Aetna Better Health®
of New Jersey

Provider Newsletter

Winter 2023

Provider Manual Updates

Updates to the Provider Manual are now available on the website.
Updates include:

- NJ Smiles information for EPSDT
- Diabetes program
- Dental directories for IDD and children up to age 6
- Negotiations with nonparticipating providers when service cannot be provided in-network
- Caries Risk Assessments

You can view the provider manual by visiting our website.

Clinical Practice Guidelines Location

Respected professional and public health organizations create clinical practice guidelines that document best practices and recommendations for care. We've chosen certain clinical guidelines to help our providers give members high-quality, consistent care with effective use of services and resources. These include treatment protocols for specific conditions, as well as preventive health measures.

The intention of these guidelines is to clarify standards and expectations. They should not:

- Take precedence over your responsibility to provide treatment based on the member's needs
- Substitute as orders for treatment of a member
- Guarantee coverage or payment for the type or level of care proposed or provided

Please review our Clinical Practice Guidelines for more information.

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Balance Billing is Prohibited

Providers may not bill Aetna Better Health® of New Jersey members for any services that are covered by NJ Medicaid and/or Aetna Better Health® of New Jersey.

- Any member copayments you must collect are included in the benefit listing on our website. Please note that copayments are not considered balance billing.
- Per your contract with us, when a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

NOTE: Providers can make payment arrangements with a member for services that are not covered by NJ Medicaid and Aetna Better Health® of New Jersey only when they notify the member in writing in advance of providing the service(s), and the member agrees. We want to make sure you are aware of these requirements because we value your partnership with us.

Federal and State laws are clear that providers are prohibited from balance billing Medicaid beneficiaries (42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n), 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9 and/or 15.2(b)7ii.

Before you decide to send accounts to any collection agency you may be using, it is critical that you **NOT** include Aetna Better Health® of New Jersey member accounts.

Providers who balance bill members could face the following consequences:

- Termination from the ABHNJ network
- Referral to the NJ Medicaid Fraud Division to open an investigation into the provider's action
- Referral to the Federal Department of Health & Human Services, US Office of Inspector General (HHS-OIG).

Extra Help During Pregnancy

Is any parent ever prepared enough for a new baby? If you have patients, our members that feel overwhelmed, we can help them stay healthy through their pregnancy and get the care they need.

Our team can help our members:

- Learn more about your pregnancy
- Make a care plan that's right for them
- Get services and care
- Work with health care providers, agencies and groups
- Get services after hours in a crisis
- Arrange services for children with special health care needs

Just call Member Services at **1-855-232-3596 (TTY: 711)**.

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Updates to the Appointment Availability Standards

The table below shows updates to the standard appointment wait times for primary and specialty care. The table also reflects the standard for acceptable wait time in the office when a member has a scheduled appointment.

Provider Type	Emergency Services	Urgent Care	After-hours care	Regular & Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Within twenty-four (24) hours	Within twenty-four (24) hours	Within forty-eight (48) hours	Within twenty-eight (28) days [1]	No more than forty-five (45) minutes
Obstetrics / Gynecology and other High-Volume Specialist	Within twenty-four (24) hours	Within forty-eight (48) hours	Return call within forty- five (45) mins of member contact	Within twenty-eight (28) days	No more than forty-five (45) minutes
Oncologist and other High Impact Specialist	Within twenty-four (24) hours	Within forty-eight (48) hours	Return call with one (1) hour of member contact	Within thirty (30) days of referral	No more than forty-five (45) minutes

Prenatal Care: Members shall be seen within the following timeframes:
First Trimester – within seven (7) calendar days of request

Provider Type	Emergency Services	Non-Life-Threatening Urgent Care	Urgent — no immediate danger	Initial Visit for Routine Care	Wait Time in Office Standard
Behavioral Health	Immediately	Within six (6) hours	Within forty-eight (48) hours	Initial visit: Within ten (10) business days of original request	No more than forty-five (45) minutes

- Non-life-threatening urgent: There is no immediate danger to self or others and/or if the situation is not addressed within six (6) hours, it may escalate resulting in a risk to self or others:
  - Extreme anxiety
  - Parent child issues
  - Passive suicidal ideation
  - Excess drug or alcohol usage
- Urgent – no immediate danger: There is no immediate danger to self or others and/or if the situation is not addressed within forty-eight (48) hours, it may escalate resulting in a risk to self or others:
  - Follow-up to a crisis stabilization
  - Escalating depression
  - Escalating anxiety
  - Escalating drug/alcohol usage
  - Escalating behavioral issues in children
  - Additionally, behavioral health providers are contractually required to offer:

Provider Type	Follow-up BH Medication Mgt.	Follow-up BH Therapy	Next Follow-up BH Therapy
Behavioral Health (prescribers)	Within three (3) months of first appointment	Within ten (10) business days of first appointment	Within thrity (30) business days of first appointment

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Member Acuity and Risk Adjustment (Long Term Institutionalization)

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.

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.

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Breast Cancer Prevention

Many factors over the course of a lifetime can influence your patient's breast cancer risk.

Please remind your patients, our members they can help lower their risk of breast cancer by taking care of their health in the following ways:

- Keep a healthy weight
- Be physically active
- Choose not to drink alcohol, or drink alcohol in moderation
- If they are taking, or have been told to take, hormone replacement therapy or oral contraceptives (birth control pills), ask their doctor about the risks and find out if it is right for them
- Breastfeed their children, if possible
- Talk to you if they have a family history of breast cancer or inherited changes in their BRCA1 and BRCA2 genes.

Source: Centers for Disease Control & Prevention

Cervical Cancer Prevention

To prevent cervical cancer, remind your patients, our member to get vaccinated early and have regular screening tests.

The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers.

Two screening tests that can help prevent cervical cancer or find it early:

- The Pap test (or Pap smear) looks for precancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- The HPV test looks for the virus (human papillomavirus) that can cause these cell changes.

Source: Centers for Disease Control & Prevention

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Vaccine Reminder

Members staying up-to-date on their immunizations is important now more than ever. As an accessible health care professional, you are afforded the ideal opportunity to remind patients to get their immunizations.

Please remind your patients, our members to stay up to date on their influenza (flu) vaccine, COVID-19 vaccine, and pneumococcal vaccine.

Flu: Everyone 6 months & older should receive a yearly flu vaccine.

COVID-19: CDC recommends COVID-19 vaccines for everyone ages 6 months and older, and boosters for everyone 5 years and older, if eligible.

Pneumococcal:

CDC recommends PCV13 or PCV15 for:

- All children younger than 5 years old
- Children 5 through 18 years old with certain medical conditions that increase their risk of pneumococcal disease.

For those who have never received any pneumococcal conjugate vaccine, CDC recommends PCV15 or PCV20 for:

- Adults 65 years or older
- Adults 19 through 64 years old with certain medical conditions or other risk factors
- CDC recommends PPSV23 for children 2 through 18 years old with certain medical conditions that increase their risk of pneumococcal disease
- Adults 19 years or older who receive PCV15.

Source: cdc.gov

Prescribing Opioids

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, review our guides for more information.

All Short Acting opiates in New Jersey have a five-day supply limit for members 18 years 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 Morphine Equivalent Dosing (MED) 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 to download prior authorization form.

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Risk of Continued Opioid Use (COU)

Assesses potentially high-risk opioid analgesic prescribing practices. The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Source: ncqa.org/hedis/measures/risk-of-continued-opioid-use/

Use of Opioids from Multiple Providers (UOP)

Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers. Three rates are reported.

1. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
2. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
3. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Note: A lower rate indicates better performance for all three rates.

Source: ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/