Keeping directory information up-to-date

Help us keep your practice information updated in the directory. Having a correct listing is a prerequisite for proper handling of your claims and is important in ensuring uninterrupted care for our members. The following elements are critical to the accuracy of your listing:

- Street address
- Phone number
- Ability to accept new patients
- Any other changes that affect availability to patients

If you notify us of any changes, we have 30 days to update our online directory.

For more information, view the fact sheet at: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-04-06.html.

The Council for Affordable Quality Healthcare® (CAQH) helps meet this need

CAQH has a unique solution to ensure that directory information is accurate and to assure periodic updates happen. They developed it with our help and that of other health plans. CAQH’s directory confirmation process uses data from your CAQH ProView™ profile. You simply review, update and confirm your information in ProView. Then, CAQH does the rest. They’ll share it with all participating health plans that you authorize to receive it. This eliminates the need for every plan in which you participate to contact you for the same directory information.

CAQH will send you an e-mail titled, CAQH provider directory validation invitation, which has instructions on how to update your profile. CAQH will call you if you don’t reply, so respond promptly.
Care management and disease management

You can refer your Aetna Better Health of New Jersey patients for care management or disease management services by calling 1-866-638-1232. You can also contact our inpatient concurrent review nurse for patients in an inpatient facility.

Identifying members for care management and disease management

We use the following sources to identify members for care management and disease management:

• Enrollment data from the state
• Predictive modeling tools
• Claim/encounter information including pharmacy data, if available
• Data collected through the utilization management process
• Laboratory results
• Hospital or facility admissions and discharges
• Health risk appraisal tools
• Data from health management, wellness or health coaching programs

We may also use referrals from our health information or special needs lines, members, caregivers, providers or practitioners to identify members appropriate for care management and stratification levels for case managed members.

Disease management and automatic enrollment

We offer disease management programs to members with specific medical conditions including:

• Asthma
• Chronic obstructive pulmonary disease (COPD)
• Heart failure (HF)
• Diabetes

Members don’t have to enroll. We automatically enroll members when we identify them as having one of the above conditions. We’ll inform you of their participation and make sure that we work with you to reinforce their treatment plan. Our goal is to educate, support and prevent the disease from getting worse. We want to reduce hospitalization and high usage of health care resources by giving members the tools they need to better manage their health.

For more information about our care management and disease management programs, visit www.aetnabetterhealth.com/newjersey.

Do your patients have care management needs?

We can help your patients enhance their self-management skills with chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes and other conditions. Our program is integrated with Case Management and Condition Management, so your patient has one care manager. We can help with assisting members increase their knowledge about how to be healthier and improve their health outcomes. Call or e-mail the Integrated Care Management Team at:

Robin Zappitielli, RN, BSN, MA, CCM, CMCN  Diane Staines, RN, CCM
Manager, Clinical Health Services  Supervisor, Clinical Health Services
609-282-8227  609-282-8198
ZappitielliR@Aetna.com  StainesD@Aetna.com

Availability of criteria

Providers and members have the right to request a copy of a guideline that Aetna Better Health has used to make a treatment authorization decision. Specific criteria or guidelines are available upon request with the following disclosure:

“The material provided to you are guidelines used by this plan to authorize, modify, or deny care for the person with similar illnesses or conditions. Care and treatment may vary depending on individual need and the benefits covered under your contract.”

If you would like to obtain a copy of the criteria, call Member Services at 1-855-232-3596.
Aetna Better Health of New Jersey promotes correct claims coding including the appropriate selection of level of Evaluation and Management Service (E/M). To support this effort and our goal of physician education, outlined below is a summary of the documentation guideline requirements for use of the highest levels of Evaluation and Management Codes for Outpatient Services.

The Current Procedural Terminology (CPT) codes described are used to report E/M services in the physician’s office, outpatient or other ambulatory facility. A patient is an outpatient until an in-hospital admission occurs.

E/M codes are used to describe different types of visits physicians and non-physician practitioners have with their patients. Selecting the correct E/M code depends on the place of provided service, the type of patient, and the level of service performed.

There are E/M codes for different categories of service based on where the service was provided, including: office, hospital, emergency room, nursing facility, etc. In most of these categories, there are E/M codes for new patients and other E/M codes for established patients. Within each category, there are also different levels of service based on history, examination and medical decision making.

Documentation guidelines for choosing appropriate E/M services were established in 1995 and 1997. These guidelines as well as an E/M Services Guide are accessible through the Centers for Medicare & Medicaid Services website at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html.

The primary concept of E/M coding is that documentation must be present that supports the services being reported. Basically, if it wasn’t documented, it wasn’t done. In addition, to appropriate documentation, the level of service must be considered reasonable and necessary and be compliant with the standards of good medical practice. For example, doing a complete history, physical examination and diagnostic work-up would not be appropriate for a follow-up visit with a patient who had a minor problem.

Three key components to E/M documentation
• History
  – History may be problem focused, expanded problem focused, detailed or comprehensive. It includes chief complaint, history of present illness, review of systems and past, family and/or social history.
• Examination
  – Examination may be problem focused, expanded problem focused, detailed or comprehensive depending upon how extensive the examination is.
• Medical decision making/progress notes
  – Medical decision making/progress notes may be straightforward, low complexity, moderate complexity or high complexity based on the number of diagnoses and/or management options, the amount and/or complexity of data to be reviewed and the risk of significant complications, morbidity, and/or mortality.

Levels of evaluation and management services
Five levels of services are recognized by the CPT codes for both the new and established patient office visits. Descriptions for each level of service are taken from the American Medical Association CPT manual.

Six components are recognized as descriptors for the (E/M) services, five of which are used in defining the levels of E/M services. These components are:
• History
• Examination
• Medical decision making
• Counseling and/or coordination of care
• Nature of the presenting problem
• Time

The first three of these components (history, examination and medical decision-making) are the “key factors” for selecting a level of E/M service.

The next two factors (counseling and/or coordination of care and the nature of the presenting problem) are “contributory factors” in choosing an E/M service for the majority of encounters.
The correct coding corner  Continued from page 3

The final component is “time.” When counseling and/or coordination of care represent more than 50 percent of the encounter, time is considered to be the important determinant of the level of service. The medical record needs to document the time spent and the details of counseling and/or coordination of care during the physician and patient face-to-face encounter.

New patients (codes 99201-99205)
The CPT manual defines a new patient as one who has not received any professional services from the physician or another physician of the same specialty in the same group, within the past three years. A patient who has been seen within the last three years is classified as an established patient.

Requirements for a “level five” new patient or initial visit
99205 office visits require the following “three key components” are met:

• A comprehensive history
  – Chief complaint
  – Extended history of present illness
  – Review of systems which is directly related to the problem(s) identified in the history of present illness, plus a review of all additional body systems
  – Complete past, family and social history
• A comprehensive examination
  – A general multi-system exam, or
  – Complete exam of a single organ system
• Medical decision making of high complexity
  – Extensive number of diagnoses/management options
  – Extensive amount or complexity of data obtained, reviewed and analyzed
  – High risk of complications or morbidity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established patients (codes 99211-99215)
Requirements for a “level five” established patient visit
99215 office visit documentation requirements are the same as for the 99205 initial office visits with the exception that only two out of the three “key components” are met. Although it can be any combination of the three key components, it is the medical decision making and/or nature of presenting problem(s) which should drive the selection of an E/M service.

Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Aetna Better Health partners with eviCore for authorization
Aetna Better Health of New Jersey is pleased to announce its partnership with eviCore healthcare to provide authorization for radiology services for members enrolled in Managed Medicaid programs. Our partnership with eviCore healthcare will be effective soon. Be sure to check our website, www.aetnabetterhealth.com/newjersey, for the program start date.

Authorization is required for:

• MRI
• PET
• CT
• OB and Non-OB Ultrasound
• Pain Management
• Radiology Services

Services performed in conjunction with an inpatient stay, 23-hour observation or emergency room visit, are not subject to authorization requirements.

Up to four obstetrical ultrasound studies may be authorized per pregnancy without clinical review as long as they are registered for auto-authorization in the system.

To request an authorization, submit your request online, by phone or fax:

• Visit https://myportal.medsolutions.com
• Call us at 1-888-693-3211
• Fax an eviCore healthcare request form (available online) to 1-888-693-3210

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, call 1-888-693-3211 for expedited authorization reviews. Be sure to tell your representative the authorization is for medically urgent care.

We recommend that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service(s) listed on the authorization need to be changed, the rendering facility must contact eviCore healthcare for review and authorization prior to claim submission.

Have questions?
Obtain a copy of our online orientation presentation by contacting clientservices@evicore.com.
**Hysterectomy and sterilization requests**

Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information form (FD-189). A copy of the form is available at [www.aetnabetterhealth.com/newjersey](http://www.aetnabetterhealth.com/newjersey). You must attach it to the claim prior to submission.

We require providers to submit a properly completed FD-189 form with the request for precertification for all non-emergent hysterectomies.

Claim payment for a hysterectomy, without a copy of the Hysterectomy Receipt of Information form, may only be made if the physician performing the hysterectomy certifies that:
- The woman was already sterile and the cause of sterility is stated
- The hysterectomy was required because of a life-threatening emergency and a description of the emergency is stated

Specific Medicaid requirements must be met and documented on the HHS-687 Consent for Sterilization form. The form must be completed and signed by the member at least 30 days in advance of both female and male sterilization procedures.

If the procedure is performed less than 30 days from the consent form execution date due to a premature birth, the expected date of birth must be noted in the consent form. A copy of the form is available at [www.aetnabetterhealth.com/newjersey](http://www.aetnabetterhealth.com/newjersey). The form must be attached to the claim prior to submission. The individual who has given voluntary consent for a sterilization procedure must be 21-years-old at the time the consent is obtained and must be a mentally competent person.

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**The importance of lead screenings**

Childhood lead poisoning is still a major preventable public health problem. Lead has adverse effects on nearly all organ systems in the body. Even at low levels, it can irreparably damage children’s intelligence, hearing and growth. Aetna Better Health of New Jersey would like to remind providers to talk with parents about the importance of blood lead screenings for their children.

**Who is at risk?**
- Children under the age of 6-years-old
- Children living at or below the poverty line
- Children living in older housing
- Children living in areas with older lead water pipes

**When should children get a lead poisoning screening?**
- All children should be screened for lead poisoning at 12 and 24 months
- Any child between 3 and 6-years-old who has never been screened
- Any child who is 6 months or older and is exposed to a known or suspected lead hazard
- All children living in urban areas of New Jersey, such as Newark and Camden counties

We cover lead screening costs for our members. Thank you for your partnership in ensuring the safety and health of our youngest members.

Sources: New Jersey Department of Health ([www.nj.gov/health/fhs/newborn/lead.shtml](http://www.nj.gov/health/fhs/newborn/lead.shtml)) and the Center for Disease Control ([www.cdc.gov/nceh/lead/tips.htm](http://www.cdc.gov/nceh/lead/tips.htm))
Peer-to-peer reconsiderations

Peer-to-peer requests are available. Hospital representatives will be educated on this process and the designated contacts to use when requesting a peer-to-peer discussion with the medical director.

Peer-to-peer discussion requests can be accepted up to 48 hours post discharge of an inpatient admission, unless there are extenuating circumstances.

A medical professional such as a nurse practitioner, medical resident or physical therapist can make requests acting on behalf of the attending physician.

Affirmative statements about incentives

Utilization Management (UM) decisions are based on appropriateness of care and service and existence of coverage. Aetna Better Health does not specifically reward practitioners or individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. Providers and practitioners are not prohibited from acting on behalf of the member. Physicians can’t be penalized in any manner for requesting or authorizing appropriate medical care.

Aetna Better Health® of New Jersey contact information

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Help us stop the flu from spreading

Aetna Better Health of New Jersey needs your help in keeping our members healthy and stopping the flu from spreading. Please encourage members in your care to get a flu shot this year. We cover flu shots at no cost to our members. As a reminder, flu shots are available for:
- Children ages 6 months or older
- Pregnant women
- People with serious health conditions
- Healthy adults

Introducing Glenn A. MacFarlane as Chief Executive Officer

Aetna Better Health of New Jersey is pleased to introduce Glenn A. MacFarlane as Chief Executive Officer of Aetna Better Health of New Jersey. He joined our health plan on June 27, 2016.

Mr. MacFarlane brings with him a wealth of health care experience and leadership, and is committed to fostering relationships with our network of physicians and related professionals.

Prior to joining us, Mr. MacFarlane was the President and Chief Executive Officer at Affinity Health Plan, one of the largest managed care plans in New York City. Mr. MacFarlane joined Affinity in November 2012 as Senior Vice President, Strategy, Business & Product Development, and then assumed the additional role of Chief Financial Officer on January 2014. He became the Chief Executive Officer on January 1, 2015. Mr. MacFarlane is a Certified Public Accountant in New York State with extensive experience in financial management in the healthcare, finance services and accounting fields.

He also spent 12 years at TIAA-CREF, the Fortune 100 financial services firm based in New York City, where he held numerous senior finance roles in product, asset management and operations.

Mr. MacFarlane began his career at Coopers & Lybrand, one of the then “Big 8” consulting firms, focused on the health care industry. He later held senior finance roles for several years at the Health Insurance Plan of Greater New York (HIP), one of EmblemHealth’s legacy companies, and at a national physical therapy company. He also served as Chief Financial Officer at Horizon Mercy, a joint Medicaid managed care program between Mercy Health Plan of Pennsylvania and Blue Cross/Blue Shield of New Jersey.

Mr. MacFarlane earned a B.A. in business administration from Iona College. He also completed the executive program in managed care at the University of Missouri.

Please join us in welcoming Mr. MacFarlane to Aetna Better Health of New Jersey.