request:

- Member Information (correct and legible spelling of name, ID number, date of birth, etc.)
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s) if known
- Description of the service requested and reason for request
- All supporting relevant clinical documentation to support the medical necessity in legible format
- Include an office/department contact name, telephone and fax number
- NPI numbers for referring provider and servicing provider

Prior Authorization Decision Timeframes

Decision	Decision/ notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner/Provider	Telephone and in writing
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner/Provider	Telephone and in writing
Continued / extended services approval (non-ED/acute inpatient)	1 business day of receipt of necessary information	Practitioner/Provider	Telephone and in writing
Post-service approval of a service for which no pre-service request was received	30 calendar days from receipt of the necessary information	Practitioner/Provider	Telephone and in writing

Utilization Management

- Discharge planning begins on first day of hospitalization to ensure a timely and appropriate discharge plan
- Utilization Management and Case Management staff partner with hospital discharge planners and work together to resolve difficult placement issues
- Acute hospitals are assigned a designated ABHNJ nurse to collaborate with and facilitate post discharge care

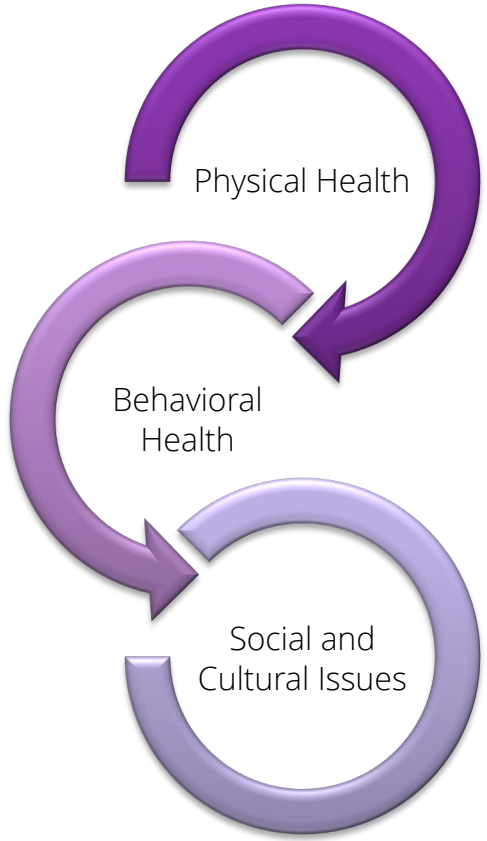
Case Management/ Care Coordination

Case Management

- Case Management Integrated approach
  - Assist with coordination of care for ALL members with behavioral health needs and physical health needs
  - Members in care management are screened for behavioral heath needs as part of the standard process
- Referrals can be made to behavioral health case management which include, but is not limited to:
  - Acute behavioral health need or decompensation
  - Assistance with behavioral health resources
  - Non-adherence with appointments and medications
  - Inpatient behavioral health with complex needs
  - Complex behavioral health and medical needs requiring coordination of care
  - Behavioral health expertise for case review/IDT's

Care Management Programs

Our Integrated Care Management Program manages members holistically and combines both Case and Disease Management. This assures one stop shopping and a single point of contact for members and providers.



Features of our bio-psycho-social integrated care model:

- Empowering members to self-manage their condition to facilitate optimum level of functioning and improve quality of life
- Promoting partnership and enhancing communication between provider and member
- Involving provider and member in care planning

Care Management Components

Condition Management

- Congestive Heart Failure, Diabetes, COPD, Low and High Risk Pregnancy, HIV/AIDS, Hypertension, Depression

Care Management

- Recurrent admissions, inappropriate ER utilization, Intensive Case Management of complex illness or situations

Managed Long Term Services and Supports (MLTSS)

- All members in MLTSS are care managed
- Inclusion of both traditional and non-traditional benefits

Care & Case Management Components

Care Management:

- Is member-centered, goal-oriented, culturally relevant
- Addresses prevention, safety, continuity & coordination of care
- Helps in early identification of special needs
- Assesses member risk factors
- Develops a plan of care
- Refers and helps w/ timely access to providers
- Coordinates care actively linking the member to providers, medical services, residential, social and other support services where needed
- Monitors, follows-up and documents interactions and interventions
- Seeks quality-based outcomes: Improved functional/clinical status, quality of life, satisfaction, safety, savings…

Care & Case Management Components (continued)

Case Management:

- Includes a set of care management activities tailored to meet a Member's situational health-related needs:
  - Situational health needs can be defined as time-limited episodes of instability

- Facilitates access to clinical and non-clinical services by connecting the Member to resources that play an active role in the self-direction of their health care needs
- Works toward an expectation for quality based outcomes

If you have a member who could benefit from Case or Care management, call **1-855-232-3596** and ask to speak to a Care Manager

MLTSS: Managed Long Term Services & Supports

- Specialized care management process
- Most vulnerable population deemed at “Nursing Facility Level of care”
- Expanded benefit package
- Goal is to maximize services so that members can safely remain in community setting
- Collaboration with providers in developing and implementing the Plan of Care

Guiding Principles of Aetna MLTSS

- Use integrated, holistic approach to support members in the most integrated/least restrictive environment
- Engage each member and address critical physical, behavioral, environmental, and social needs
- Provide for access to a continuum of services and supports facilitating transitions between systems of care
- Employ evidence-based practices to create optimal outcomes for members

MLTSS Benefits

- Care managers assist with discharge planning back to a community setting
  - Transition services
  - NF Contact Sheet
- Access to Member Representatives also known as Member Advocate
- Access to housing specialist
- 24/7 Access to Nurse line

MLTSS Care Management

- Assigned Care Manager
  - Face to face visits with care manager
  - Every 90 days for members residing in home
  - Every 180 days for members in Nursing Facility of Assisted Living
  - When there is a change in condition
- If you have a member who might be eligible call Member Services at 1-855-232-3596.

Critical Incident Reporting: What is a Critical Incident?

Critical incident is an occurrence involving the care, supervision, or actions involving a Member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the Member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.

Critical Incident Reporting

Examples of a Critical Incident

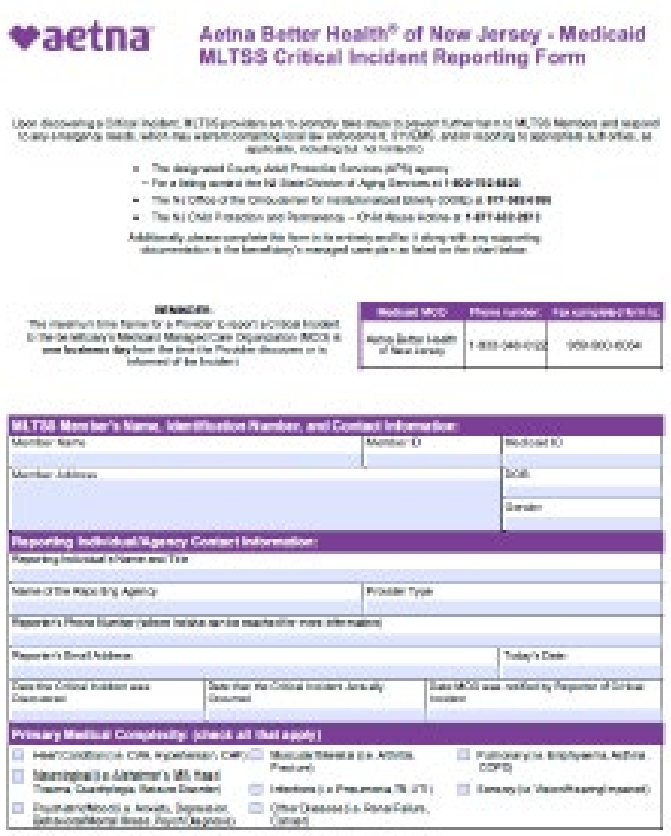
- Severe injury or fall resulting in the need for medical treatment
- Suspected or evidence of physical or mental abuse, including self abuse and neglect
- Law enforcement contact and/or incarceration
- Medication error
- Medical or psychiatric emergency
- Missing person or unable to contact

Critical Incident Reporting (continued)

- The initial report of a Critical Incident must be made within one business day and may be submitted verbally, but the verbal report must be followed up by a written report within two business days. - form is available on the Aetna Better Health of NJ website
- Contracted providers must immediately (not to exceed one business day) take steps to prevent further harm to any and all members and respond to emergency needs of members.
- Providers with a Critical Incident are required to conduct an internal Critical Incident investigation and submit a report on the investigation within 15 calendar days
- Providers are still required to also report Critical Incidents to the state, as they do today
- Critical Incident Reporting forms can be found on the Aetna Better Health of New Jersey website

Critical Incident Report Form – CLICK HERE TO DOWNLOAD

- The Critical Incident Report Form must be completed in its entirety.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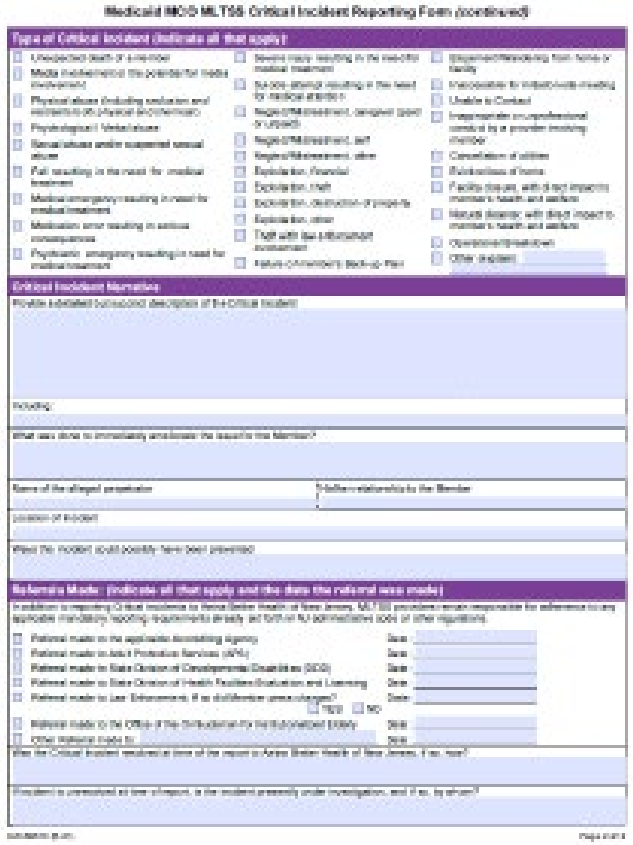
Aetna Better Health® of New Jersey - Medicaid
MLTSS Critical Incident Reporting Form


Medicaid MCO MLTSS Critical Incident Reporting Form (continued)

Critical Incident Reporting (continued)

Contact Information

MLTSS Member Services
By Phone: 1-833-346-0122
By Fax: 1-959-900-6054

Provider Services
1-855-232-3596 (Phone)

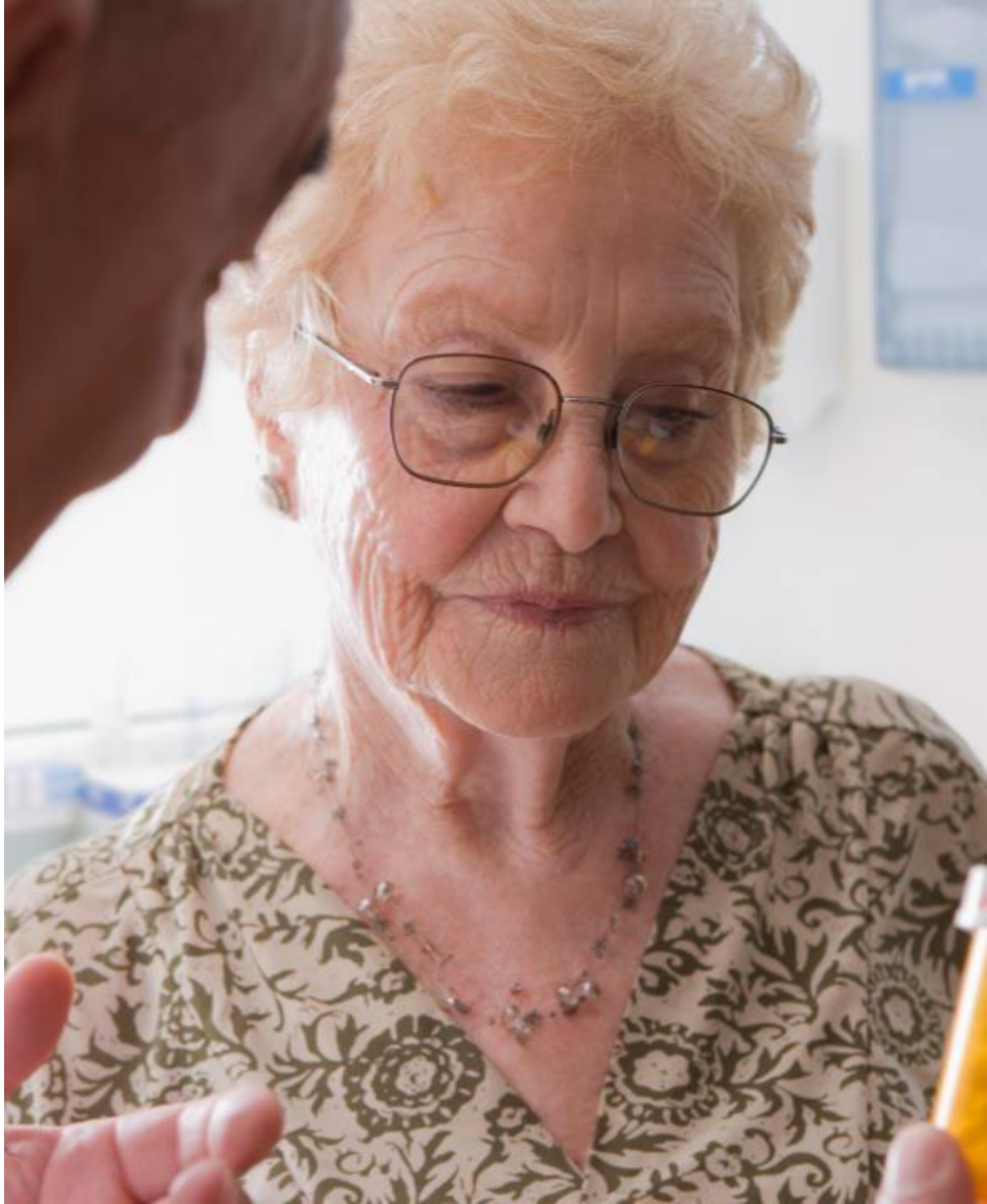
Mail Report to
Aetna Better Health New Jersey
Attention: Quality Department
3 Independence Way, Suite 400
Princeton, NJ 08540

https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/resources/NJ-Critical_Incident_Reporting_Form.pdf

Pharmacy Coverage

CVS Caremark administers the prescription drug benefit for our members:

- Please review the Provider Manual for copay information
- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications
- The following document are available online:
    - Preferred Drug List (PDL)
    - Over-the-Counter Drug List
    - Prior Authorization Form
    - Mail Order Form



Mental Health/Substance Abuse (MH/SA)

To meet the behavioral health needs of our members, we provide a continuum of services to members at risk of or suffering from mental, addictive or other behavioral disorders. We expect mental health issues to be identified expeditiously 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 primary care providers' scope of practice
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to an in-network behavioral health care provider without a referral from the member's PCP
- Whenever a PCP is concerned about that a member may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen members with possible MH/SA concerns.

Member Rights & Responsibilities

It is our policy that no provider will unfairly 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 in the Provider Manual. 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 being treated according to the above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee; further action may be undertaken by us if necessary.

For a complete list of member's right and responsibilities, review the Provider Manual.

Provider Services

Availity Provider Portal

Effective 1/19/2021, Aetna Better Health Of New Jersey and Aetna Assure Premier Plus (HMO-DSNP) utilize the Availity Provider Portal.

Provider Portal Benefits include:

- Payer Spaces
- Claim Submission Link
- Contact Us & Messaging
- Claim Status Inquiry
- Grievance Submission
- Appeals Submission
- Grievance and Appeals Status
- Provider Data Management
- Ambient (Business Intelligence Reporting)
- Clear Claim
- ProPAT
- Provider Intake
- Dynamo (Case Management
- Prior authorization requests

Availity Provider Portal (continued)

If you are already registered in Availity, you will simply select Aetna Better Health or Aetna Assure Premier Plus (HMO-DSNP) from your list of payers to begin accessing the portal and all of the above features.

- ABHNJ Medicaid: https://www.aetnabetterhealth.com/newjersey/login
- Aetna Assure Premier Plus HMO-DSNP: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

If you are not registered, we recommend that you do so immediately by going to the above portal locations

Grievance/Appeal Correspondence for ABHNJ

Appeals and Grievances

- Effective 7/1/2021, we will no longer accept Provider Grievance and Appeal mail that is directed to our Princeton, NJ office.

- Whenever possible please submit your appeal or grievance electronically. You can submit by fax to: 844-321-9566; or you can submit through the Availity provider portal using the direct application for Grievance and Appeals: https://apps.availity.com/availity/web/public.elegant.login

- If you prefer to mail hard copy requests for appeal or grievance, please update your systems to direct Grievance and Appeal correspondence to:

Aetna Better Health of New Jersey
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

IMPORTANT REMINDER FOR CLAIM APPEALS

Complete the DOBI mandated Health Care Provider Application to Appeal a Claims Determination form when submitting claim appeals. If you do not fill out this mandated form completely, the claim appeal will not be accepted.

Health Care Provider Application:
https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/ABHNJ%20Claim%20appeal_DOBI%20mandated%20form.pdf

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Aetna Better Health of New Jersey Website

www.aetnabetterhealth.com/newjersey

Find the following important information:

- **Provider Training Deck**
- **Provider Resources** – forms, guidelines, processes and materials to assist provider interactions with Aetna Better Health
- **Provider Newsletters**, which can be viewed and downloaded
- **Searchable Provider Directory**
- **Provider Manual** and Provider Manual updates, which can be viewed and downloaded
- **Fraud, Waste and Abuse** information and reporting
- **Access for entry of Appeal** and Provider Disputes
- **Secure Web Portal Registration**
- **Member Rights and Responsibilities**

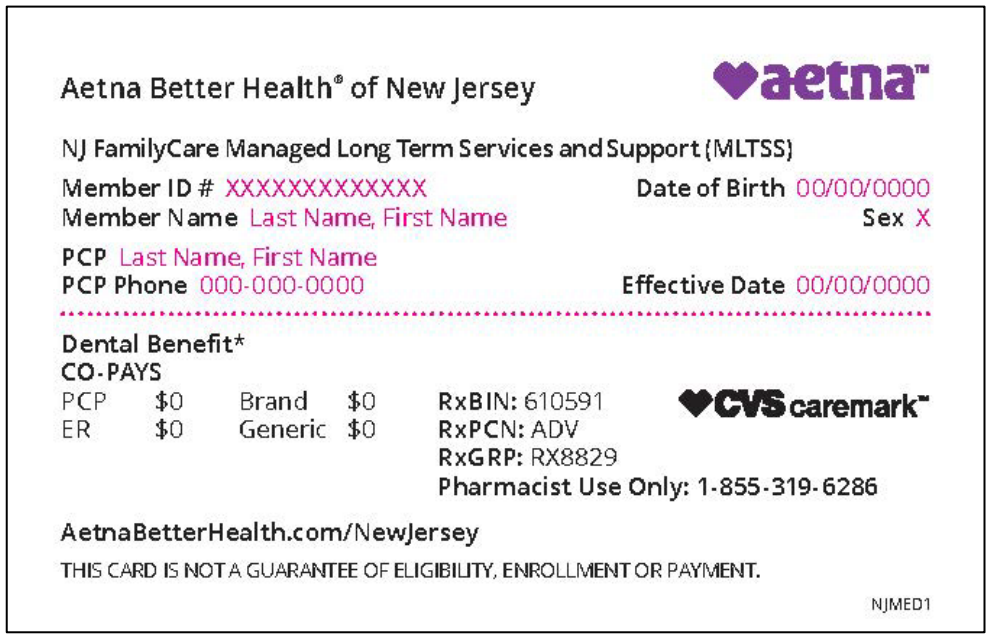
Provider Training Resources

www.aetnabetterhealth.com/newjersey/providers/training

Find the following important information:

- Provider Training Presentation
- WebEx Training Dates
- Cultural Competency
- Health Literacy
- Trauma Informed Care

Sample ID Cards



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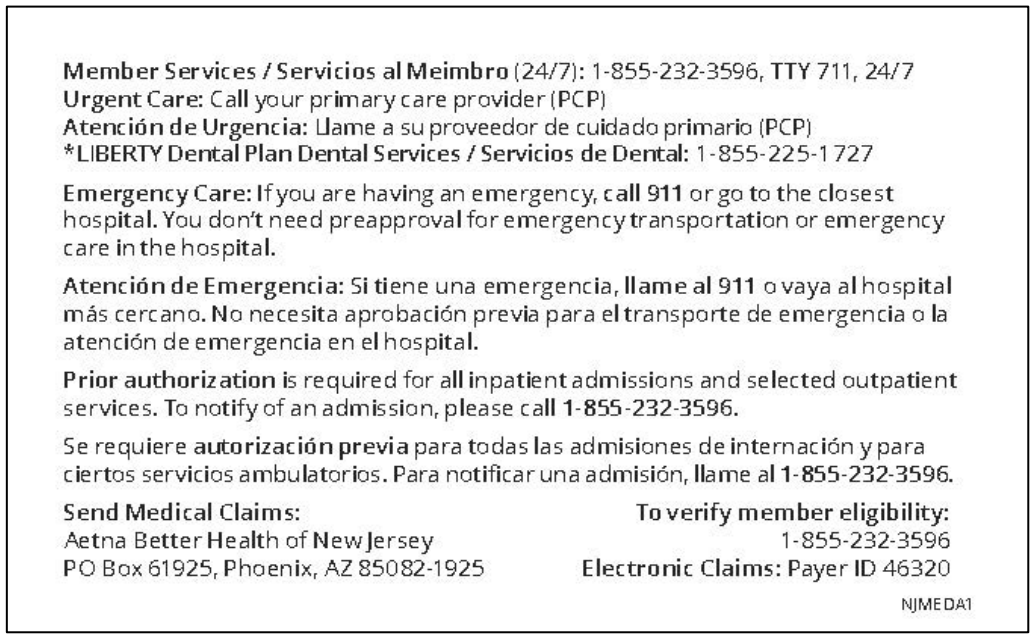


BACK

Provider Services Department

Provider Services Manager

- Responsible for oversight of Provider Services Representatives
- Responsible for training Provider Services Reps in all areas (i.e., provider questions, provider complaints, provider responsibilities prior authorization requirements and member eligibility)

1-855-232-3596

AetnaBetterHealth-NJ-ProviderServices@aetna.com

Provider Services Representative

- Educate network providers on our policy and procedures & claim submission
- Inform providers of changes through face-to-face visits, provider forums, webinars
- Provide written or electronic communication including the Provider Manual, Periodic Provider Newsletters and fax/email blasts

*If you're interested in participating in our EFT program and/or would like electronic 835 remits, email us for additional information.

Clearinghouse & Clean Claims

We accept paper and electronic claims

- Emdeon is preferred clearinghouse for electronic claims:
  - EDI claims received directly from Emdeon
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate member enrollment
    - Facilitate daily upload to Aetna Better Health system

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 all claims (the totality of claims received whether contested or uncontested) submitted electronically by medical providers within 30 days of receipt
  - 90% of all claims filed manually within 40 days of receipt
  - 99% of all claims, whether submitted electronically or manually, within 60 days of receipt; and
  - 99.5% of all claims within 90 days of receipt

Billing and Claims

- Timely filing is **180 days from the date of service**
- Coordination of Benefits (COB) claims must be submitted within **60 days** from the date of primary insurer's Explanation of Benefits (EOB) or **180 days** from the date of services, whichever is later
- National Provider Identifier (NPI):
  - Be certain that your claim form has a NPI number to match each corresponding provider name

Claim Submission

Aetna Better Health encourages participating providers to electronically submit claims through Emdeon.

You can submit claims by visiting Emdeon at www.emdeon.com.

Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Emdeon. Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health of New Jersey:

- Payer ID# 46320

Paper Claims:
Aetna Better Health of New Jersey
P.O. Box 61925
Phoenix, AZ 85082

Claim Submission

Please note that we follow New Jersey's billing practices, (i.e., required diagnosis codes, CPT, HCPCs and associated modifiers), and New Jersey's fee schedule methodologies. We also follow New Jersey's timely filing requirements along with the claim dispute processes and timeframes.

Common Barriers:

- 5010 Requirements (Rendering NPI and pay-to NPI; Both are required)
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

Resubmissions:

- Electronic and paper resubmitted claims are accepted; however, we prefer electronic claims. Resubmitted claims must be labeled appropriately
- Our Provider Services staff, Manager or the Director of Operations are available for any escalated issue and/or concerns

Claim Submission

ICD -10 HELPFUL GUIDES

Road to 10 The Centers for Medicare and Medicaid Services (CMS) has created a website that's a great resource for small physician practices and specialty practices.

- Crosswalks for the Top 50 Codes by Specialty at the AAPC website
- 100 Tips for ICD-10-PCS Coding at icd10monitor.com
- Free code conversion tool from icd10monitor.com

Claim Submission

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

- How to fill out a CMS 1500 Form
  cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
- Sample CMS 1500 Form
  cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf
- How to fill out a CMS UB-04/1450 Form
  cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Claims Resubmissions

- Providers have 365 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute a reconsideration or claim dispute
- Electronic Resubmission:
  - Include the appropriate resubmission code “7” or “8”
  - Any claims with a frequency code of “5” will not be paid
- Include the following information when filing a resubmission:
  - Resubmission Form located on our website
  - An updated copy of the claim; all lines must be rebilled; a copy of the original claim (reprint or copy is acceptable) must be included
  - 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
  - Clear label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address

EFT/ERA

- Electronic Funds Transfer:
  - EFT is a safe, convenient way to receive payments
  - EFT is quick and easy to sign up
  - EFT is accompanied by Electronic Remittance Advice (ERA)

- EFT and ERA forms on the website
- https://apps.availity.com/public/apps/home/#!/loadApp?appUrl=%2Fweb%2Fspaces%2Fspaces%2F%3FcacheBust%3D1624366670%23%2FByxfvuwdzU

Demographic Changes

All Demographic changes can be submitted by:

- Mail
- Fax
- Provider Relations email: AetnaBetterHealth-NJ-ProviderServices@aetna.com
- Please remember to submit in writing any Demographic changes prior to the change effective date
- Changes include address and telephone numbers

Credentialing and Recredentialing

Aetna Better Health of New Jersey is responsible for ensuring credentialing/recredentialing processes are completed for:

- Practitioners (Professionals)
- Ancillary Facilities
- Hospitals

Provider Contracting: Provider Network manages the contracting process

Questions about Contracting and Credentialing?

1-855-232-3596
AetnaBetterHealth-NJ-ProviderServices@aetna.com

Provider Participation in Committees

Grievance & Appeals

- Member complaints and appeals
- Provider complaints and appeals

Dental Advisory

- Input to Quality activities from the local dental provider community
- Opportunities to improve dental care and services

Credentialing

- Review of candidates to join and maintain plan participation
- Review of delegated credentialing

Utilization Management

- Guideline adoption
- Utilization processes and best practices

Provider Participation in Committees (continued)

Provider Advisory & Pharmacy Forum

- Input to Quality activities from the local provider community
- Review of Clinical Practice Guidelines, preventive health guidelines
- Opportunities to improve clinical care and services
- Discussion of changes to Pharmacy programs from National Pharmacy and Therapeutics Committee

Quality Assurance Committee

- Review the Quality Program and Work Plan
- HEDIS, Accreditation, Surveys of members and providers, Provider medical record audits
- Service performance measures
- Program components regarding availability of care, accessibility of care, barriers to care, cultural competency and other plan initiatives to meet state goals
- Make recommendations regarding plan Quality activities within the Program
- Review potential quality of care concerns
- Review fraud and abuse issues
- Review outcomes of chronic condition programs
- Has Peer Review Subcommittee reporting to it

Provider Communications

Provider Newsletters

We publish periodic provider newsletters available to all participating network providers. The purpose of periodic newsletters is to provide a consistent and reliable method of communication with participating network providers. The newsletter is posted on our webpage at **aetnabetterhealth.com/newjersey/providers/newsletters.**

Special Provider Communications

Special provider communications are used to distribute information updates to our provider practices, when the distribution and implementation timeline for the information (e.g., new evidence-based practice guidelines) precedes the next regularly scheduled provider communication.

Provider Appointment Standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventive & Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 28 days (1)	No more than 45 minutes
Specialty Referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 45 minutes
Dental Care	Within 48 hours (2)	24		Within 30 days of referral	No more than 45 minutes
Mental Health/ Substance Abuse (MH/SA)	Same day	Within 24 hours		Within 10 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Provider Appointment Standards *(continued)*

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

Provider Appointment Standards *(continued)*

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

Provider Appointment Standards *(continued)*

Initial:	
Initial Pediatric Appointments	Within 3 months of enrollment
Supplemental Security Income (SSI) and New Jersey Care (ABD & Disabled Members)	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.

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

Cultural Competency

Full Document in Packet

CULTURAL COMPTENCY

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

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

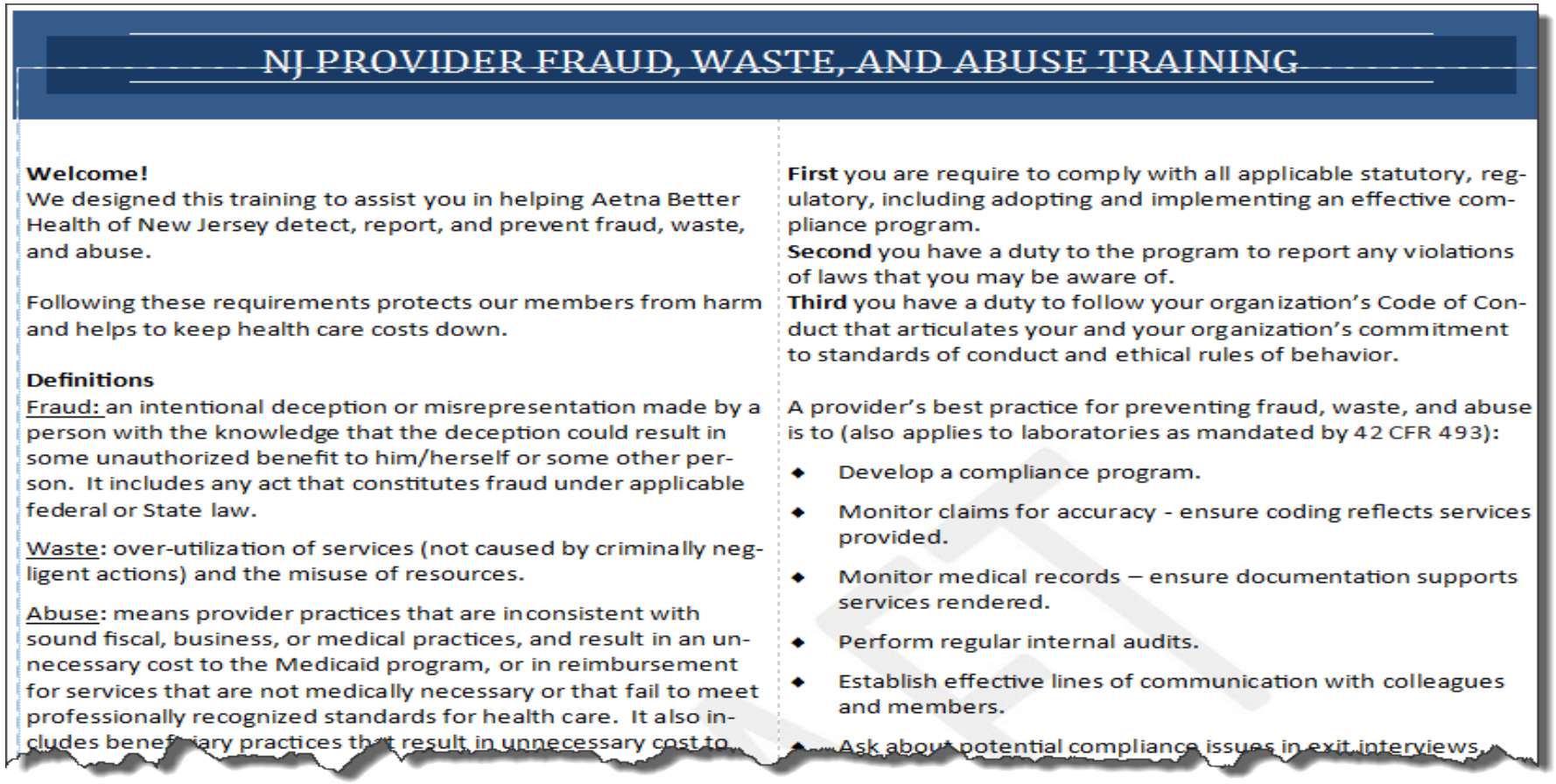
To access Aetna Better Health's online cultural competency courses, please visit: http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Our Qual[illegible]tions® course series is designe[illegible]o

need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern. To train providers to care for diverse populations, the U.S. Department of Health and Human Services (HHS) Office of

Fraud, Waste, & Abuse

Full Document in Packet



NJ PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

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

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

Definitions
Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to...

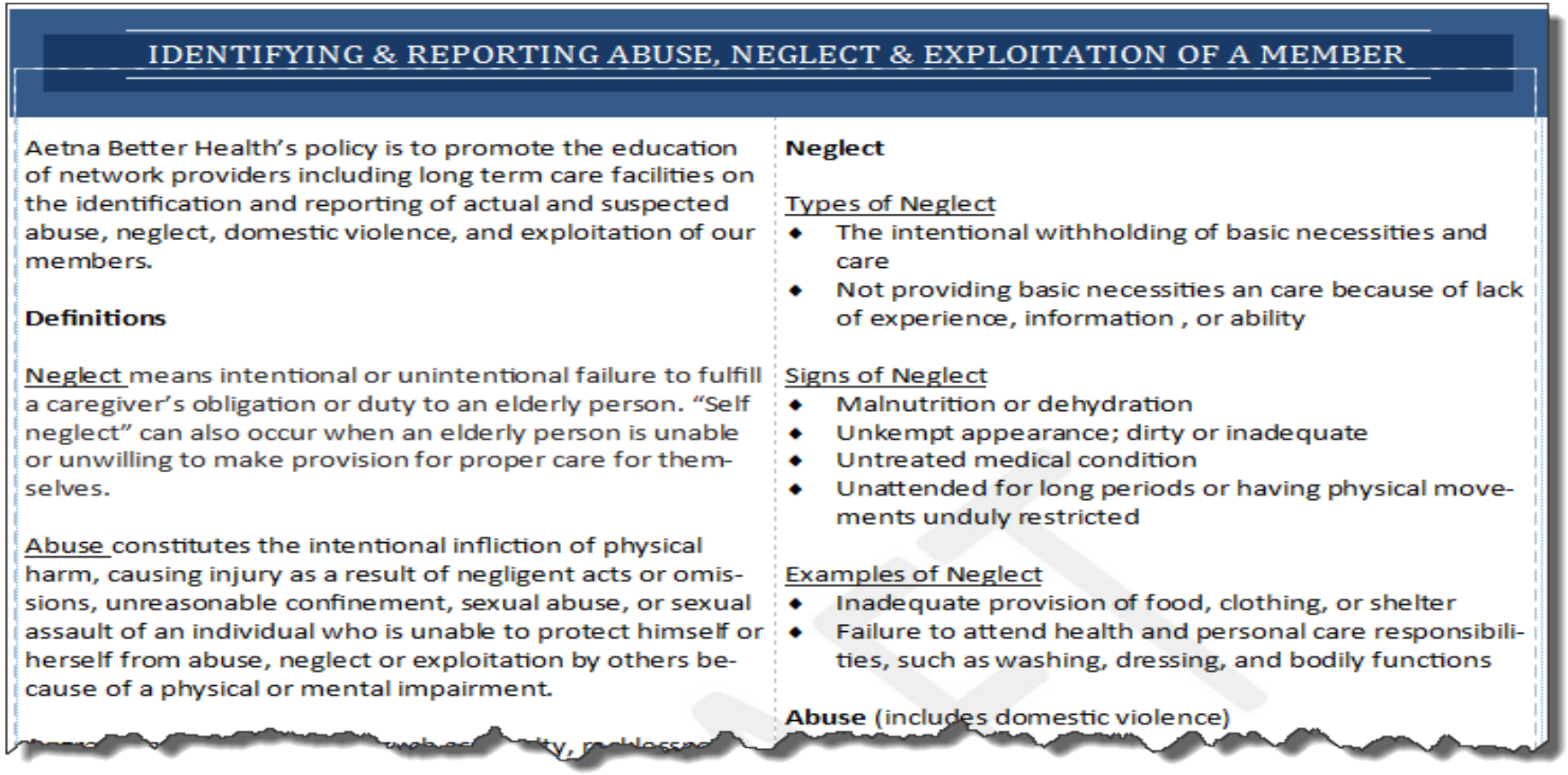
First you are require to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.
Second you have a duty to the program to report any violations of laws that you may be aware of.
Third you have a duty to follow your organization's Code of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

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

- Develop a compliance program.
- Monitor claims for accuracy - ensure coding reflects services provided.
- Monitor medical records – ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and members.
- Ask about potential compliance issues in exit interviews.

Member Abuse and Neglect

Please pull out your hand-out.



IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

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

Definitions

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

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

Neglect

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

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

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

Abuse (includes domestic violence)

Americans with Disabilities Act (ADA)

The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. Our providers are obligated to provide:

- Reasonable accommodations to those with hearing, vision, cognitive or psychiatric disabilities (e.g., accessible and appropriate physical locations, waiting areas, examination space, furniture, bathroom facilities and diagnostic equipment)
- Waiting room and exam room furniture that meet the needs of all members, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or adequate parking
- Clear signage and directions (e.g., color and symbol signage) throughout doctors' offices/facilities

Resources: **ada.gov/reg3a.html**

Additional Information & Important Requirements

Providers must:

- Not refuse treatment to qualified individuals with disabilities, including but not limited to, individuals with the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Accommodate members with special needs, which includes but is not limited to: offering extended office hours to include night and weekend appointments, promoting practices offering extended hours and offering flexible appointment scheduling systems
- Ensure that hours of operation are convenient to and do not discriminate against members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals; all services must be available 24-hours-a-day, 7-days-a-week when medically necessary

Medical Records - Standards

Laws, rules and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a members or to their contract with Aetna Better Health of New Jersey to permit inspection, evaluation and audit for the longer of:

- A period of 5 from the date of service; or 3 years after final payment is made under the provider contract/subcontract and all pending matters are closed

Additional Information:

- Providers must maintain member records in either a paper or electronic format
- Providers must also comply with HIPAA security and confidentiality of records standards

Our standards for medical records have been adopted from our state contract, NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Provider Complaints, Grievances & Appeals

Provider Complaints

- Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of New Jersey that can be resolved outside of the formal appeal and grievance process
- Provider complaints include but are not limited to dissatisfaction with:
  - Policies and procedures
  - A decision made by the Aetna Better Health of New Jersey
  - A disagreement as to whether a service, supply or procedure is a covered benefit, is medically necessary or is performed in the appropriate setting
- Providers can file a complaint with Aetna Better Health of New Jersey by calling the Provider Services Department at 1-855-232-3596
- Provider complaints about Aetna Better Health of New Jersey staff, contracted vendors or other issues, not requesting review of an action, that require a written decision will automatically be transferred to the provider grievance process in cases where the complaint was transferred to the formal appeal or grievance process
- Provider complaints requesting review of an action; that cannot be resolved through the informal complaint process; or that require a written decision will automatically be transferred to the provider appeal process

Provider Complaints, Grievances & Appeals

Provider Grievances

Both participating an non participating providers may file a formal written grievance with ABHNJ regarding dissatisfaction with our policies and procedures; dissatisfaction with a decision made by ABHNJ; Disagreement with ABHNJ as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting; and any other issue of concern to the provider.

Providers can also file a verbal grievance by calling **1-855-232-3596**.

To file a grievance in writing, providers should write to:

Aetna Better Health of New Jersey
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Provider Complaints, Grievances & Appeals

Provider Appeals

- Participating and Non-Participating Providers have the right to appeal ABHNJ claims determination(s) within sixty (60) calendar days of receipt of the claim denial. To appeal ABHNJ claims determination(s), providers must utilize the Health Care Provider Application to Appeal a Claims Determination (PDF)

A provider MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF our determination:

Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation

Resulted in the claim being paid at a rate the provider did not expect based upon a contact with us or the terms of the member's Medicaid/FamilyCare coverage.

Resulted in the claim being paid at a rate the provider did not expect because of differences in Our treatment of the codes in the claim from what the provider believes is appropriate

Indicated that we require additional substantiating documentation to support the claim and the provider believes that the required information is inconsistent with Our stated claims handling policies and procedures, or is not relevant to the claim.

Provider Complaints, Grievances & Appeals

Provider Appeals Continued

A provider also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

The provider believes we have failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law, and the terms of the provider's contract (if any)

Our determination indicates we will not pay because of lack of appropriate authorization, but the provider believes they obtained appropriate authorization from Us or another carrier for the services

The provider believes we have failed to appropriately pay interest on the claim

The provider believes Our statement that We overpaid one or more claims is erroneous, or that the amount We have calculated as overpaid is erroneous

Community Resources

Community Resources & Counseling Options

Jamila Vasquez BSN RN
Director, MLTSS
VasquezJ5@aetna.com
609-480-4302

Samantha Nadler LSW
Manager, MLTSS
NadlerS@aetna.com
609-955-1717

Danielle Almero-Rodriguez
Supervisor, MLTSS Support Team/Authorizations
AlmeroRodriguezD@aetna.com
609-439-2865

Contacts

Case Management /Care Coordination Contacts

ABHNJ Medicaid Plan Contacts:

Malvina Williams, RN
Supervisor, Clinical Management
ICM Discharge Planning, Care Coordination, Special needs, and Maternity Contact
Office: 609-282-8236
Email: WilliamsM5@aetna.com

Ann Marie McGinnis, RN
Supervisor, Clinical Health Services
Office: 609-282-8183
Email: McGinnisA@aetna.com

Deborah Kim
Supervisor, ICM Audits and Regulatory Compliance
Office: 609-282-8190
Cell: 609-580-0254
Email: KimD@aetna.com

Aetna Assure Premier Plus (HMO D-SNP) Contacts

Ashley Eith
Supervisor, Health Services
860-687-2345
Email: eitha@cvshealth.com

Andrea Price
Integrated Care Management (ICM) Director, Health Services
513-267-1570
Email: pricea4@aetna.com

Thank you!