Provider Newsletter

Self-service coming soon

In 2019 you'll be able to get the information you need - anytime you need it.

Interactive voice technology (IVR) is coming soon. With IVR self-service, you'll have 24/7 access to information you need for your patients with Aetna Better Health® of New Jersey, like:

- Eligibility
- Claim status
- Benefit information

No limits to eligibility inquiries
In the past, you may have had limits to a certain number of eligibility inquiries. Now you will have no limits, so it will be faster and easier to get the information you need.

No need to wait in queue
In a hurry? No need to speak with a representative or wait in queue. You can do it all with self service.

No trouble connecting with a real person
Now you will have the information you need at your fingertips, faster and easier than before. And don't worry. You can still talk with a real person when you need to. Questions? We're here to help. Just call your provider relations representative at **1-855-232-3596** to learn more.

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Aetna Better Health® of New Jersey

aetna®

aetnabetterhealth.com/newjersey

NJ-18-12-12

Winter 2019

New Behavioral Health Benefit changes took effect 10/1/2018

Aetna Better Health of New Jersey assumed the responsibility for additional behavioral health benefits effective 10/1/2018. Please review the changes below and call **1-855-232-3596** with any questions.

For our DDD and MLTSS members
Aetna Better Health of New Jersey will cover substance use services including:

- Hospital based services
- Outpatient substance use services
- Substance use intensive outpatient (IOP)
- Substance use partial care
- Ambulatory detoxification/ambulatory withdrawal management (AWM)
- Substance use short term residential
- Medication assisted treatment (MAT)

In addition, for our DDD members
Aetna Better Health of New Jersey will be covering mental health partial care and partial hospitalization services.

For all New Jersey Family Care Beneficiaries
Aetna Better Health of New Jersey will be covering **ALL** admissions to an acute care hospital despite the diagnosis or age. Admissions to facilities that are State and County psychiatric facilities will continue to be covered by FFS.

The following services will remain in FFS Medicaid:

- Targeted Case Management (TCM) including services provided by or through Justice Involved Services (JIS), Children's System of Care (CSOC) Care Management Organizations (CMOs), Integrated Case Management Services (ICMS), Projects for Assistance in Transition from Homelessness (PATH),
- Programs in Assertive Community Treatment (PACT),
- Behavioral Health Homes (BHH), and
- Community Support Services (CSS)

Use Participating Laboratories

Aetna Better Health of New Jersey has contracts with Quest, LabCorp and BioReference, each with a broad menu of available clinical tests and multiple points of access throughout the state of New Jersey. Please remember to utilize a contracted lab. We are changing our policy for coverage of non-contracted laboratories. As of February 2019, we will no longer cover testing at non-contracted laboratories in the absence of an authorization. For special situations, a request to authorize testing at a non-participating lab can be submitted through the prior authorization process. If you have questions about this change, please contact Provider Services at **1-855-232-3596**.

Genetic Testing

All genetic testing (with limited exceptions) requires prior authorization both for in-network and out of network requests. Aetna Better Health of New Jersey contracts with three national laboratories serving New Jersey: Quest, LabCorp and BioReference. Each laboratory has an extensive test menu to address the vast majority of your genetic testing needs for your patients, our members. Providers are reminded that they should send their genetic test requests to participating labs. Before sending a request for a non-contracted laboratory, please check the test menu at any of our participating labs to see whether the test is available. Participating labs should be used unless the requested test is not available. All genetic test requests are subject to clinical review using established medical necessity criteria. In the event of a denial, providers can request a copy of the specific guideline used for an individual request.

The link for Aetna's Clinical Policy Bulletin is below:
https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html

Definitive Urine Drug Testing

Urinary drug testing is an important clinical tool in the treatment of chronic pain and substance use disorders. Tests document which drugs and medications members have taken, whether prescribed or not, and inform treatment plans. Testing can be qualitative (with results as positive or negative) or quantitative (measuring specific amount of drug). Qualitative testing can screen for multiple drug classes; positive classes can be analyzed further to determine actual drug levels. Ordering clinicians should choose the specific, medically necessary test(s) for each patient based on current evidence and clinical guidelines. Medical records should document the specific reasons why care deviates from current guidelines.

When any provider or lab submits a claim for G0482 (definitive drug testing for 15 - 21 drug classes) or G0483 (definitive drug testing for more than 21 drug classes) for an outpatient place of service they must submit clinical records with the claim that substantiates the medical necessity of the test. Records must include a specific list of drug classes in question. Claims received without records will be denied for lack of documentation.

In the rare instances where these tests may be clinically indicated, the medical record should document the rationale and medical necessity for use of large panels of quantitative testing.

Prescribing Opioids

New research shows that opioids are not always the best pain relief options for chronic pain. Safer alternatives that don't use opioids should always be tried if possible. Our Prior Authorization process assures that, when they are needed, current treatment recommendations are being used. All Long-Acting opioids require Prior Authorization; you can see our guidelines at this link: **https://www.aetnabetterhealth.com/newjersey/assets/pdf/pharmacy/Opioid%20Guideline_8.1.18.pdf.pdf**

All Short Acting opiates in New Jersey have a five Day Supply limit for members 18 and older or a three Day Supply limit for members less than 18 years of age. In addition, all opiates are limited to a 90 MED (Morphine Equivalent Dosing) per day. Members with pain due to active cancer, palliative care, or end-of-life care are exempt from these requirements. Evidence of a treatment plan, risk assessment and counseling must be submitted along with a completed Opioid Prior Authorization (PA) form.

Visit our website at **aetnabetterhealth.com/nj** > For Providers, Prior Authorizations to download the below resources:

- Pharmacy Prior Authorization Formulary Process
- Prior Authorization form (recently updated)
- How to Guide: Prior Authorization and Formulary Selection Procedures

Get your members tested and earn an incentive

Lead exposure and lead poisoning are a significant public health concern in New Jersey. Aetna Better Health of New Jersey is committed to addressing this public health issue together with our providers.

Get your members tested and earn an incentive
Providers are required to ensure that **all of their assigned members 9 months to 6 years old get a blood lead screening. We are offering a special incentive to providers who send us a completed lead test result for the annual screening.**

To help you complete testing on our members, we have contracted with Laboratory Corporation of America (LabCorp), including MedTox Laboratories, to provide our contracted physicians with a Filter Paper Lead Screening method that is a fast, less invasive and easy way to conduct lead testing.

We strongly encourage you to use the fingerstick method of lead testing provided through MedTox. This ensures that testing is completed while the family is in your office.

Providers can also use our other contracted laboratories - Quest and BioReference. These labs (LabCorp/MedTox, Quest and BioReference) send results to us. Other laboratories do not send us results.

Any provider who sends a screening annual lead test to us for an Aetna Better Health of New Jersey member will receive a **$25** incentive payment.

Guidelines:
- Blood lead tests that are completed in 2019
- Any member age 9 months to 6 years
- One blood lead test per member per year

All children at average risk should be screened:
- Once between 9 and 18 months, preferably at 12 months, and
- Once between 18 and 26 months, preferably at 24 months

If a child has no prior test result, blood lead testing must be done if the child is between 27 months and 6 years of age.

Remember health maintenance visits should include a verbal lead risk assessment for every member between the ages of 6 months and 72 months to help identify any infant or child who has higher risk and should have immediate testing by blood lead level.

Submit results directly to our secured provider fax at **959-282-1622**. Please include your provider or practice **NPI and TIN** with all submissions. **Questions?** Contact **Provider Services** directly at **1-855-232-3596**.

Gabapentin Abuse

CNS depressants are often misused or abused in conjunction with opioid analgesics. They are purported to enhance the euphoric effects of the opioids. Gabapentin is among this group of medications. It is unclear whether the reinforcing euphoric effects are additive or synergistic with co-administration. Gabapentin is not classified as a controlled substance by the Drug Enforcement Administration (DEA); however the state of New Jersey began to monitor Gabapentin prescriptions in May 2018 and requires providers to check the Prescription Monitoring System before prescribing. Gabapentinoids are CNS depressants and increase the risk for respiratory depression, coma, and death when combined with opioids[1,2].

The number of emergency room visits involving nonmedical use of gabapentin increased by 90% in the U.S. since 2008 according to the Drug Abuse Warning Network (DAWN). Gabapentin has the potential to induce suicidal thoughts and behaviors. Unlike opioids, there is no antidote in the case of an overdose. Dependency can develop with gabapentin and abrupt discontinuation can increase the likelihood of seizures.

As such, Aetna Better health of New Jersey has implemented a 3,600 mg per day limit on gabapentin. The 3,600 mg limit is calculated based on all current gabapentin products in the patient's claim history, i.e. a cumulative dose limit calculation. The usual effective dose of gabapentin is 1800mg/day. Doses of 3600mg/day have been administered to a small number of patients for a relatively short duration and have been well tolerated according to package labeling. Prior authorization is required for dosing to exceed this limitation.

1. *Schifano F, Misuse and Abuse of Pregabalin and Gabapentin: Cause for Concern? CNS Drugs. 2014;28(6):491-496*
2. *Smith RV, Havens JR, and Walsh SL. Gabapentin Misuse, Abuse and Diversion: a Systematic Review. Addition. 2016 Jul; 111(7)1160-1174.* ***https://www.ncbi.nlm.nih.gov/pubmed/27265421****. (Accessed on 3/29/18).*

USP OTC Fish Oil and Other OTC supplements

Aetna provides coverage to our members for certain over-the-counter (OTC) products when they are listed on the formulary. Coverage is not only for some medications, such as aspirin and diphenhydramine, but also a limited number of supplements. The coverage of OTCs has been limited to those products determined to provide clinical value. There are laws governing the quality standards for pharmaceuticals, but similar approval processes are optional for manufacturers of OTC supplements.

The United States Pharmacopeia (USP) establishes quality standards for all OTC medicines. Per the USP website, USP designated supplements are put "Through a rigorous testing and auditing process, USP evaluates voluntarily submitted products against science-based quality standards - including federally recognized USP-NF standards of quality, purity, potency, performance, and consistency - and FDA current good manufacturing practices."

Aetna encourages providers that issue prescriptions for covered OTC vitamins, minerals and/or supplements to write "USP certified" in addition to the product name on the prescription. This will help ensure that the patient receives a trusted and quality product.

Unlisted Codes

Effective September 15, 2018, we changed the way unlisted and non-specific CPT and HCPCS codes are reviewed and paid.

With a few exceptions listed below, these codes will no longer be managed through the prior authorization process. They will be managed **with Medical Records** at the time of claim submission. That is, records supporting the use of these codes must be submitted with the claim. These claims will pend to our AMA Edit Team who will review for:

- Experimental/Investigational status per relevant Aetna Clinical Policy Bulletins (CPBs); and
- Medical necessity, applying relevant criteria; and
- Assignment of a more appropriate specific code if one exists; or
- Approval to pay as submitted.

Codes not included in the process change are:

Code(s)	Process
41899 – General Anesthesia for dental procedures	Prior Authorization
E1399 and K0108 – wheelchair components and services	Prior Authorization
90999 – unlisted dialysis procedure	Prior Authorization with dialysis services
Unlisted J code	Prior Authorization

If records are not submitted with any claim that includes one of the codes listed below (see link), the claim will be denied for lack of documentation. You may resubmit the claim with required supporting records.

Download the list of the codes covered by this process on our website at aetnabetterhealth.com/newjersey/providers/notice.

Member Acuity and Risk Adjustment

Aetna Better Health of New Jersey's members have a broad distribution of health status, ranging from good health to multiple chronic illnesses. Collectively, the sickest members of any health plan require the most attention and care; they also drive the highest cost of care. To address this, New Jersey Medicaid funds Medicaid Managed Care plans based on a complex calculation that includes members' degree of morbidity (referred to as acuity) through the State's Risk Adjustment Payment Model. In this model, the more a plan's members have certain chronic conditions, the higher the Risk Score the State assigns to the plan. Accurate Risk Scoring requires that members with these conditions have all of their chronic conditions addressed at least yearly, recorded in medical records and documented in claims. Reporting on member acuity starts and ends with the provider.

Diagnosis Coding in Claims

Encounters are electronic documents created in the claims process and reported to the State of New Jersey, showing each service provided to members. The diagnosis codes in each encounter drive the calculation of each plan's Risk Score. Each time a member with a chronic condition has that condition addressed at a visit, the diagnosis should appear on the claim. It is critical that providers document all chronic illness diagnosis codes on every applicable claim. Evaluation of the codes and subsequent Risk Adjustment analysis is done by the State on a bi-annual basis. Thus, providers should include the diagnosis code on every patient claim at every visit when it was addressed to ensure that the diagnosis is captured and utilized in the most current encounter analysis.

Acute visits

Members with chronic conditions who may not have seen their provider for periodic checkups may still present for episodic or acute conditions. These visits are opportunities to address their chronic conditions. If your member visits you for an episodic or acute condition and a chronic condition is currently present and addressed during the visit, the chronic condition diagnosis should be coded and included on the claim.

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Member Acuity and Risk Adjustment *Continued from page 6*

For example, a member with type 2 diabetes presents to the office with bronchitis. During the visit, along with treatment of bronchitis, you also provide reminders on the management of diabetes and the risk of elevated blood-glucose levels related to the acute bronchitis. The claim should include both the diagnosis of acute bronchitis and the diagnosis of diabetes.

Our partnership
Aetna Better Health of New Jersey is your partner in caring for all of our members, including our highest acuity members. We offer Integrated Care Management and our Quality program mails visit reminders and calls members, all in an effort to get them the care that they need.

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 **aetnabetterhealth.com/nj**. You must attach it to the claim prior to submission. Claims for hysterectomy and sterilization must be sent by mail/paper and cannot be electronic.

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 that lacks 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 **aetnabetterhealth.com/nj**. The form must be attached to the claim prior to submission. The individual who has given voluntary consent for a sterilization procedure must be at least 21-years-old at the time the consent is obtained and must be a mentally competent person.

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

You can verify your information through our **online provider directory**. If you have changes to your information, please complete the Provider Directory Spot Check Submission Form found in the **Forms section** of our website. If you notify us of any changes, we have 30 days to update our online directory.

Billing Tips from our Encounters Department:

Corrected claims:

All CMS claims being submitted as a correction to a previously submitted claim must be billed with a descriptor stamped on the claim. Any of the following terms can be used: Resubmission, Resub, Rebill, Reconsideration, Corrected Claim, or Second Submission.

All UB type claims being submitted as a correction to a previously submitted claim must be billed with a type of bill indicator that ends with a seven (XX7).

Please note: Providers cannot resubmit only the corrected/denied lines; **all lines** must be rebilled on the corrected claim.

Repeat modifiers:

If a repeat modifier is being billed, it must be billed in the first two fields of the modifier billing location for all providers.

Ambulance providers:

All ambulance services being billed must be billed with an origin and destination modifier. If there is more than one trip for the same patient on a given day, a repeat modifier is required as well.