Aetna Better Health® of New Jersey

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Provider Newsletter

Spring 2021

Availity Provider Portal

New Provider Portal

We are happy to announce we have transitioned from our current provider portal to Availity. We are excited about the increase in online interactions available to support you as you provide services to our members.

Some highlights of increased functionality include:

- EFT registration
- Claims look back
- Online claim submission
- Prior authorization submissions and look up
- Grievance and appeals submission.

And best of all, Aetna Better Health of New Jersey will continue to build upon this platform by rolling out enhanced functions in 2021 such as:

- Panel searches
- A new robust prior authorization tool
- Review of G&A cases
- Eligibility and member look up.

Be on the lookout over the next few months for co-branded emails directly from Availity as new products roll out and training plans are developed. Please be sure to reach out to your Provider Representative to ensure we have your most recent email address.

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Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations — either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health of New Jersey providers. The purposes are to render medical advice or determine the need for emergency and other after-hours services, including authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent and/or emergent health care issues are held to the same accessibility standards regardless of whether after hours coverage is managed by the PCP, current service provider or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff.

We routinely measure the PCP's compliance with these standards:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern whereby a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver and provider grievances regarding afterhours access to care to determine if a PCP is failing to comply on a frequent basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs.
- Triage for medical and dental conditions and special behavioral needs of noncompliant individuals who have intellectual disability or dementia.
- Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues – within 30 to 45 minutes; same day for non-symptomatic concerns; 15 minutes for crisis situations.
- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

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Telephone Accessibility Standards (continued)

Acceptable and unacceptable telephone responses

Acceptable: An active provider response

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The answering service either:
  - Connects the caller directly to the provider;
  - Contacts the provider on behalf of the caller and the provider returns the call; or
  - Provides a telephone number where the provider/covering provider can be reached.
- The provider's answering machine message provides a telephone number to contact the provider/covering provider.

Unacceptable

- The Answering Service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine; or
  - Responds in an unprofessional manner.
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room for care, regardless of the exigencies of the situation, without enabling the caller to speak with the provider for non-emergent situations.
  - Instructs the caller to leave a message for the provider.
- Calls receive no answer.
- Listed number is no longer in service.
- Provider is no longer participating in the contractor's network.
- Caller is on hold for longer than 5 minutes.
- Answering Service refuses to provide information for survey.
- Telephone lines are persistently busy despite multiple attempts to contact the provider.

Providers must make certain that their hours of operation are convenient to, and do not discriminate against members. This includes offering hours of operation that are no fewer than those for non-members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Relations Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards and work to correct the barrier to care.

Appointment Accessibility Standards

Waiting Time Standards

The waiting time standards for Aetna Better Health® of New Jersey require that members, on average, should not wait at a PCP's office for more than forty-five (45) minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit or is treating a member with a difficult medical need, the waiting time may be expanded to one hour. The above access and appointment standards are provider contractual requirements. Aetna Better Health of New Jersey monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

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Appointment Accessibility Standards (continued)

Acceptable Appointment Wait Time Standards

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

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventative & 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]	Within 3 days of referral	N/A	Within 30 days of referral	No more than 45 minutes
Mental Health/Substance Abuse (MH/SA)	Same day	Within 24 hours	N/A	Within 10 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

1 Non-symptomatic office visits include, but are not limited to, well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

2 Emergency dental treatment no later than forty-eight (48) hours or earlier, as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider.

Physicals

Provider Type	Emergency Services
Baseline Physicals for New Adult Members	Within one hundred-eighty (180) calendar days of initial enrollment.
Baseline Physicals for New Child Members and Adult Clients of DDD	Within ninety (90) days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals	Within four (4) weeks for routine physicals needed for school, camp, work, or similar.

Prenatal Care

Members shall be seen within the following timeframes:

- 3 weeks of a positive pregnancy test (home or laboratory)
- 3 days of identification of high-risk
- 7 days of request in first and second trimester
- 3 days of first request in third trimester.

Initial Appointment

Provider Type	Emergency Services
Initial Pediatric Appointments	Within 3 months of enrollment
Aged, Blind & 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

- 4 per hour for adults
- 4 per hour for children.

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Lead Screening

Every child enrolled in Medicaid or NJ FamilyCare, regardless of risk, must be tested at 12 months of age AND again at 24 months of age.

Click here **to learn more about:**

- The screening requirements
- The verbal risk assessment
- Lead screening questions
- Our Lead Care Management Program

The Provider Incentive Program

We are offering a special $25 incentive to provider's who send us a completed blood lead test for our members who are between the ages of 9 and 72 months.

- One (1) blood lead test per member per calendar year
- Blood lead tests must be completed in 2021.

Send all blood lead test results to our secure fax line at **1-959-282-1622** and be sure to include your provider or practice NPI and TIN with all submissions.

Here's a HEDIS Lead Screening Tip!

A lead screening should be completed on all children before their second (2nd) birthday. A verbal risk assessment does not count. Screening must be a capillary or venous blood lead test.

Stay Updated

Please be sure to reach out to us via email at AetnaBetterHealth-NJ-ProviderServices@Aetna.com to ensure we have your most recent email address. Your email subject line should include the title and + NPI #. Example (Email Address Update + 12345678).

If you have any questions, please feel free to contact us via e-mail. You can also call us through our Provider Relations telephone line: **1-855-232-3596 (TTY: 711)**.

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COVID Vax and Testing Codes

NJDOH Vax Matters Newsletter

View the latest Vax Matters issue.
Subscribe to the Vax Matters newsletter.

COVID Vax Codes

Code	CPT Short Descriptor	Labeler Name	Vaccine/Procedure Name	Effective Dates
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Pfizer	Pfizer-Biontech Covid-19 Vaccine	12/11/2020 – TBD
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Pfizer	Pfizer-Biontech Covid-19 Vaccine Administration – 1st Dose	12/11/2020 – TBD
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	Pfizer	Pfizer-Biontech Covid-19 Vaccine Administration – 2nd Dose	12/11/2020 – TBD
91301	SARSCOV2 VAC 100MCG/0.5ML IM	Moderna	Moderna Covid-19 Vaccine	12/18/2020 – TBD
0011A	ADM SARSCOV2 100MCG/0.5ML1ST	Moderna	Moderna Covid-19 Vaccine Administration – 1st Dose	12/18/2020 – TBD
0012A	ADM SARSCOV2 100MCG/0.5ML2ND	Moderna	Moderna Covid-19 Vaccine Administration – 2nd Dose	12/18/2020 – TBD

COVID Testing Codes

Code	Description
U0001	2019-NCOV DIAGNOSTIC P
U0002	COVID-19 LAB TEST NON-CDC
U0003	IA DET DNA/RNA; COVID-19 AMP P T
U0004	2019-NCOV CRONAVIRUS/COVID-19
87635	SARS-COV-2 COVID-19 AMP PRB
87426	SARSCOV CORONAVIRUS AG IA

Upcoming Provider Trainings

You're Invited!

As a participating provider with Aetna Better Health of New Jersey, we would like to invite you and your office staff to join us for a very important training session about our programs and services. These webinars will provide valuable information on the following: authorization, claim processing, cultural competency, credentialing, nursing and assisted living and other important topics.

Please visit our website to choose a date and time that works best for your practice. Scroll to the bottom of the page for topics and meeting time options. Click on the link to register.

Aetna Better Health of New Jersey values our partnership with your practice to serve the people in the state of New Jersey by providing quality health care and accessible, medically-necessary services. Our providers are one of the most critical components of our service delivery approach and we are grateful for your participation. We look forward to speaking with you.

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Office Based Addiction Treatment (OBAT) Services

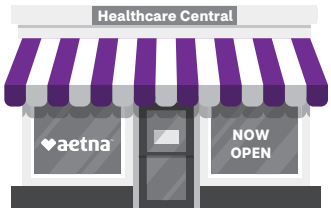
Office Based Addiction Treatment (OBAT) Services OBAT is a program to support non-methadone Medication Assisted Treatment (MAT) for members with substance use disorder including opioid, alcohol and poly-substance abuse. Physicians who are DATA 2000 Waivered including physician assistants and APN's can participate in the OBAT program. The OBAT program supports providers by an increased reimbursement rate for OBAT services. OBAT providers must designate a Navigator who works within their practice. The Navigator is an essential component to ensure the member's psychosocial needs are addressed and assist with coordination of care with counseling, resources for recovery supports and family education. Physicians, physician assistants and APN's who are not DATA 2000 Waivered can participate in training to obtain their certification.

Please call member services at **1-855-232-3596** for more information.

Healthcare Central: NJ FamilyCare Guidance Center

If you have a patient in need of insurance in the Newark area, direct them to Healthcare Central for help finding coverage.

- Sign up for NJ FamilyCare
- Get assistance with finding a provider
- Understand the renewal process for NJ FamilyCare
- Understand your Aetna Better Health® benefits



Monday–Friday, 10 AM–6 PM
959-299-3102 (TTY: 711)

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CAHPS & Member Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) Survey measures member satisfaction. Patients report on and evaluate their experiences with health plans, providers, and healthcare facilities. Aetna Better Health of New Jersey uses the NCQA HEDIS CAHPS 5.0H Membership Satisfaction Survey to assess member satisfaction. Members surveyed were selected from a random sample of all eligible members. **As participating providers, the care you give our members impacts their satisfaction with Aetna Better Health of New Jersey.**

Physician-related measures for future improvement

- Personal MD Overall
- Specialist MD Overall
- Getting Care Quickly
- Getting Needed Care
- Health Care Overall

Enhance your time with patients

- Be an active listener.
- Ask the member to repeat instructions their own words.
- Rephrase instructions in simpler terms if needed.
- Clarify words with multiple meanings to the member.
- Limit use of medical jargon.
- Be aware of cultural or language barriers.

2020 CAHPS Survey Results

	Measure	NJ 2020 Adult CAHPS Results Summaries	2020 CSS Adult Medicaid Avg.	2019 NCQA QC National Avg. Medicaid HMO
Adult CAHPS Survey	Rating of Personal Doctor	80.00%	81.59%	82.10%
	Rating of Specialist Seen Most Often	NA	81.90%	82.29%
	Rating of All Health Care	72.67%	73.74%	75.35%
	Rating of Health Plan	71.19%	75.62%	77.56%
	Getting Needed Care	81.57%	83.40%	82.48%
	Getting Care Quickly	79.03%	83.19%	81.97%
	How Well Doctors Communicate	93.41%	93.08%	91.99%
	Customer Service	NA	90.28%	88.75%
	Coordination of Care	NA	83.43%	83.67%
Child CAHPS Survey	Rating of Personal Doctor	89.45%	90.65%	90.05%
	Rating of Specialist Seen Most Often	NA	87.02%	87.45%
	Rating of All Health Care	85.88%	86.77%	87.53%
	Rating of Health Plan	80.70%	86.04%	86.49%
	Getting Needed Care	80.25%	86.92%	84.50%
	Getting Care Quickly	92.43%	91.20%	89.38%
	How Well Doctors Communicate	95.26%	96.25%	93.97%
	Customer Service	88.79%	90.92%	88.36%
	Coordination of Care	88.89%	86.02%	83.77%

Helpful resources for you

Case Managers are available to assist you in arranging timely care/services for our members. You can call us at **1-855-232-3596** and ask to be transferred to a Case Manager.

Member Service Representatives can assist with general member issues including claims and billing questions. You can reach Member Services at **1-855-232-3596**.

Your **Provider Relations Representative** is available to assist you with any questions or issues. Call **1-855-232-3596** and select **option 2** for Provider Relations.

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Risk Adjustment Coding and Medical Documentation

Helpful Tips

- Include patient's name and date of service on each page of the medical record.
- Five+ diagnosis codes for every visit represents "best practice" documentation.
- Document all diagnosis codes to the highest level of specificity.
- Include assessment and treatment plans for each diagnosis (i.e. Assessment: Improved – Treatment Plan – Discontinue Medication).
- Reaffirm and document prior chronic conditions reflected in past visit notes during every visit.
- For each condition noted, documentation must support that the physician Monitored, Evaluated, Assessed/Addressed, Treated (MEAT).
- Include notes on any areas in need of assessment, evaluation or screening.
- Ensure physician signature, credentials, and date are included to authenticate medical record.
- Utilize and provide Clinical Documentation Improvement (CDI) alerts from your EMR system.
- Encourage members to visit regularly.
- Submit an encounter form to ABHNJ, even if the member has another primary insurance provider.
- The more information, the better to ensure proper documentation of the medical record.

Proper coding and documentation ensures:

- Appropriate reimbursement
- Accurate claims data
- Increased specificity to identity patients for disease and care management programs
- More comprehensive descriptions of patients' health and conditions.

It's a win-win for physicians and health plans.

Tobacco-Free Ride NJ

Clean Air for Kids in Cars

Tobacco smoke/vapor can linger and cling to car seats, windows and fabric for hours.

Opening the window **is not** enough to ventilate.

Cracking the windows or turning on the air system **does not** get rid of secondhand tobacco smoke/vapor.

Visit TobaccoFreeRidePledge.com to learn more.

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Appeals and Grievances

- Complete the DOBI form when submitting appeals.
- Resubmitted claims should include the Reconsideration or Dispute form and be clearly marked “Resubmission” on the envelope.
- Clearly separate multiple appeals by staples, paper clips, rubber band or envelopes.

Whenever possible please submit your appeal or grievance electronically.

Aetna Better Health® of New Jersey Fax: **844-321-9566.**

Availity provider portal direct application: Grievance and Appeals.

Effective 7/1/2021, we will no longer accept Provider Appeal and Grievance mail that is directed to our Princeton, NJ office. Please update your systems to our new address.

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

Resubmissions, Reconsiderations and Disputes

If you are mailing hard copy claims or claim resubmissions, reconsideration or disputes, please direct those to:

Aetna Better Health® of New Jersey
Claims and Resubmissions
PO Box 61925
Phoenix, AZ 85082-1925

Authorization Fax Numbers for Providers

Inpatient Concurrent: **959-333-2850**
Appeals: **844-321-9566**
Requests for Prior Auth services: **855-232-3596**
Initial request for custodial care: **959-333-2850**
Subsequent custodial inquiries to MLTSS: **855-444-8694**

Request for Peer to Peer

Call: **959-299-7816**
or **959-299-7916**

Return Address for Refunds

If you are submitting a refund that was originally paid by Aetna Better Health® of New Jersey check, please mail to:

Aetna Better Health®
4500 E Cotton Center Blvd.
Phoenix, AZ 85040