



Horizon NJ Health Provider Administrative Manual

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Introduction

1.1 Welcome to Horizon NJ Health

We are pleased you are a participating provider and part of Horizon NJ Health. Horizon NJ Health is a health care management company that administers a managed care program for Medicaid recipients and those enrolled in NJ FamilyCare, Managed Long Term Services and Supports (MLTSS), Supplemental Security Income (SSI), Division of Child Protection & Permanency (DCPP) and clients of the Division of Developmental Disabilities (DDD) in New Jersey.

As a member of our provider network, you have an opportunity to build a mutually beneficial program for all members and for yourself. Horizon NJ Health regards your efforts as indispensable in making this program successful and for providing the highest quality medical care and services to our members. Horizon NJ Health is committed to supporting you, and we look forward to working with you to provide the best quality service possible to our members.

1.2 About this Document

The Horizon NJ Health Provider Administrative Manual (“Manual”) is a guide to the policies and administrative procedures of Horizon NJ Health. The Manual, updated periodically, is available on horizonNJhealth.com. Hard copies of the Manual are also available by calling **1-800-682-9091**. The Manual should be kept in your office or facility for easy access and referral. Use this document as a guide to answer questions about authorization policies, member benefits, claim submissions and many other issues. Your failure to comply with any policies, rules and procedures may constitute a breach of your Participating Physician, Hospital or Ancillary Provider Agreement and will certainly impact claims payment.

This Manual also provides day-to-day operational details that can be helpful to you and your staff. The Manual will clarify and detail the requirements identified in the Horizon NJ Health Agreement. If you or your staff have any questions or concerns about the information in this Manual, please contact Horizon NJ Health’s Provider Contracting and Strategy (PC&S) Department at **1-800-682-9091**.

We also publish a Provider Quick Reference Guide (QRG) that outlines some of the most important policies and procedures within the Manual as well as important Horizon NJ Health contact information. The QRG is available on our website at horizonNJhealth.com/for-providers/resources/guides.

1.3 Medicaid/NJ FamilyCare Program

As a managed care organization, our participation in the Medicaid and NJ FamilyCare program enables us to provide or arrange for the provision of services covered under the Medicaid/NJ FamilyCare program. These include comprehensive, preventive, diagnostic and therapeutic health care services. NJ FamilyCare is a federal and state-funded health insurance program created to help New Jersey’s uninsured have affordable health coverage. It is not a welfare program. NJ FamilyCare is for hard-working families who cannot afford to pay for health insurance privately. Eligibility is based on family size and monthly income. Coverage is provided for children and adults with dependent children as well as adults without children. Please refer to Sections 2 and 3 for more information regarding eligibility and benefits for Medicaid/NJ FamilyCare members.

The NJ FamilyCare program helps reduce reliance on the hospital charity care program among low- and moderate income residents of the state, by placing these individuals into a regular system of primary and preventive care. Those persons who have health care coverage are more likely to not only address their health problems, but

ensure that their children obtain necessary care, including immunizations and well-child visits with a primary care provider.

1.4 Managed Long Term Services & Supports (MLTSS)

Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency.

Horizon NJ Health coordinates all services for MLTSS members. The program provides comprehensive services and supports, whether at home, in an assisted living facility, in community residential services, or in a nursing home.

Managed Long Term Services and Supports (MLTSS) includes:

- Adult Family Care
- Assisted Living Program
- Assisted Living Services
- Caregiver/Participant Training
- Chore Services
- Community Residential Services
- Community Transition Services
- Home-Based Supportive Care
- Home-Delivered Meals
- Medication Dispensing Device
- Non-Medical Transportation
- Nursing Facility Services (Custodial)
- Pediatric Day Health
- Personal Emergency Response Systems
- Private Duty Nursing (Adult)
- Residential Modifications
- Respite (Daily and Hourly)
- Social Adult Day Care
- Traumatic Brain Injury (TBI) Behavioral Management (Group and Individual)
- TBI Cognitive Therapy (Group and Individual)
- TBI Occupational Therapy (Group and Individual)
- TBI Physical Therapy (Group and Individual)
- TBI Speech, Language and Hearing Therapy (Group and Individual)
- TBI-Structured Day Program
- TBI-Supported Day Services
- Vehicle Modifications

1.5 Horizon NJ TotalCare (HMO D-SNP)

In 2017, Horizon Blue Cross Blue Shield of New Jersey reentered the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) marketplace under the management of Horizon NJ Health. The plan is known as Horizon NJ TotalCare (HMO D-SNP), a Medicare Advantage plan that integrates all covered Medicare and Medicaid managed care benefits into one health plan. This health plan does not require referrals for specialty care, including long-term specialty care. There is comprehensive information about Horizon NJ TotalCare (HMO D-SNP) in Section 14 of this Manual.

Providers who are participating in this program have an addendum to their contract or have a unique contract covering FIDE-SNP. When payment is made for a Horizon NJ TotalCare (HMO D-SNP) member, providers will

receive a unique Electronic or Paper Remittance Advice showing how payment was made and indicating whether payment was for a Medicare or Medicaid service. Examples of these remittances are located in Section 14.6 of this Manual.

1.6 Horizon NJ Health's Website

The Horizon NJ Health website, horizonNJhealth.com, is a source of information about plan features, important news, tools and resources, as well as corporate policy. Our goal is to provide relevant information for members, physicians, health care professionals and the general public. Horizon NJ Health's Medical Policies and Clinical and Preventive Guidelines are available on the site.

Medical policies are posted for a minimum of 30 days prior to their effective date. Additional materials are posted as a resource for all providers, including the formulary, forms and guides. If you have any questions or would like a printed copy of any of these items, please contact your Professional Relations Representative.

NaviNet.net

Horizon NJ Health offers multiple online services via NaviNet that can greatly benefit providers. This free, secure website offers a single sign-on where providers can access transactions and services for multiple health plans. With its efficient electronic transactions and multi-payer database, NaviNet helps providers reduce their administrative costs and greatly reduces administrative time. When providers have a claim inquiry, they should consult NaviNet first.

By joining NaviNet, Horizon NJ Health providers get access to:

- Administrative Reports
- Utilization Management Tool
- Care Gap Reports
- Claim Appeals Status
- Claim Status Inquiries
- Online Referral Submission

The online Administrative Reports that are available include:

- Authorization Status Summary
- Claim Appeal Status
- Claim Status Summary
- Panel Rosters

The online Care Gap reporting feature allows better access to patients' medical information and helps ensure that patients are receiving their required screenings.

The online Care Gap reports that are available include:

- Adult Access to Preventive/Ambulatory Health Services
- Adolescent Well-Care Visits
- Annual Dental Visits
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults in Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Child and Adolescent Access to Primary Care Physician (PCP)
- Childhood Immunization – Combo 2

- Childhood Influenza Immunizations
- Childhood Pneumococcal Immunizations
- Colorectal Cancer Screening
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – HbA1C < 8%
- Emergency Room Visits
- Well-Child Visits (First 15 months of life)
- Well-Child Visits (3rd – 6th year of life)

To enroll with NaviNet:

- Visit horizonNJhealth.com and select the *Providers* tab, then select *Register Today*.
- Complete the NaviNet Enrollment Request Form.
- Your NaviNet username and temporary password will be sent via email once your registration is completed.

If you need more information, call NaviNet at **1-888-482-8057**.

1.6.1 Utilization Management Request Tool

Providers who use NaviNet can access the Utilization Management Request Tool portal to submit authorization requests easily and securely. Utilization Management Request Tool allows providers to communicate directly with Horizon NJ Health by checking the status of all requests in real time. It also sends providers notifications when requests are completed. The main features in Utilization Management Request Tool include authorization requests and the ability to view status of authorization requests. It can also be used for authorizations for home care, DME purchase/rental, surgical procedures and inpatient admissions. Not all MLTSS services are eligible for authorization through the Utilization Management Request Tool.

Providers can use Utilization Management Request Tool to easily change dates of service while the authorization request is pending for review and to upload attachments in Excel, Word or PDF. Utilization Management Request Tool is a single submission process and also includes printable approvals. For medically urgent requests, providers should contact Provider Services at **1-800-682-9091**. For more information, go to horizonNJhealth.com/for-providers/resources.

1.7 Provider Enrollment

To enroll as a network provider with Horizon NJ Health, as a PCP, Specialist, Ancillary or MLTSS provider, you will need:

- CAQH or NJ Universal Application (less than 180 days old)
- If not attached- automatic withdraw (not processed)
 - Signed agreement(s)
- Group agreement (with current roster) or link letter from group authorizing link
 - ADA survey per location
 - Special Needs Survey

For a detailed list of requirements, go to [our website](#).

If the application is incomplete, processor will outreach 3 times within 15 days. The application status remains as pending during this time. If missing information is not received then the application will be withdrawn. It will take up to 90 days for the credentialing process to be completed. Upon acceptance, the provider will be notified of the credentialing committee's decision and, if approved, be added to the Horizon NJ Health Provider Network. Until credentialing is complete providers are not allowed to treat Horizon NJ Health members. When a provider

does provide treatment prior to credentialing being completed, no reimbursement is allowed. An authorization is required for services rendered by nonparticipating providers.

All PCPs or Specialists seeking applications or more information on the credentialing process should contact the Senior Manager of Network Relations at 1-800-682-9094. All MLTSS providers seeking applications or credentialing information should contact the Manager of MLTSS Network Relations at **1-800-682-9094**.

Credentialing applications should be submitted to:

**Horizon BCBSNJ
3 Penn Plaza East
Mail Station PP 14 C
Newark, NJ 07105**

1.7.1 Provider Inquiries, Grievances and Appeals

Providers can check the status of appeals by going to NaviNet.net and can check the status of and grievances by contacting Provider Services at **1-800-682-9091**.

Claims inquiries or questions should be directed to Provider Services at 1-800-682-9091 or sent to:

**Provider Correspondence
PO Box 24077
Newark, NJ 07101-0406**

Horizon NJ Health can only accept timely inquiries for claims in dispute when all elements shown are presented. Other inquiries will be returned. Timely inquiries for claims are those that are filed within 90 days of processing date.

Taxonomy codes must be provided on all claims.

Note: IT IS VITAL THAT THE PROPER TAXONOMY CODE BE INCLUDED WHEN BILLING. WITHOUT THIS CODE CLAIMS PAYMENT WILL BE DENIED.

Red and White paper claims are the only claims that are accepted. Black and white, faxed, copied, handwritten or any other versions of these paper claims cannot be processed.

1.7.2 Provider Relations Representative

Horizon NJ Health's list of Professional Relations Representatives that serve physicians can be found listed by counties served at horizonNJhealth.com/PCSstaff.

This list also includes MLTSS and Ancillary contracting staff denoted by specialty. Information for the Provider Relations staff can also be obtained by calling Provider Services at **1-800-682-9091**.

1.7.3 21st Century Cures Act

To remain in the Horizon NJ Health network providers are required to submit a completed 21st Century Cures Act application to DXC Technology.

Providers who choose to serve Medicaid MCO beneficiaries are referred to as 21st Century Cures registered or ROPA (referring, ordering, prescribing or attending) providers in the NJ FamilyCare Fee-For-Service (FFS) program. You only have to complete this application once.

Providers under contract with multiple Managed Care Organizations (MCO) only need to submit one application.

How to register for 21st Century Cures Act

To download a 21st Century Cures Act application, go to njmmis.com, select *Provider Enrollment Applications* and then select *21st Century Cures Act Application* as the Provider Type.

21st Century Cures Act registered providers:

- Are not eligible to receive NJ FamilyCare FFS payments
- Are not required to provide services to NJ FamilyCare FFS beneficiaries
- Will not be listed in the NJ FamilyCare FFS Provider Directory and will not be assigned a FFS Medicaid ID number

Enroll in NJ FamilyCare FFS

If you are eligible to serve FFS beneficiaries and would like to enroll, you must complete a full NJ FamilyCare FFS enrollment application. This application can be found at njmmis.com under Provider Enrollment Application.

Please note there are some provider types that are not eligible to enroll in FFS Medicaid.

How to submit completed applications and credentials:

Mail: **DXC Technology Provider Enrollment Unit**
PO Box 4804
Trenton, NJ 08650

Or Fax: **1-609-584-1192**

If you have any additional questions regarding how or why you were identified as a provider who needs to enroll in the NJ FamilyCare Program, please contact the NJMMIS provider enrollment unit at **1-609-588-6036**.

Compliance is mandatory. Failure to comply may result in termination from the Horizon NJ Health network.

1.8 HealthSphere

HealthSphere, our sophisticated, HIPAA-compliant, online health care data management and analytics tool, is available to physicians, other health care professionals, ancillary providers and facilities to help make sure your patients get the right care. MLTSS providers do not have access to HealthSphere. We strongly encourage you to register for and start using HealthSphere.

Through the HealthSphere platform, you have access to a 360-degree view of your Horizon NJ Health patient records. HealthSphere merges and organizes clinical patient information collected from a variety of internal and external health care information sources and systems and makes it available to users. For example, the tool allows you to review data and utilization management claims, see when your patient visits a specialist to identify gaps in care or monitor a patient's coordination/transition of care.

The information accessed on HealthSphere can help you improve patient outcomes, lower costs and enhance patient experience.

HealthSphere offers:

- Easy access to near real-time patient information
- Comprehensive, reliable information allowing for timely interventions, improved health outcomes and proactive monitoring of chronic disease management across the continuum of care
- Ability to identify diagnostic and treatment opportunities

- Care coordination and transition-of-care improvement opportunities

How to register for HealthSphere

Security Officers at participating practices, ancillary providers or facilities, can register for HealthSphere using the following steps:

1. Log in to [NaviNet](#) and select *Horizon NJ Health* from the *My Health Plans* menu.
2. Click *HealthSphere Registration* within *Workflows for this Plan*.
3. Complete the required fields within the online form and review a copy of the Non-Integrated Partnership Agreement.
4. Click *Submit*.

Once the Security Officer completes the HealthSphere registration process, he/she can then grant HealthSphere access to other NaviNet users within the organization.

How to access HealthSphere

Once signed in to [NaviNet](#), you can access HealthSphere:

1. Select *Horizon NJ Health* from the *My Health Plans* menu.
2. Click *HealthSphere* within the *Workflows for this Plan* section.

To watch HealthSphere training videos, visit horizonNJhealth.com/HealthSphere.

Questions

If you have questions about HealthSphere, email HealthSphere_Training@HorizonBlue.com.

HealthSphere data input sources are currently fixed. At this time, we are not seeking to incorporate additional patient information from any provider practice management systems or electronic health records.

1.9 Provider Directory

Horizon NJ Health publishes a searchable Provider Directory at horizonNJhealth.com. All participating providers are listed, including doctors, hospitals, laboratory services, pharmacies and dental providers. The information is updated daily. Printed copies of the Provider Directory are available by calling Provider Services at **1-800-682-9091**.

As a condition of their participation in the Horizon NJ Health network, providers are required to update their demographic and practice roster information when it changes. Please notify us when you have changes in your practice, such as:

- Office relocation address
- Changing the name of your practice
- Changing your phone number
- Changing your fax number
- Changing your tax ID number
- Adding or removing a physician to or from your practice
- Changing your hospital affiliation
- Receiving new or updated documents related to your credentialing or recredentialing process
- Changing the status for accepting new patients at a location
- Changing your address, including your billing address.

How to update your demographic information

Details on how to submit changes to your information can be found at horizonNJhealth.com/demographicupdates.

Documentation can be mailed to:

Horizon BCBSNJ
3 Penn Plaza East, Mail Station PP 14 C
Newark, NJ 07105

Failure to update this information can result in denial of payment and potentially in removal from the network.

Newly enrolled members are sent a Provider Directory that is limited to include only the primary care providers, dentists, Ob/Gyns, vision providers, hospitals, health centers, and pharmacy locations specific to their county. These county directories are updated monthly.

1.10 Health Literacy

Health literacy is defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.” Low health literacy affects people of every age, ethnicity, background and education level.

Impacts on Patient Care

People with low health literacy are less likely to adhere to prescribed treatment and self-care regimens. They are also less likely to seek preventive care and are at a higher risk for hospitalization. People with low health literacy often require additional care that results in annual health care costs four times higher than for those with a higher literacy level. Horizon NJ Health has adopted improvements in health literacy as a means of eliminating barriers to care and improving member health outcomes.

What you, the provider, can do:

- Create a safe environment where patients feel comfortable talking openly with you.
- Use plain language instead of technical language or medical jargon.
- Sit down (instead of standing) so you are eye level with your patient.
- Use visual models to illustrate a procedure or condition.
- Ask patients to perform a return demonstration of the care instructions you give to them.

Visit horizonNJhealth.com for additional health literacy resources. In addition to the above, Horizon NJ TotalCare (HMO D-SNP) offers members a customized care management program designed to meet their individual needs. Each member’s personalized plan of care includes information and health education to address health literacy in partnership with their primary care provider. To learn more about the Horizon NJ TotalCare (HMO D-SNP) Care Management Program, please call **1-888-621-5894**, prompt **2**, (TTY **711**), Monday through Friday between 8:30 a.m. and 5 p.m. ET.

2.0 Eligibility

2.1 Individuals Eligible to Enroll

New Jersey residents who belong to one of the following categories are eligible for enrollment with Horizon NJ Health:

- Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF)
- AFDC/TANF-related New Jersey Care: Special Medicaid Program for Pregnant Women and Children
- Social Security Insurance – Aged, Blind, Disabled
- New Jersey Care: Special Medicaid Programs for Aged, Blind and Disabled
- New Jersey Care: Special Medicaid Program for Breast and Cervical Cancers
- Division of Developmental Disabilities Clients, including the Division of Developmental Disabilities Community Care Waiver
- Medicaid only or SSI-related Aged, Blind and Disabled
- Medicaid/NJ FamilyCare for Parents or Caretakers
- Medicaid/NJ FamilyCare for Adults without Children
- Children who qualify for NJ FamilyCare programs
- Individuals eligible through the Division of Child Protection & Permanency (DCPP)
- Individuals who are enrolled in both Medicare and Medicaid (dual eligible) may enroll in Horizon NJ TotalCare (HMO D-SNP)

2.1.1 Eligibility Requirements for MLTSS Membership

To be eligible to enroll with Horizon NJ Health's MLTSS program, a person must:

- Be a resident of New Jersey.
- Be 65 years of age or older, or between the ages of 21 and 64 and determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services.
- Be determined by the Division of Medical Assistance and Health Services to meet clinical eligibility.
- Qualify for Medicaid financial eligibility by:
 - Qualifying for SSI in the community, or
 - Qualifying for Medicaid Only – Institutional Level, or
 - Qualifying for NJ FamilyCare (with income at or below 100% of the Federal Poverty Level and resources at or below \$4,000).
- Meet clinical eligibility, which is determined by a state or county professional as needing nursing facility level of care.
- MLTSS members may also be eligible for Horizon NJ TotalCare (HMO D-SNP) if they qualify for both Medicare and Medicaid.

If a provider wishes to refer a current or potential member for consideration for MLTSS services, he or she can call MLTSS Member Services at **1-844-444-4410**.

2.1.2 Assessment Process for Nursing Facility Level of Care

Only individuals who are determined to require Nursing Facility Level of Care (NFLoC) may be enrolled in MLTSS. The process and standardized tool that is used in New Jersey to make this determination is the NJ Choice Assessment System as approved and codified by the State of New Jersey.

Upon enrollment, the Care Manager will conduct an initial assessment of each patient. This initial assessment is conducted by communicating with the member and primary caregiver/family member (if available), observing the member in his or her home environment, and reviewing any secondary documents when available. The member is

considered to be the primary source of information; the Care Manager is encouraged to talk with the member in private if at all possible.

The purpose of the NJ Choice Assessment system is to complete a comprehensive assessment of the member with the goal of:

- Maximizing the individual's functional capacity and quality of life.
- Addressing health problems through integrated care.
- Ensuring that the individual remains in his or her home as long as possible.

MLTSS members must agree to and allow face-to-face visits with their Care Manager at least every 90 days. When an individual is determined not to require NFLoC, the person is informed by the Office of Community Choice Options of the New Jersey Department of Human Services' Division of Aging Services by letter of his or her right to request a Fair Hearing to appeal the determination.

2.1.3 Eligibility Requirements for Horizon NJ TotalCare (HMO D-SNP) Membership

To be eligible for Horizon NJ TotalCare (HMO D-SNP), an enrollee must:

- Be a full-time New Jersey resident residing in one of the counties in which the plan is available.
- Have Medicare Parts A and B.
- Have NJ FamilyCare eligibility.
- Not be enrolled in a breast cancer or cervical cancer waiver program.
- Not be enrolled in a Program for All Inclusive Care for the Elderly (PACE).
- Members of this plan may also be eligible for Managed Long Term Services and Supports (MLTSS).

2.2 Medicaid/NJ FamilyCare Program

The Medicaid/NJ FamilyCare programs are the New Jersey programs that provide managed care coverage to eligible adults and children. Medicaid/NJ FamilyCare eligibility is based on income level. Medicaid/NJ FamilyCare A provides comprehensive managed care coverage to:

- Children under the age of 19 with family incomes up to and including 133 percent of the Federal Poverty Level
- Children under the age of one year and pregnant women eligible under New Jersey Care Special Medicaid Programs
- Pregnant women with an income up to 200 percent of the Federal Poverty Level
- AFDC eligibles with incomes up to and including 133 percent of the Federal Poverty Level
- Non-institutionalized aged, blind and disabled individuals enrolled under Medicaid, SSI or New Jersey Care Special Medicaid Programs. In addition to covered managed care services, eligible under this program may access certain other services, which are paid by Medicaid fee for service. Medicaid/NJ FamilyCare ABP provides comprehensive managed care coverage to:
 - Adults without children under the age of 65 with income up to and including 133 percent of the Federal Poverty Level
 - Parents/Caretakers with family incomes up to and including 133 percent of the Federal Poverty Level

In addition to covered managed care services, eligible under this program may access certain other services, which are paid by Medicaid fee for service. NJ FamilyCare B provides comprehensive managed care coverage, including all benefits provided through New Jersey Care Special Medicaid Programs, to uninsured children under the age of 19 with family incomes above 133 percent and up to and including 150 percent of the Federal Poverty

Level. In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid fee for service.

NJ FamilyCare C provides comprehensive managed care coverage, including all benefits provided through New Jersey Care Special Medicaid Programs, to uninsured children under the age of 19 with family incomes above 150 percent and up to and including 200 percent of the Federal Poverty Level. In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid fee for service.

NJ FamilyCare D provides managed care coverage to uninsured:

- Children under the age of 19 with family incomes between 201 percent and up to and including 350 percent of the Federal Poverty Level

In addition to covered managed care services, eligible under this program may access certain services, which are paid by Medicaid fee for service and are not covered under this contract.

Upon collection of a copayment, a physician is responsible for issuing a receipt to the member. This receipt should include the physician's name, address and phone number.

2.3 Special Needs Enrollees

Adult special needs enrollees under the NJ State Medicaid program are defined as adults with physical, mental, substance use disorder and/or developmental disabilities. Children with special health care needs are those who have (or are at an increased risk for) a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond what is generally required by children.

2.4 Member Identification Cards

Identification Card

Upon enrollment, Medicaid/NJ FamilyCare programs issue the member a Health Benefits Identification (HBID) card, which is a permanent, plastic magnetic-stripped card. The HBID can be used by members to access services covered by fee for service and those benefits not covered by Horizon NJ Health.

2.4.1 Horizon NJ Health Identification Card

Members enrolled with Horizon NJ Health will receive a white, plastic Horizon NJ Health ID card in addition to the State of New Jersey-provided HBID card.

Digital ID Card

Horizon NJ Health members are able to access their digital Horizon NJ Health ID card by signing in to the **Horizon NJ Health app**. Members can use the app to email or text a copy of their digital ID card to a provider office.

Providers may not refuse to provide services to a patient if a physical member ID card is not presented. Please continue to verify membership and benefits on NaviNet. For more information, review Section 2.5 Determining Eligibility.

Member ID cards can aid you in:

- Eligibility verification
- Admission coordination
- Delivery of service

- Claim submission
- Collection of copayments (NJ FamilyCare C and D)

Providers who refuse to provide treatment to members who do not present a traditional physical Horizon NJ Health ID card will be addressed in a manner consistent with contractual rights and remedies, including, but not limited to, termination with cause from our network(s). Horizon NJ Health ID cards contain the following information:

- Member name
- Horizon NJ Health issued member identification number (may be truncated to 7 characters of first name and 11 characters of last name)
- Primary care provider's (PCP) name and phone number
- Indication of dental benefits
- Coverage effective date
- Copayment amounts (NJ FamilyCare C and D)
- Note that the phrase "BC/BS Plan Codes 280/780" as well as "YHZ for Medicaid members and YKU for Horizon NJ TotalCare (HMO D-SNP) members" before the member ID number appear on the face of the member ID cards. Please disregard this information. Participating Horizon NJ Health physicians are not required to include the alpha-prefix when referring to a member ID number.

MLTSS members will have "MLTSS" printed on the front of their card.

Both the Horizon NJ Health and the HBID cards are for identification purposes only. Eligibility must be verified before services are provided.

2.5 Determining Eligibility

The Horizon NJ Health member ID card cannot be accepted as the sole verification of a member's eligibility to receive benefits. ID cards do not list an expiration date and are not always returned to Horizon NJ Health when a member's coverage terminates. To confirm eligibility, visit NaviNet.net or call **1-800-682-9091** at the time of service. A member should present an HBID card in addition to a Horizon NJ Health ID card. Ask the member for all forms of insurance to facilitate claims processing. See Section 9.6.2 Other Third Party Medical Insurance for more information. Also see Section 1.5 for more information on NaviNet and member eligibility.

2.5.1 Determining Newborn Eligibility

If a newborn's mother is covered under Horizon NJ Health Medicaid plan on the day of the newborn's birth, Horizon NJ Health will provide health care coverage for the newborn from birth through the end of the month of the 60th day.

To fully enroll the newborn into a health plan, the newborn's family can contact the New Jersey State Board of Social Services or NJ FamilyCare to determine the newborn's eligibility under a Medicaid program. Each newborn is issued an individual Horizon NJ Health member ID number for billing purposes. State guidelines allow 60 days for these claims to be honored. They will not be paid after 60 days.

Providers are required to verify a newborn's eligibility prior to providing care. Mothers receive a letter for their newborn that serves as a temporary enrollment notification for their baby to receive health care services for **the first 60 days after birth**.

If you have a newborn present for care without a "proof of coverage" letter, the following steps must be taken:

- Call Member Services at **1-800-682-9090**.

- Horizon NJ Health will request to speak with the newborn's mother/legal guardian to verify demographic information. Note: The mother/legal guardian must be present at the provider's office.
- The Enrollment Department will enroll the newborn and create an identification number.
- The provider's office will be notified of the newborn identification number within one business day.
- The provider's office cannot bill for services under the mother's identification number.
- The newborn must have his or her own identification number.

Notes:

- A mother should submit a request to Horizon NJ Health for newborn coverage at least one business day before going to the doctor's office. The newborn's coverage with Horizon NJ Health ends on the last day of the month in which the newborn completes the 60th day, unless the baby has been registered through the New Jersey State Board of Social Services or NJ FamilyCare and subsequently enrolled into Horizon NJ Health. Once the baby has been registered with the State or NJ FamilyCare and enrolled into Horizon NJ Health with a valid Medicaid recipient ID, a permanent Horizon NJ Health member ID card will be issued for the newborn. The newborn will receive a Health Benefits Identification card (HBID) from the State.
- Infants of inmates of a public institution living in a prison nursery cannot be enrolled in Horizon NJ Health Medicaid Plan until this newborn is assigned to Horizon NJ Health by New Jersey DMAHS via electronic enrollment process.

During their office visit, members who require this service can ask their provider to call Provider Services at **1-800-682-9091 (TTY 711)**, Monday through Friday, from 8 a.m. to 5 p.m. After hours, members can ask their provider to call Horizon NJ Health Member Services at **1-800-682-9090 (TTY 711)**.

3.0 Benefit Overview

3.1 Medicaid/NJ FamilyCare Benefit Matrix and Managed Care Protocols

This benefit matrix provides a comprehensive overview of the benefits for preventive and medically necessary services provided to Medicaid and NJ FamilyCare members enrolled in Horizon NJ Health. NJ FamilyCare members enrolled in Horizon NJ Health through NJ FamilyCare A, ABP and B do not incur a copayment. Members enrolled through NJ FamilyCare C and D are required to pay a copayment for certain services. Notwithstanding, the following is the benefit matrix for the Medicaid contract and sets forth the services that are reimbursable to the physician by Horizon NJ Health. Benefits are established by the State of New Jersey and are subject to change.

Note: In 2018, the benefit package was updated to reflect changes to the MCO contract. This includes behavioral health services for DDD, FIDE SNP and MLTSS members for hospital-based, inpatient psychiatric, inpatient medical detox and substance use disorder services.

The following behavioral health services may be available to DDD, FIDE-SNP and MLTSS members:

- Adult Mental Health Rehabilitation (AMHR) group homes and apartments
- Ambulatory withdrawal management (ASAM 2-WM)
- Electroconvulsive Therapy (ECT)
- In-network outpatient psychiatric/medication management
- In-network outpatient psychotherapy
- In-network outpatient treatment for substance use disorders
- Inpatient psychiatric treatment
- Inpatient SUD Rehab (ASAM 3.7)
- IOP SUD (ASAM 2.1)
- Medically Managed Detox (ASAM 4.0)
- Medically Monitored Detox (SUD ASAM 3.7D)
- Medication assisted treatment – not including actual medication
- Partial care
- Partial hospitalization (PHP)
- Partial SUD (ASAM 2.5)
- Psychological testing
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Residential Mental Health
- Residential SUD (ASAM 3.1) Clinically Managed Low- Intensity Residential Services
- Residential SUD (ASAM 3.5) Clinically Managed High Intensity Residential Services
- Short term residential treatment (ASAM 3.7)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by Fee-For-Service. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered by Horizon NJ Health.			
Autism Services	Covered by Horizon NJ Health. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; and Applied Behavior Analysis (ABA) treatment.			
Blood and Blood Plasma	Covered by Horizon NJ Health. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered by Horizon NJ Health. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			
Cardiovascular Screenings	Covered by Horizon NJ Health. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.			
Chiropractic Services	Covered by Horizon NJ Health. Covers manipulation of the spine.			
Colorectal Screening	Covered by Horizon NJ Health. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.			
• Barium Enema	Covered by Horizon NJ Health. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.			
• Colonoscopy	Covered by Horizon NJ Health. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.			
• Fecal Occult Blood Test	Covered by Horizon NJ Health. Covered once every 12 months.			
• Flexible Sigmoidoscopy	Covered by Horizon NJ Health. Covered once every 48 months			
Dental Services	Covered by Horizon NJ Health. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); x-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal		Covered by Horizon NJ Health. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); x-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary x-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity.		and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary x-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. NJ FamilyCare C and D members have a \$5 copay per dental visit (except for diagnostic and preventive services).	
Diabetes Screenings	Covered by Horizon NJ Health. Screening is covered (including fasting glucose tests) if the member has any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if the member meets other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, the member may be eligible for up to two diabetes screenings every 12 months.			
Diabetes Supplies	Covered by Horizon NJ Health. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.			
Diabetes Testing and Monitoring	Covered by Horizon NJ Health. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.			
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered by Horizon NJ Health. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered by Horizon NJ Health.			
Emergency Care	Covered by Horizon NJ Health. Covers emergency department and physician services.		Covered by Horizon NJ Health. Covers emergency department and physician services. NJ FamilyCare C members have a \$10 copayment.	Covered by Horizon NJ Health. Covers emergency department and physician services. NJ FamilyCare D members have a \$35 copayment.
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered by Horizon NJ Health. Coverage includes (but is not limited	Covered by Horizon NJ Health. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnosis medical examinations, dental, vision, hearing, and lead screening services.		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	<p>to) well child care, preventive screenings, medical examinations, dental, vision, and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.</p>	<p>For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the Fee-For-Service program.</p>		
<p>Family Planning Services and Supplies</p>	<p>Covered by Horizon NJ Health. Horizon NJ Health will reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Services furnished by out-of-network providers are covered by Medicaid Fee-for-Service. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).</p>			
<p>Federally Qualified Health Centers (FQHC)</p>	<p>Covered by Horizon NJ Health. Includes outpatient and primary care services from community-based organizations.</p>			
<p>Hearing Services/ Audiology</p>	<p>Covered by Horizon NJ Health. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.			
Home Health Agency Services	Covered by Horizon NJ Health. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.			
Hospice Care Services	Covered by Horizon NJ Health. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. - Covered in the community as well as in institutional settings. - Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. NOTE: Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.			
Immunizations	Covered by Horizon NJ Health. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.			
Inpatient Hospital Care	Covered by Horizon NJ Health Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semiprivate room accommodations; physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.			
• Acute Care	Covered by Horizon NJ Health. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).			
• Psychiatric	<i>For coverage details, please refer to the Behavioral Health chart.</i>			
Mammograms	Covered by Horizon NJ Health. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.			
Maternal and Child Health Services	Covered by Horizon NJ Health. Covers medical services for perinatal care, and related newborn care and hearing screenings, including midwifery care, Centering Pregnancy, immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.			
Medical Day Care (Adult Day Health Services)	Covered by Horizon NJ Health. A program that provides preventive, diagnostic, therapeutic and Rehabilitative services under	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.			
Nurse Midwife Services	Covered by Horizon NJ Health.		Covered by Horizon NJ Health. \$5 copayment for each visit (except for prenatal care visits)	
Nursing Facility Services	Covered by Horizon NJ Health. Members may have patient pay liability.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
• Long Term (Custodial Care)	Covered by Horizon NJ Health. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
• Nursing Facility (Hospice)	Covered by Horizon NJ Health. Hospice care can be covered in a Nursing Facility setting. * See Hospice Care Services.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
• Nursing Facility (Skilled)	Covered by Horizon NJ Health. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
• Nursing Facility (Special Care)	Covered by Horizon NJ Health. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.			
Organ Transplants	Covered by Horizon NJ Health. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered by Horizon NJ Health.			
Outpatient Hospital/ Clinic Visits	Covered by Horizon NJ Health.		Covered by Horizon NJ Health. \$5 copayment per visit (no copayment if the visit is for preventive services).	
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered by Horizon NJ Health. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered by Horizon NJ Health. Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.		
Pap Smears and Pelvic Exams	Covered by Horizon NJ Health. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.			
Personal Care Assistance	Covered by Horizon NJ Health. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	Not covered for NJ FamilyCare B, C, or D members.		
Podiatry	Covered by Horizon NJ Health. Covers routine exams and medically necessary podiatric services, as well as		Covered by Horizon NJ Health. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.		or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. \$5 copayment per visit for NJ FamilyCare C and D members. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	
Prescription Drugs	Covered by Horizon NJ Health. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.		Covered by Horizon NJ Health. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.	
Physician Services - Primary and Specialty Care	Covered by Horizon NJ Health. Covers medically necessary services and certain preventive services in outpatient settings.		Covered by Horizon NJ Health. Covers medically necessary services and certain preventive services in outpatient settings. \$5 copayment for each visit (except for wellchild visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).	
Private Duty Nursing	Covered by Horizon NJ Health. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, to members on DDD Supports Plus PDN and to members with MLTSS (of any age).			
Prostate Cancer Screening	Covered by Horizon NJ Health. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.			
Prosthetics and Orthotics	Covered by Horizon NJ Health. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.			
Renal Dialysis	Covered by Horizon NJ Health.			
Routine Annual Physician Exam	Covered by Horizon NJ Health.		Covered by Horizon NJ Health. No copayments.	
Smoking/Vaping Cessation	Covered by Horizon NJ Health. Coverage includes counseling to help the member quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support the member in quitting smoking/vaping:			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	<ul style="list-style-type: none"> • NJ Quitline: Design a program that fits the member’s needs and get support from counselors. Call toll free 1-866-NJ-STOPS (1-866-657-8677) (TTY 711), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at njquitline.org. • NJ QuitNet: Free peer support and trained counselors, available 24 hours a day, seven days a week at quitnet.com. • NJ Quitcenters: Receive professional face-to-face counseling in individual or group sessions. Locate a center by calling 1-866-657-8677 (TTY 711) or visit quitnet.com. 			
Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)	Covered by Horizon NJ Health. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.			
Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)	<p>Covered by Fee-for-Service. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered.</p> <p>For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered.</p> <p>May require medical orders or other coordination by the health plan, PCP, or providers. MovidCare, “Transportation services are a covered for NJ FamilyCare B, C, or D members. All transportation including livery is available for all members including B, C and D.</p>			
Urgent Medical Care	Covered by Horizon NJ Health. Covers care to treat a sudden illness or injury that isn’t a medical emergency, but is potentially harmful to the member’s health (for example, if the doctor determines it’s medically necessary for the member to receive medical treatment within 24 hours to prevent the member’s condition from getting worse).		Covered by Horizon NJ Health. Covers care to treat a sudden illness or injury that isn’t a medical emergency, but is potentially harmful to the member’s health (for example, if the doctor determines it’s medically necessary for the member to receive medical treatment within 24 hours to prevent the member’s condition from getting worse). NOTE: There may be a \$5 copayment for urgent medical care provided by a physician, optometrist, dentist or nurse practitioner.	
Vision Care Services	Covered by Horizon NJ Health. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.		Covered by Horizon NJ Health. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. \$5 copayment per visit for Optometrist services.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Corrective Lenses	Covered by Horizon NJ Health. Covers 1 pair of lenses/frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.			

Translator Services

With just a call, Horizon NJ Health can provide language translator services for members during office visits. You, the provider, or members can request a translator at the time of service. In order to use translator services, the member must be actively enrolled with Horizon NJ Health, you must be a participating provider in the Horizon NJ Health network and the office visit must be for covered services.

Behavioral Health Benefits

Horizon NJ Health covers a number of Behavioral Health benefits for members. Behavioral Health includes both Mental Health services and Substance Use Disorder Treatment services. Some services are covered for members by Horizon NJ Health, while some are paid for directly by Medicaid Fee-for-Service (FFS). You will find details in the chart below.

When requesting prior authorization for Behavioral Health Services, members and providers should call the Interim Managing Entity at **1-844-276-2777** for services covered below under FFS and call Horizon NJ Health for all services below covered by the plan. The phone numbers to request prior authorization from Horizon NJ Health are as follows:

NJ FamilyCare: **1-800-682-9091**

DDD: **1- 877-695-5612**

MLTSS: **1-855-777-0123**

FIDE-SNP: **1-800-543-5656**

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health					
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered by Horizon NJ Health.	Covered by FFS.	<i>Not covered for NJ FamilyCare B, C, and D members.</i>		
Inpatient Psychiatric	Inpatient Psychiatric services are covered by Horizon NJ Health for members in DDD, MLTSS, or FIDE SNP.	Covered by Horizon NJ Health. — Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF) , or critical access hospital.			

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered by Horizon NJ Health.	Covered by FFS.			
Outpatient Mental Health	Covered by Horizon NJ Health.	Covered by FFS. Coverage includes services received in a General Hospital Outpatient setting, Mental Health Outpatient Clinic/Hospital services, and outpatient services received in a Private Psychiatric Hospital. Services in these settings are covered for members of all ages.			
Partial Care (Mental Health)	Covered by Horizon NJ Health.	Covered by FFS. Limited to 25 hour per week (5 hours per day, 5 days per week). Prior authorization required.			
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered by Horizon NJ Health.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.			
Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	Covered by FFS for all members.				
Substance Use Disorder Treatment	The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).				
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification ASAM 2 – WM	Covered by Horizon NJ Health.	Covered by FFS.			
Care Management	Covered by Horizon NJ Health.	Covered by FFS.			
Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital-based) ASAM 4 - WM	Covered by Horizon NJ Health.				
Long Term Residential (LTR)	Covered by Horizon NJ Health.	Covered by FFS. Clinically Managed Low-Intensity Residential Programs Level 3.1 programs are appropriate for patients whose recovery is aided by a time spent living in a			

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
ASAM 3.1 (Low Intensity)		stable, structured environment where they can practice coping skills, self-efficacy, and make connections to the community including work, education and family systems.			
Long Term Residential (LTR) ASAM 3.5 (High Intensity)	Covered by Horizon NJ Health.	Covered by FFS. Clinically Managed Residential Programs (high intensity for adults, medium intensity for adolescents). This gradation of residential programming is appropriate for individuals in imminent danger with functional limitations who cannot safely be treated outside of a 24-hour stable living environment that promotes recovery skill development and deters relapse. Patients receiving this level of care have severe social and psychological conditions. This level of care is appropriate for adolescents with patterns of maladaptive behavior, temperament extremes and/or cognitive disability related to mental health disorders.			
Office-Based Addiction Treatment (OBAT)	Covered by Horizon NJ Health. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.				
Mental Health					
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management ASAM 3.7 – WM	Covered by Horizon NJ Health.	Covered by FFS.			
Opioid Treatment Services	Covered by Horizon NJ Health.	Covered by FFS. Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment. Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1	Covered by Horizon NJ Health.	Covered by FFS.			
Substance Use Disorder Outpatient (OP) ASAM 1	Covered by Horizon NJ Health.	Covered by FFS.			
Substance Use Disorder Partial Care (PC) ASAM 2.5	Covered by Horizon NJ Health.	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) ASAM 3.7	Covered by Horizon NJ Health.	Covered by FFS.			

3.2 Exclusions for NJ FamilyCare A, ABP, B and C Without MLTSS

- All services not medically necessary, provided, approved or arranged by a Horizon NJ Health participating physician or other provider (within his/her scope of practice), except emergency services
- Any service or items for which the provider does not normally charge
- Any service covered under any other insurance policy or other private or governmental health benefit system or third-party liability
- Cosmetic surgery except when medically necessary and approved
- Experimental procedures, or procedures not accepted as being effective, including experimental organ transplants
- Infertility diagnoses and treatment services (including sterilization reversals and related medical and clinic office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures)
- Services provided by or in an institution run by the federal government, such as the Veterans Health Administration
- Respite care
- Rest cures, personal comfort, convenience items and services and supplies not directly related to the care of the patient. Examples include guest meals and phone charges
- Services in which health care records do not reflect the requirements of the procedure described or procedure code utilized by the billing provider
- Services involving the use of equipment in facilities in which its purchase, rental or construction has not been approved by the State of New Jersey
- Services furnished by an immediate relative or member of the beneficiary's household
- Services resulting from any work-related condition or accidental injury when benefits are available from any workers' compensation law, temporary disability benefits law, occupational disease law, or similar law
- Services or items provided or started while the covered person is on active duty in the military
- Services or items reimbursed based on submission of a cost study in which there is no evidence to support the costs allegedly incurred or beneficiary income to make up for these costs. If financial records are not available, a provider may verify costs or available income using other evidence that the NJ FamilyCare program accepts
- Services provided in an inpatient psychiatric institution that is not an acute care hospital, to individuals under 65 years of age and over 21 years of age
- Services provided outside the United States and territories
- Services provided to all persons without charge
- Services and items provided without charge through programs of other public or voluntary agencies shall be utilized to the fullest extent possible

Refer to horizonnjhealth.com/for-providers/resources/policies/reimbursement-policies-guidelines/telemedicine-and-telehealth, for details of the Telemedicine and Telehealth reimbursement policy.

3.2.1 Exclusions for NJ FamilyCare D Members

The following services are not covered for NJ FamilyCare D participants either by Horizon NJ Health or Division of Medical Assistance and Health Services (DMAHS):

- Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery
- Audiologist services, except for children under 16 years
- Biofeedback

- Blood and blood plasma, except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered
- Chiropractic services
- Cosmetic services
- Court-ordered services
- Custodial care
- Early and periodic screening, diagnostic and treatment (EPSDT) services (except for well-child care, including immunizations and lead screening treatments)
- Experimental and investigational services
- Hearing aid services for members over the age of 16
- Infertility services
- Intermediate care facilities for individuals with intellectual disabilities
- Medical day care services
- Non-medically necessary services
- Nursing facility services
- Orthotic devices
- Personal care assistant services
- Private duty nursing unless authorized by the contractor
- Radial keratotomy
- Recreational therapy
- Rehabilitative services
- Religious non-medical institutional care and services
- Residential treatment center psychiatric programs
- Respite care
- Self-initiated care without referral/authorization
- Sleep therapy
- Special remedial and educational services
- Thermograms and thermography
- Weight-reduction programs or dietary supplements, except surgical operations, procedures or treatment of obesity, when approved by Horizon NJ Health

3.2.2 MLTSS Services and Benefits

MLTSS services are provided by a network provider. The benefits provided, and the frequency and length of time they are provided depend on the medical, health and social needs of the member. A service is medically necessary if it is needed to prevent, diagnose, correct or cure conditions that may cause acute suffering, endanger life, result in illness, interfere with a member's capacity for normal activity, or may cause a serious handicap.

In addition to NJ FamilyCare A benefits, the following services may be available to MLTSS members:

- Adult Family Care
- Assisted Living Services
- Assisted Living Program
- Behavioral Health Services (including mental health and substance use disorder treatment)
- TBI Behavioral Management (Group and Individual)
- Chore Services
- Cognitive Therapy (Group and Individual)
- Community Residential Services
- Community Transition Services

- Home-Based Supportive Care
- Home-Delivered Meals
- Adult Day Health
- Pediatric Day Health
- Medication Dispensing Device
- Personal Care Assistant
- Non-Medical Transportation
- Nursing Facility Services (Custodial)
- Occupational Therapy (Group and Individual)
- Personal Emergency Response Systems
- Physical Therapy (Group and Individual)
- Private Duty Nursing (Adult)
- Residential Modifications
- Respite (Daily and Hourly)
- Social Adult Day Care
- Speech, Language and Hearing Therapy (Group and Individual)
- TBI-Structured Day Program
- TBI-Supported Day Services
- Vehicle Modifications

3.2.3 Horizon NJ TotalCare (HMO D-SNP)

Members enrolled in Horizon NJ TotalCare (HMO D-SNP) receive benefits for both Medicaid/NJ FamilyCare and Medicare Advantage and do not incur any cost sharing or copayments. Additional benefits available to these members include:

- Quarterly credit to purchase over the counter health items and certain medicines
- Special Supplemental Benefits for the Chronically Ill (SSBCI) funds to use to purchase healthy groceries and pay towards utility bills (must meet eligibility requirements to qualify)
- Access to additional funds by completing tests and screenings
- Free 24/7 Nurse Line
- Free Routine Podiatry Services (8 visits per year)
- A Personalized Horizon Care Management Plan of Care
- A broad network of participating physicians, specialists and hospitals.
- A care manager to assist in coordination of care and services
- No referrals required

3.3 Family Planning

Horizon NJ Health members are entitled to receive family planning services. Services that prevent or delay pregnancy are covered, including:

- Medical history and physical examination (including pelvic and breast)
- Diagnostic and laboratory tests
- Drugs and biologicals
- Medical supplies and devices
- Counseling
- Continuing medical supervision
- Continuing care and genetic counseling

Elective/induced abortions and related services are not covered under this contract, but will continue to be paid on a fee-for-service basis by Medicaid. Infertility diagnoses and treatment services, including sterilization reversals and related office (medical or clinical) drugs, laboratory, radiological and diagnostic and surgical procedures are not covered.

Hysterectomy is not a covered service if it is performed solely for the purpose of sterilization. Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. This service requires authorization. See Section 3.4 Obstetrical and Gynecological Care. Horizon NJ Health is available to assist members in locating family planning services. Members can access services through Horizon NJ Health's physician network or through participating Medicaid family planning providers (NJ FamilyCare D members may only access services through participating Horizon NJ Health physicians). Members may self-refer and go directly to a family planning clinic or call Horizon NJ Health directly. A Horizon NJ Health representative may coordinate family planning services for a member. Horizon NJ Health is responsible for payment of all claims related to family planning services when rendered by a participating physician, including voluntary sterilization, tubal ligation, vasectomy, or similar procedures having the purpose of pregnancy prevention. An HHS-687 Consent for Sterilization Form must be completed and signed by the member in advance of the sterilization procedures being performed. A copy of the consent form must be attached to the claim prior to submission to Horizon NJ Health.

A copy of the form can be printed from the Horizon NJ Health website. 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 not be a mentally incompetent person. Horizon NJ Health is responsible for the payment of claims from nonparticipating physicians. Family planning claims from participating providers should include the member's Social Security Number and be submitted to:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

All family planning services and supplies providers must enroll in the 21st Century Cures Act to receive reimbursement for services.

3.4 Obstetrical and Gynecological Care

Horizon NJ Health provides a full range of obstetrical and gynecological (Ob/Gyn) services to members.

Obstetrical and Gynecological Care Policy

Members may self-refer to a participating physician for routine Ob/Gyn services. NJ FamilyCare C and D members are responsible for a \$5 copayment for Ob/Gyn services unrelated to well visits, prenatal visits and Pap smears. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician's name, address and phone number.

The Obstetrician/Gynecologist will assume responsibility for referring the member to their PCP for medical services unrelated to the Ob/Gyn care.

Obstetrical and Gynecological Care Procedure

Ob/Gyn physicians should refer members and send specimens to the laboratory service center assigned to their office affiliated with Laboratory Corporation of America Holding (Labcorp), which is the exclusive contracted laboratory for Horizon NJ Health. Please refer to labcorp.com for the Labcorp Patient Service Center in your area.

CPT Codes for Ob/Gyn Services

For 1-3 Antepartum Care Visits, use E&M Codes.

All newly enrolled members must receive prenatal care within their first trimester or within 42 days of enrolling in Horizon NJ Health.

- 59425 Antepartum Care Only: 4-6 visits
- 59426 Antepartum Care Only: 7 or more visits

A Delivery claim should be billed by the delivery physician only.

- 59409 Regular Vaginal Delivery
- 59514 Cesarean Section Delivery Only
- 59612 Vaginal After Cesarean Delivery
- 59620 Vaginal After Cesarean Delivery

A postpartum visit must be completed between 21 and 56 days after delivery.

- 59430 Postpartum Care Visit Only

The following codes are used when billing for maternity support services:

Maternity Support Services

Code	Modifier	Description
99202-99215	HD	Appropriate evaluation/management (E/M) CPT code; Initial antepartum maternity health support services
59425 or 59426	None	Antepartum care only, report a single claim submission after the sessions have been completed
59409	HD	Regular vaginal delivery
59430	HD	Postpartum care visit only
59514	HD	Cesarean section delivery only
J2790	None	Rho (D) Immune globin, human

*HD modifier applies to HealthStar providers only

Non-Invasive Prenatal Testing

The informaSeqSM Prenatal Test is available via Labcorp for all pregnant members. This test uses a blood sample from the pregnant woman to look for fetal DNA and detects trisomies of chromosomes 21, 18 and 13 with a high degree of accuracy. Prior authorization will not be required. However, testing will only be covered for members meeting medical criteria. For more information about informaSeq, please call Labcorp at **1-800-631-5250**.

Newborn Biochemical Screening Testing

New Jersey has expanded its statewide system of newborn biochemical testing to include disorders that, if not detected early, can cause severe health problems, mental problems and even death. Hospitals submit newborn blood samples to the Department of Health and Senior Services' Public Health and Environmental Laboratories, which perform the tests.

Examples of disorders that are screened for in New Jersey are:

- Argininosuccinic aciduria
- Biotinidase deficiency
- Citrullinemia
- Congenital adrenal hyperplasia (CAH)

- Congenital hypothyroidism
- Cystic fibrosis
- Galactosemia
- Hemoglobinopathies
- Long chain acyl-CoA dehydrogenase (LCAD) deficiency
- Maple syrup urine disease (MSUD)
- Medium chain acyl-CoA dehydrogenase (MCAD) deficiency
- Phenylketonuria (PKU)
- Short chain acyl-CoA dehydrogenase (SCAD) deficiency
- Very long chain acyl-CoA dehydrogenase (VLCAD) deficiency

There is a critical need for timely medical evaluation, diagnostic laboratory testing, referral and treatment for these disorders. Appropriate diagnosis and management of infants with these disorders requires specialized and timely care. A physician should contact the UM department when a newborn has a positive laboratory result. Horizon NJ Health will contact the member to coordinate care.

**Utilization Management Department
1-800-682-9094**

Hysterectomy

Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189).

A copy of the form can be printed from the Horizon NJ Health website at horizonNJhealth.com. Horizon NJ Health requires that a properly completed FD-189 form be submitted during the request for precertification for all nonemergent hysterectomies. Claim payment for a hysterectomy without a copy of the Hysterectomy Receipt of Information form will be made only if the physician performing the hysterectomy certifies that:

- a) The woman was already sterile, stating the cause of that sterility; or
- b) The hysterectomy was required because of a life-threatening emergency situation. The physician must also include a description of the nature of the emergency.

Colposcopies

- Fee for service, if performed in a PCP office
- UM authorization is required if done in an outpatient setting (other than the Ob/Gyn office) by using the Utilization Management Request Tool or calling Pre-Cert at **1-800-682-9094**

Check to verify member eligibility by calling Provider Services at **1-800-682-9091** or through Horizon NJ Health Plan Central on NaviNet.

Delivery Claims

A gestational age diagnosis code (Z3A.XX) is required for professional and facility claims submitted for delivery services. This will become effective six months after the last day of the current public health emergency (date to be determined).

Claims submitted for early elective deliveries (prior to 39+0 weeks) also require an additional diagnosis code(s) to be considered medically necessary. A specific diagnosis code from one of the following series is required:

O10 O11 O12 O13 O14 O15 O16 O24 O30 O31
O33 O35 O36 O42 O43 O44 O45 O71 R03

If the delivery occurs prior to the 39th week of gestation, use the appropriate O60 series code.

3.5 Podiatry Services

When medically necessary, members are eligible for podiatry services. Members must be referred to a participating podiatrist by their PCP. Horizon NJ Health will reimburse podiatrists for the following X-rays performed in the office:

- X-ray ankle: 73600
- X-ray tibia AP & LAT: 73590
- X-ray ankle, complete: 73610
- X-ray foot AP & LAT views: 73620
- X-ray foot, complete, min 3 view: 73630
- Calcaneus, min 2 view: 73650

Routine foot care, including nail clipping, corn and callus removal and other hygienic care, such as cleaning or soaking feet, is covered only when medically necessary. NJ FamilyCare C and D members are responsible for a \$5 copayment for specialty care visits. Please issue a receipt to the member, upon collection of a copayment. This receipt should include the physician's name, address and phone number.

3.6 Chiropractic Care

Chiropractic care, when it meets medical necessity criteria, is limited to "manual manipulation of subluxation of the spine." CPT Codes 98940, 98941 and 98942 are eligible for reimbursement. Chiropractic services, including the initial visit and initial treatment. All subsequent treatments require prior authorization.

The following evaluation and management codes are only eligible for payment when billed during the initial office visit:

- 99201-99205

NJ FamilyCare C members are responsible for a \$5 copayment for chiropractic visits. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician's name, address and phone number. Chiropractic benefits are not covered for NJ FamilyCare D members.

3.7 Organ Transplants

Donor and recipient costs for non-investigational and non-experimental organ transplants are reimbursable by Horizon NJ Health. Eligible organ transplants include, but are not limited to:

- Bone marrow
- Cornea
- Heart
- Heart/lung
- Intestine
- Kidney (For FIDE-SNP members, as of 2021, this is paid for by FFS Medicare)
- Liver
- Lung
- Pancreas

All costs associated with the procurement and transplantation of organs for eligible members are covered by Horizon NJ Health. The PCP will coordinate all transplant services with the specialty care physician. The specialty care physician must obtain an authorization for services through the Utilization Management Request Tool on NaviNet.

3.8 Hospice Care

The PCP or the requesting provider must submit a request through the Utilization Management Request Tool to arrange for hospice care.

A PCP who prescribes a hospice program for a member must discuss with the member and their family the status of an advance directive or “living will.” Review Section 12.21 for more information. Horizon NJ Health’s physicians are encouraged to review the guidelines published by the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care. The guidelines can be viewed at horizonNJhealth.com.

3.9 Durable Medical Equipment (DME) and Medical Supplies

Horizon NJ Health will provide benefits for DME and medical supplies when medically necessary and approved.

- If the billed charge of the non-rental item is less than \$250, the participating provider may dispense the item without prior authorization from Horizon NJ Health, with the exception of enteral formula, which requires an authorization regardless of billed charges. Provisions have been made for participating network pharmacies to dispense certain DME and medical supplies when written on a prescription.
- If the billed amount of the claim is equal to or greater than \$250, authorization must be obtained from the Horizon NJ Health UM department before the item is dispensed. To receive authorization, the requesting provider must submit a request using the Utilization Management Request Tool or call Provider Services at **1-800-682-9091**.
- All rental items require authorization.

Certain DME/medical supply items require the completion of a letter of medical necessity prior to authorization.

3.10 Prosthetics/Orthotics

Participating providers may dispense prosthetic/orthotic devices to members when medically necessary. Prosthetics require a signed and dated prescription from the prescribing physician. All repair and replacement of parts for custom-made prosthetic devices require a signed and dated prescription.

Prosthetic devices are limited to the initial provision for NJ FamilyCare members. Repair and replacement services are covered when due to congenital growth. Prosthetics are limited to the initial provision of a prosthetic device for NJ FamilyCare D members.

Orthotic Devices

Orthotic devices for members are preauthorized by Horizon NJ Health. Orthotics require a signed and dated prescription from the prescribing physician. All repair and replacement of parts for custom-made orthotic devices require a signed and dated prescription from the physician. If the billed charge for the purchase, repair or replacement of parts is under \$500 and the provider is participating, no prior authorization from Horizon NJ Health is required. If the billed charge for the purchase, repair or replacement of parts is equal to or greater than \$500, prior authorization is required. Orthotics and orthotic devices are not a covered benefit for NJ FamilyCare D members.

3.11 Home Health Care

When medically appropriate, Horizon NJ Health encourages the use of home health care services as an alternative to hospitalization to allow early hospital discharge, avoid unnecessary admissions and allow the member to receive care in familiar surroundings. Among the home health care services covered are the following:

- Home care visits for prenatal and postpartum needs
- IV therapy
- Lead outreach
- Occupational therapy
- Physical therapy
- Private duty nursing for members under age 21
- Skilled nursing
- Social work
- Speech therapy

Horizon NJ Health's UM department shall coordinate all medically necessary home care. The UM department will review each case to assess and authorize the length or type of service required. An authorization number will be assigned and should appear on all bills submitted for preauthorized services provided to the member.

Home care agencies receiving requests to provide care must contact the UM department to verify eligibility and benefit availability and obtain authorization for services prior to providing the service, except in emergency circumstances.

Payment of a maternity/postpartum or health management home visit is contingent upon our receipt of the assessment. If you need a copy of the assessment form, please call the Utilization Management department at **1-800-682-9094**.

An authorization is given for each service type requested. However, the authorization number may be updated for continuance of any service, which will extend beyond the initial approval period. Contact should be made at least five days prior to the end date of the original authorization.

Physician orders and care plans need not be submitted with claims for home care services; however, the physician must keep such information on file for presentation to Horizon NJ Health's UM department, if requested. All claims submitted by the Home Care provider that include DME or pharmaceutical supplies must be accompanied by a physician-issued prescription. All claims submitted are subject to eligibility and benefit availability.

Private-duty nursing services require authorization in all instances. They are an EPSDT benefit and covered for children who meet the EPSDT age requirement. They are not a covered benefit for NJ Family Care D members, unless authorized by Horizon NJ Health. For more information, please call the UM department.

For NJ FamilyCare D members, home health services are limited to skilled nursing visits for homebound beneficiaries when provided or supervised by a registered nurse and home health aide, when the purpose of the treatment is skilled care and medical social services necessary for treatment of medical condition.

3.12 Personal Care Assistant Services

Personal care assistant service is available to members with Medicaid and NJ Family Care Plans A and ABP. This service provides hands-on personal care to members, including bathing, grooming and toileting. A nurse completes an assessment to determine care needs based on the member's functional status, and members who qualify are authorized for a specific number of service hours per week.

The State of New Jersey, Division of Medical Assistance and Health Services (DMAHS) requires the reporting of electronic visit verification (EVV) data to the data aggregator determined by DMAHS for personal care assistance services. Providers of these services should consult <https://hhaexchange.com/nj-dmahs/> for more specific information on reporting requirements, provider types impacted, specific codes requiring EVV and formats to transmit EVV information to the State's data aggregator or contact edisupport@hhaexchange.com for additional questions and support. You may also reference our website for [Frequently Asked Questions](#) regarding EVV requirements.

For EVV Aggregator Technical Support and Questions:

- CareBridge Users: **1-855-782-5976**; njevv@carebridgehealth.com
- Third-Party EVV Solutions Integrated with CareBridge: **1-844-924-1755**; evvintegrationsupport@carebridgehealth.com

3.13 Medical Day Care Services

Medical day care service is available to members with Medicaid and NJ FamilyCare A and ABP. This is a facility-based service for medical care for children and adults. Preauthorization is required following an assessment to determine medical needs. For Medical Day Care/Personal Care Assistant authorizations, please call **1-800-682-9094, x81364** (fax: **1-609-583-3048**).

3.14 Therapeutic Services

The following outpatient therapeutic services are covered by Horizon NJ Health:

- Physical therapy
- Speech/pathology services
- Occupational therapy
- Cognitive rehabilitation, limited to those with an identifiable event

For outpatient physical and occupational therapy, participating providers do not need an authorization for the initial evaluation. After the initial evaluation is completed, the provider needs to request authorization for initial visits through the Utilization Management Request Tool. The UM department will process the request based on the clinical information provided. Follow-up requests for additional authorizations, such as those for daily treatment notes or flow sheets, will require proof that all previously authorized visits have been completed.

Participating providers must be licensed by the state in their respective disciplines in order to provide these services. Further treatments must also be coordinated by the treating provider(s) and authorized by the UM department. There are limitations for speech and cognitive therapy for NJ FamilyCare D members.

Audiology

Under this program, certain members are eligible for audiology services. Audiology services are not a covered benefit for NJ FamilyCare D members. The audiologist must send a copy of the completed initial evaluation to the PCP. The PCP and the audiologist will discuss the recommended treatment plan for medically necessary treatment.

Further treatments must also be coordinated by the PCP and authorized by the Utilization Management department.

Utilization Management Department
1-800-682-9094

3.15 Vision Care

Davis Vision administers the vision care benefit for Horizon NJ Health members, including vision exams, eyeglasses, corrective lenses and contact lenses, if prescribed. Members may self-refer and go directly to a participating Davis Vision provider.

If a condition that requires further treatment is detected during the annual exam, the PCP must be contacted. A network optometrist or ophthalmologist may provide treatment for eye disorders that requires specialized attention beyond the routine services provided by a Davis Vision provider.

Davis Vision optometrists or ophthalmologists rendering therapeutic services as a result of a routine visit must contact Davis Vision to obtain an authorization.

If you are a Davis Vision provider, please contact Davis Vision at **1-800-773-2487** to verify eligibility and to obtain a comprehensive Davis Vision Physician Manual.

NJ FamilyCare C and D members are responsible for a \$5 copayment for optometry visits. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician's name, address and phone number.

3.16 Dental Services

Horizon NJ Health offers comprehensive dental services to NJ FamilyCare A, B, C, D, and ABP members as well as MLTSS members and Horizon NJ TotalCare (HMO D-SNP) members. These groups have an identical dental benefit. These services include preventive, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgical, and adjunctive dental services. Some procedures require prior authorization. When necessary, orthodontic services are age-restricted (covered for members under 21 years of age or as allowed by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and only approved with adequate documentation of medical necessity. Referring a member to a dentist by 1 year of age is mandatory. Except for diagnostic and preventive dentistry services, NJ FamilyCare C and D members are responsible for a \$5 copayment for dental services.

3.16.1 Medical versus Dental Services

Horizon NJ Health recognizes that medical conditions may exist that can exhibit one or more dental components. These dental components/conditions may be 1) causative to the medical situation of the patient, 2) completely unrelated, or 3) the sequelae of the medical condition or its treatment. A physician or oral surgeon may perform procedures that may be considered medical or dental (e.g., surgical procedures for fractured jaw, removal of cyst, or provision of maxillofacial prosthetics).

For more information on how Horizon NJ Health administers benefits for conditions with both medical and dental components, please consult Appendix D, Section H (Medical Versus Dental Services).

3.16.2 Fluoride Varnish Provider Incentive Program

This program encourages trained non-dental providers in pediatric practices during and well-child visit for children through the age of 5 to apply fluoride varnish for children's teeth, perform caries risk assessments and anticipatory guidance, and refer young dental members to a dental home.

See additional information in Appendix D.

3.17 Behavioral Health (including mental health and substance use disorder treatment)

Horizon NJ Health's participating physicians will systematically identify and address behavioral health needs for all Horizon NJ Health members at the earliest possible time following initial enrollment with Horizon NJ Health

or after the onset of the condition, through a behavioral health screening tool administered by the member's PCP. PCPs and other physicians are to utilize screening tools, as well as other mechanisms, to facilitate early identification of behavioral health needs for treatment. For your reference, the Well-Being Screening Tool has been posted to horizonNJhealth.com.

Coordination of medical care and behavioral healthcare is a best practice model. Collaboration improves the quality of care for members and Horizon collects data on the accuracy, sufficiency, timeliness and frequency of information exchange between medical and behavioral health providers.

Horizon NJ Health is responsible for managing the behavioral health benefits for members of our DDD, MLTSS and FIDE-SNP programs. Horizon NJ Health is also responsible for managing the acute inpatient behavioral health benefits for all of our Medicaid members, while the State manages the non-acute behavioral health benefits through the NJ Medicaid Fee-for-Service program. Horizon NJ Health PCPs refer non-DDD, non-MLTSS and non-FIDE-SNP members to a NJ Medicaid Fee-for-Service behavioral health professional.

Horizon NJ Health's Care Management Department can coordinate the behavioral health services for DDD, MLTSS and FIDE-SNP members with the PCP, the Horizon Behavioral Health program and its professional network.

Horizon Behavioral Health can be contacted at **1-800-682-9094**.

Organizational Structure

- Manager – GP
 - Supervisor, After Hours BH
 - Clinicians
 - Managed Care Coordinators (MCC)
- Supervisor, CCR/MA CM/FAH
 - BH Clinicians
 - MCCs
- Supervisor, Prior Auth/OP
 - MCCs
 - BH Clinicians
 - BH Psych Clinician

The PCP will perform a medical diagnostic work-up to formulate a diagnosis or effect the treatment of a behavioral health disorder and ongoing medical care for any member with a behavioral health diagnosis, as well as to coordinate the care with the behavioral health professional. This includes physical examinations, neurological evaluations, laboratory testing and radiologic examinations and any other diagnostic procedures necessary to make the diagnostic determination between a primary behavioral health disorder and an underlying physical disorder, as well as for medical work-ups required for medical clearances prior to the provision of psychiatric medication or electroconvulsive therapy (ECT), or for transfer to a psychiatric/substance use disorder facility.

Behavioral health services include, but are not limited to, comprehensive intake evaluation, offsite crisis intervention, family therapy, family conference, psychological testing and medication management.

Any member may be referred to a behavioral health professional by the PCP and other physicians, family members, state agencies or Horizon NJ Health, or a member may self-refer. The PCP must notify the behavioral health professional of the medical examination and diagnostic testing results within 24 hours of receipt for urgent

cases and five business days of receipt for non-urgent cases. The PCP should notify the behavioral health professional by phone with follow up in writing, when feasible.

Providers in need of assistance identifying applicable specialists should call Provider Services at **1-800-682-9091**. Providers in need of assistance in coordinating care for non-urgent cases can call our Care Management Department at **1-800-682-9094 x89634**. Urgent cases should call **1-800-682-9090**.

Diagnoses that are categorized as altering the mental status of an individual, but are of organic origin, will be eligible as a covered service under Horizon NJ Health. Horizon NJ Health will assume responsibility for the provision of medical care in these cases for all members. This includes, but is not limited to, the diagnoses in the following ICD-10-CM series:

- F03.90 Senile dementia, uncomplicated
- F03.90 Presenile dementia, uncomplicated
- F03.90 Presenile dementia with delirium
- F03.90 Presenile dementia with delusional features
- F03.90 Presenile dementia with depressive features
- F03.90 Senile dementia with delusional or depressive features
- F03.90 Senile dementia with delusional features
- F03.90 Senile dementia with depressive features
- F03.90 Senile dementia with delirium
- F01.50 Vascular dementia, uncomplicated
- F01.51 Vascular dementia with delirium
- F01.51 Vascular dementia with delusions
- F01.51 Vascular dementia with depressive mood
- F03.90 Other specific senile psychotic conditions
- F03.90 Unspecified senile psychotic condition
- F10.26 Alcohol-induced persisting amnestic disorder
- F10.27 Alcohol-induced persisting dementia
- F13.27 Drug-induced persisting dementia
- F13.26 Drug-induced persisting amnestic disorder
- F11.19 Unspecified drug-induced mental disorders
- F05 Acute delirium due to conditions classified elsewhere
- F05 Subacute delirium
- F06.2 Transient organic psychotic condition, paranoid type
- F06.0 Transient organic psychotic condition, hallucinatory type
- F06.30 Transient organic psychotic condition, depressive type
- F06.4 Organic anxiety syndrome
- F04 Amnestic syndrome
- F06.0 Other persistent specified organic brain syndromes
- F06.1 Other persistent specified organic brain syndromes
- F06.8 Unspecified, persistent organic brain syndrome
- F17.200 Tobacco use disorder
- F17.201 Tobacco use disorder
- F17.210 Tobacco use disorder
- F17.211 Tobacco use disorder
- F17.220 Tobacco use disorder
- F17.221 Tobacco use disorder
- F17.290 Tobacco use disorder

- F17.291 Tobacco use disorder
- F07.0 Frontal lobe syndrome
- F07.81 Postconcussion syndrome
- F07.9 Unspecified, nonpsychotic mental disorder following organic brain damage
- F09 Unspecified, nonpsychotic mental disorder following organic brain damage

Horizon Behavioral Health can be contacted at **1-800-682-9094**.

3.17.1 Behavioral Health Well-Being Screening Tool

PCPs are required to assess the behavioral health needs of enrolled members. To help facilitate your assessment, please use the Well-Being Screening Tool as a screening tool to assess early identification of behavioral health needs for each Horizon NJ Health member prior to treatment. A copy of the form can be printed from the Horizon NJ Health website at horizonNJhealth.com. A copy of the completed questionnaire should be placed in the member's medical record. If a behavioral health need is identified, please refer the member for behavioral health services, as indicated below.

For non-emergent behavioral health services regarding DDD, FIDE-SNP and MLTSS members:

- Providers may call Horizon NJ Health's Care Management Department at **1-800-682-9094 x89634**. Our Care Management Department will coordinate the behavioral health services for DDD, FIDE-SNP and MLTSS.
- Physicians and/or members may call Horizon Behavioral Health toll free at **1-800-682-9094**. A representative is available 24 hours a day, seven days a week, to coordinate behavioral health services for DDD, FIDE-SNP or MLTSS members.

For non-emergent behavioral health services for members not in the DDD, FIDE-SNP or MLTSS programs:

- Call or refer the Horizon NJ Health member to the interim managing entity (IME) at **1-800-382-6717**.

3.17.2 Applied Behavioral Analysis

Horizon NJ Health will begin covering Applied Behavioral Analysis (ABA) for all eligible members under age 21 diagnosed with autism spectrum disorder (ASD). ABA is an evidenced-based practice administered by Board Certified Behavioral Analysts (BCBAs) and other qualified paraprofessionals devoted to developing skills in individuals with ASD to produce adaptive and observable changes in behavior.

Coverage of all medically-necessary ABA services is available for Medicaid Fee-for-Service, MLTSS, FIDE-SNP and DDD eligible beneficiaries under the age of 21. ABA services may be provided in the therapist's office, a community setting or the member's home.

ABA services should be billed using the following HIPAA compliant HCPCS codes:

97151 Behavior identification assessment:

- Administered by a physician or other qualified health care professional (QHP)
- Every 15 minutes of the physician's or other QHP's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and
- Non-face-to-face analyzing past data, scoring/interpreting the assessment and preparing the report/treatment plan

97152 Behavior identification supporting assessment:

- Administered by one technician under the direction of a physician or other QHP

- Face-to-face with the patient, every 15 minutes 97153 Adaptive behavior treatment by protocol:
- Administered by a technician under the direction of a physician or other QHP
- Face-to-face with one patient, every 15 minutes

97154 Group adaptive behavior treatment by protocol:

- Administered by a technician under the direction of a physician or other QHP with two or more patients, every 15 minutes

97155 Adaptive behavior treatment with protocol modification:

- Administered by a physician or other QHP, which may include simultaneous direction of a technician
- Face-to-face with one patient, every 15 minutes

97156 Family adaptive behavior treatment guidance:

- Administered by a physician or other QHP (with or without the patient present)
- Face-to-face with guardian(s)/caregiver(s), every 15 minutes

97157 Multiple-family group adaptive behavior treatment guidance:

- Administered by a physician or other QHP (without the patient present)
- Face-to-face with multiple sets of guardians/caregivers, every 15 minutes

97158 Group adaptive behavior treatment with protocol modification:

- Administered by a physician or other QHP
- Face-to-face with multiple patients, every 15 minutes

0362T Behavior identification supporting assessment, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components:

- Administered by the physician or other QHP who is on-site, with the assistance of two or more technicians
- Patient exhibits destructive behavior
- Environment is customized to the patient's behavior

0373T Adaptive behavior treatment with protocol modification, every 15 minutes of technicians' time face-to-face with a patient, requiring the following components:

- Administered by the physician or other QHP who is on site with the assistance of two or more technicians
- Patient exhibits destructive behavior
- Environment is customized to the patient's behavior
- Billed by the QHP for treatment guidance services provided to a family with an autistic child with the child present.
- Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior.
- The provider may bill for each set of parents/caregivers once.

96170EP–96171EP are billed by the QHP for treatment guidance services provided to a family with an autistic child without the child present. Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior. The provider may bill for each set of parents/caregivers. In the event of two autistic children with the same parents/caregivers, you would only allow billing for the parents or caregivers once.

3.17.3 Developmental, Individual Difference, Relationship-based (DIR)

In 2020, Horizon NJ Health began covering Developmental, Individual Difference, Relationship-based (DIR) for any eligible member under age 21 diagnosed with autism spectrum disorder. DIR is offered as an alternative to Applied Behavioral Analysis and provides a foundation for understanding human development and the role of social and emotional development. The need for DIR services must be made by a Qualified Health Professional (QHP) and DIR treatment plans must be developed by QHPs who have specialized training, endorsement and certification in one of the following:

- DIRFloortime® Advanced Practitioner
- NJAIMH – Level II and IV Infant Mental Health Endorsed – Alliance for IMH
- Clinical, Developmental Models of Autism Intervention- DMAI
- Certificate of the Center for Autism and Early Childhood Mental Health,
- Early Start Denver Model (ESDM)
- Relationship Development Intervention (RDI)
- Licensed Independent Practitioner-LCSW, LPC, LMFT

In addition, providers must also be licensed in New Jersey in one of the following:

- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Psychologist
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Associate Counselor (LAC)
- Licensed Occupational Therapist (OT)
- Licensed Social Worker (LSW)
- Licensed Clinical Professional Counselor (LCPC)
- Masters Level or a Baccalaureate degree under the supervision of a licensed independent practitioner

DIR services should be billed using the following HIPPA compliance HCPCS codes:

96156EP

- Used for billing for development of the initial assessment and development of a treatment plan as well as reassessment and progress reporting by the QHP.
- Allowable activities include face-to-face time with the patient and/or caregivers to conduct assessments as well as non-face-to-face time for reviewing records, scoring and interpreting assessments, and writing the treatment plan or progress report.

96158EP-96159EP

- Are provided individually, by or under the direction of, a QHP.

96164EP-96165EP

- Billed for QHP group-led sessions for a minimum of 2 individual patients to a maximum of 8 individual patients.
- Billing is made for each child in the group session.

96167EP–96168EP

- Billed by the QHP for treatment guidance services provided to a family with an autistic child with the child present.

- Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior.
- The provider may bill for each set of parents/ caregivers once.

96170EP–96171EP are billed by the QHP for treatment guidance services provided to a family with an autistic child without the child present. Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior. The provider may bill for each set of parents/caregivers. In the event of two autistic children with the same parents/caregivers, you would only allow billing for the parents or caregivers once.

3.17.4 Office Based Addiction Treatment Program

The Division of Medical Assistance and Health Services, in collaboration with the Division of Mental Health and Addiction Services, launched a program to cover and support Medication Assisted Treatment (MAT) and Office Based Addiction Treatment (OBAT). This program coordinates the delivery of multiple reimbursable services provided by prescribers to NJ FamilyCare members with substance use diagnoses, including opioid, alcohol and poly-substance abuse. Prescribers are not limited to PCPs but any physician or advanced practice nurse with DATA 2000 waiver, such as: NJ licensed physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetist (CRNAs) and Certified Nurse-Midwives (CNMs) who are DATA 2000 waived and practicing under their professional license.

Prescribers and navigators work as a team to provide integrated care that ensures the patient’s psychosocial needs are being addressed; OBAT offices are required to have navigators available to provide service but the patients are not required to accept the navigation service in order to access MAT.

A navigator is a licensed healthcare provider acting within his or her scope of practice under state law or an individual with a baccalaureate degree and at least two years of lived experience **or an associate’s degree or certified medical assistant and four years of lived experience**. Navigators utilize experiential knowledge, skills and coaching to guide and assist beneficiaries to obtain, and maintain, services designed to assist them maintain recovery.

Contact your Provider Representative if would like to participate.

For more information on the OBAT program, please call Provider Services at **1-800-682-9091** or review the resources below.

- New Jersey Medication-Assisted Treatment (NJ MAT) Centers of Excellence (CoE) resources:
 - Provider Hotline: 24/7 access to advice from MAT experts for providers who have any clinical questions about MAT. Call or text **1-844-HELP-OD (1-844-435-7683)**.
 - [Northern NJ MAT CoE](#)
 - [Southern NJ MAT CoE](#)
 - [OBAT Provider Manual](#)
- [Camden Coalition](#): Navigator training, support and resources

You can take advantage of [training opportunities](#) to become DATA 2000 waived and participate in this OBAT model when you receive your DATA 2000 waiver status.

3.18 Outpatient Laboratory Services

All physicians must utilize the exclusive clinical laboratory provider for Horizon NJ Health when studies are required for members. Horizon NJ Health contracts with Laboratory Corporation of America Holdings (Labcorp) for laboratory services.

Physicians are responsible for notifying members of laboratory results. For additional information, contact Provider Services at **1-800-682-9091**.

Short Turn-Around Time (STAT) Requests

Labcorp provides STAT lab services Monday through Friday from 8 a.m. until 6 p.m. Saturday hours are from 8 a.m. until 4:30 p.m. Labcorp will notify practitioners and follow up with the results for office-based lab draws as soon as the results are available. STAT turn-around time begins when the call is placed for office-based lab draws. Labcorp's goal is to provide STAT results within four hours of the request for pick-up. Labcorp will notify the physician after hours of the test results and will follow the critical panic and alert protocol.

Labcorp Alert and Panic Results Policy

Labcorp's Alert Results Policy allows clients to customize their alert preferences based on practice needs. Labcorp recognizes that the physician can best determine the alert settings for his or her office setting.

Alert Results (excessively abnormal test results). Physicians may want the clinical laboratory to notify them whenever a test result is excessively abnormal, although not life threatening. Labcorp calls these alert laboratory results to the physician on weekdays during normal business hours.

Panic Results (potentially life-threatening laboratory results). As mandated by federal law and regulatory agencies, Labcorp phones these panic laboratory results to the physician as soon as they are verified, 24 hours a day, seven days a week. If you wish to customize the alert values that you want called or modify alert values previously set, please contact your Labcorp representative or call Labcorp Customer Service at **1-800-745-0233**.

It is important to remember that if your practice is set up with Labcorp to receive only final reports, no printed results will be sent until all testing has been completed. For example, if you order a prothrombin time/international normalized ratio (PT/INR) and a routine urine culture for a patient, you will not receive the results of the PT/INR until the urine culture result is finalized. With customized alert values, you will be advised of any excessively abnormal results without having to wait for all other testing to be completed.

Urgent/Emergent Results

Members must be notified of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases. Urgent/emergent appointment standards must be followed. See Section 12.18 Appointment Scheduling Standards. Rapid strep test results must be available to the member within 24 hours of the test.

Routine Results

Members must be notified of routine laboratory and radiology results within 10 business days of receipt of the results.

Routine testing related to the administration of methadone and atypical antipsychotic drugs and their generic equivalents are covered by Horizon NJ Health.

To facilitate outpatient laboratory services, be sure to follow the procedures identified below:

- Horizon NJ Health encourages physicians to perform venipuncture in their office. Physicians should contact Labcorp to arrange for pick-up services.
- Participating physicians who cannot perform venipuncture in their office should send members to the nearest Labcorp Patient Service Center. Please refer to the Provider Directory for a listing of the laboratory service centers in your area or call the Provider Services for assistance. A completed Labcorp

requisition form must accompany the member to the service center. Please contact Labcorp to obtain laboratory requisition forms.

Preadmission laboratory testing (PAT) should be completed by the PCP through Labcorp. However, if it is not possible to work through Labcorp, testing can be completed at the hospital where the procedure will be provided. A list of STAT, PAT and pathology tests is provided on the following page. Horizon NJ Health will not remit payment to hospitals, physicians or other laboratories for lab services that should be rendered by Labcorp.

**Labcorp Customer Service
1-800-631-5250**

NJ FamilyCare D members are responsible for a \$5 copayment when the laboratory service is not part of an office visit.

Horizon NJ Health STAT and PAT Testing Menu			
CPT Code	Test Name	PAT	STAT
CHEMISTRIES			
82947	Blood glucose, NOT test strip	X	
84520	BUN, serum	X	
80053	Comprehensive metabolic panel	X	
82565	Creatinine, serum	X	
80051	Electrolyte panel	X	
82247, 82248	Bilirubin, indirect and direct (newborns only)	X	X
ENDOCRINE and Ob/Gyn			
84703	Beta hCG, qualitative	X	
84702	Beta hCG, quantitative	X	X
85060	Blood smear, provider evaluated	X	
85004	CBC and differential, automated	X	X
85007	CBC and differential, manual	X	X
85027	CBC, differential w/ platelet count, automated	X	
85610	Blood clotting tests, various	X	X
85730	Investigation of blood transfusion reaction	X	
86900	Blood typing, various tests	X	X
URINE ANALYSIS			
81000 TO 81050	Urine analysis, varied tests	X	X
DRUG ANALYSIS			
80162	Digoxin	X	X
OTHER PATHOLOGY			
87164	Dark field exam POS 11 (unless otherwise specified by contract)		
87210	Wet mount with simple stain POS 11 (unless otherwise specified by contract)		
87177	Ova and parasites; direct POS 11 (unless otherwise specified by contract)		
87220	Tissue exam for fungi POS 11 (unless otherwise specified by contract)		
89050	Cell count, misc. body fluids POS 11 (unless otherwise specified by contract)		
89051	With different count POS 11 (unless otherwise specified by contract)		

Completing Labcorp Requisition Forms

Horizon NJ Health physicians are reminded to completely and legibly fill out the required information on the Labcorp requisition form. This will ensure that claims and payments for services provided by Labcorp are processed in the most efficient manner and will eliminate the potential for our members to be billed for laboratory services. The Insurance section must include correct and legible information in the following fields:

- Insurance Company Name: Horizon NJ Health
- Subscriber/Member #: Horizon NJ Health patient's ID number

Physicians may refer to the Labcorp website at labcorp.com for more testing information and locations of patient service centers.

Relevant Labcorp Information

- Please remember to use the correct form for Labcorp lead testing
- Please utilize the Heavy Metal Request form and indicate the source of the blood (venous or capillary)
- You can order these forms from the Labcorp Customer Service line: **1-800-631-5250**
- Labcorp will customize this form with your physician information. Labcorp can also customize this form to include any other labs you may wish to include at your request. For example, if you routinely ask for a hemoglobin and hematocrit with a lead screen, you can ask Labcorp to add this test to the Heavy Metal Request form for you. You could also add CBC and urinalysis to coordinate your EPSDT lab requirements.

3.19 Pharmacy Services

Medically necessary prescriptions are a covered benefit for most Horizon NJ Health members. Pharmacy services (legend and non-legend) for dual eligible (Medicare and Medicaid) members are mostly covered by Medicare Part B or D, except for certain wrap-around services (e.g., prescription vitamins [except prenatal vitamins and fluoride preparations]).

Many over-the-counter drugs and medical supplies are also covered when ordered with a written prescription. Horizon NJ Health requires that physicians prescribe generic medications whenever possible. If the brand name is prescribed when there is a generic alternative, you will be required to obtain prior authorization and prove medical necessity. Non-covered pharmacy benefits include but are not limited to the following: fertility medications, weight loss drugs, drugs to treat alopecia, topical agents for members 35 years old and older such as tretinoin and adapalene products, erectile dysfunction medications, and active pharmaceutical ingredients (APIs) and excipients used to compound prescriptions as covered outpatient drugs.

If a provider requests prior authorization for a formulary or non-formulary medication, a 72-hour supply of that medication may be provided to the member. Determinations for prior authorizations will be provided within 72 hours.

To request prior authorization, fill out a [medical necessity form located on our website](#). Here you can also find the [Horizon NJ Health Medical Policy Manual](#). Click the Drugs link to find detailed information about prior authorization determinations for specific drugs. Find more information about our [Pharmacy Utilization Management programs here](#).

Members should be directed to pharmacies that participate in the Horizon NJ Health network. When filling a prescription, the member will be required to present their member ID card to the participating pharmacy. See the Provider Directory for a list of participating pharmacies. NJ FamilyCare A, NJ FamilyCare ABP, and NJ

FamilyCare B members do not have copayments for generic and brand-name medications. NJ FamilyCare C and NJ FamilyCare D members have a \$1 copayment for generic drugs and a \$5 copayment for brand-name medications.

For NJ FamilyCare D members, if a supply of more than 30 days is provided, a \$10 copayment applies. In general, Horizon NJ Health allows up to a 30-day supply. For the MLTSS population currently residing in a LTC facility, there is generally a maximum of a 14-day supply of medication eligible for coverage. A supply of greater than 14 days is permitted for certain unit of use medications (e.g., ophthalmic drops). In addition, the use of institutional-sized drug products, for example, insulin, will be utilized where available for those members residing in a LTC facility. The Pharmaceutical Utilization Management (UM) Programs help ensure access to medically necessary and appropriate, cost-effective drug therapy.

The goal of the formulary is to provide cost-effective pharmacotherapy based on prospective, concurrent and retrospective review of medication therapies and utilization. The medications included in the formulary are reviewed and approved by the Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Horizon NJ Health provider community.

The Formulary List is updated annually and as changes are made or new medications approved. The Formulary List is updated as of the date that formulary changes are put in place. Changes to the Formulary List are included in the provider newsletter mailed to all providers.

Pharmacy/Provider Lock-in Program

Horizon NJ Health reserves the right to lock its members into specific pharmacies when it has been determined that the member has inappropriately used his/her pharmacy benefit or when enhanced benefit coordination is necessary. Horizon NJ Health members must use in-network, contracted pharmacies in the State of New Jersey to get their prescriptions filled. Horizon NJ Health members must use in-network, contracted Pharmacies in the State of New Jersey to get their prescriptions filled. For more information about the Pharmacy/Provider Lock-in Program, please contact Provider Services at **1-800-682-9091**.

Immunizations and Routinely Administered Parenteral Drug Therapies

PCPs should supply and administer all immunizations and routinely administered parenteral drug therapies in their office. As long as a claim is submitted on a timely basis, PCPs will be reimbursed for some of these medications above capitation.

The Vaccines for Children Program (VFC) provides all standard immunizations for individuals under age 19 with NJ FamilyCare coverage; therefore, your office will not be reimbursed for these drugs if the member has NJ FamilyCare Plan A coverage, but will be paid an administration fee. The specific CPT-4 code for the vaccine(s) given must be entered on the claim form.

Outpatient Drug Benefit Injectables

If the prescribing physician will be administering an injectable medication on an outpatient basis only, the physician may write a prescription and have the member pick it up and bring it to the office when appropriate, or the physician may contact the pharmacy and arrange to have the injectable delivered to the office. In addition, the physician is encouraged to contact one of Horizon NJ Health's preferred injectable providers:

Caremark at **1-800-237-2767** or Accredo at **1-800-803-2523**

If the member is utilizing a self-injecting medication for use on an outpatient basis only, the member can obtain the injectable at a participating pharmacy with a written prescription.

Formulary

Horizon NJ Health uses a formulary to promote the prescribing of the most cost-effective products in each therapeutic category. In some cases, it may be appropriate to use an over-the-counter (OTC) product. The pharmacy benefit provides coverage for a wide range of OTC products (see below). OTC products require a written prescription from the physician. For members residing in a long-term care facility, OTC medications are generally provided by the institution, rather than via the Horizon NJ Health pharmacy benefit.

Covered OTC Drugs (prescription is required)

- Alaway
- Analgesics
- Antacids
- Antidiarrheals
- Antiflatulents
- Antinauseants
- Blood glucose monitors
- Budesonide (Tarpeyo)
- Contraceptives
- Cough and cold meds
- Cysteamine Products
- Diabetic test strips
- Diagnostic agents for diabetes
- Differin OTC
- Elapegademase-lvlr (Revcovi)
- Eculizumab (Soliris)
- Family planning
- Gamifant (emapalumab-lzsg)
- H2 antagonists
- Hematinics
- Insulin needles and syringes
- Lancets
- Lansoprazole
- Laxatives and stool softeners
- Loratadine
- Miconazole
- Mitapivat (Pyrukynd)
- Nasal preps
- Nitisinone Products
- Odevixibat (Bylvay)
- Omeprazole
- Ophthalmic preps
- Optichamber
- Pegcetacoplan (Empaveli)
- Pilocarpine HCl (Vuity)
- Ravulizumab (Ultomiris)
- Smoking deterrents
- Tezepelumab-ekko (Tezspire)
- Topical products

- Tralokinumab-ldrm (Adbry)
- Vaginal fungicides
- Vitamins and minerals
- Voretigene neparvovec-rzyl (Luxturna)
- Vosoritide (Voxzogo)
- Zaditor OTC
- Zegerid OTC

For a copy of the formulary as well as a listing of limitations, prior authorization criteria, generic substitution procedures, step therapy procedures and other pharmaceutical management methods, contact the Pharmacy Department at **1-800-682-9094** or visit horizonNJhealth.com.

Prior Authorization

The items below require prior authorization from our Pharmacy department. This prior authorization process requires proof of medical necessity from the prescribing physician and is coordinated by our Pharmacy department.

The information required to determine medical necessity should include the following: member's diagnosis, duration of proposed treatment, treatment plan and description of failed treatment, if any exists. Upon receipt of this information, the Pharmacy department and medical director, if necessary, will review the request. Physicians are encouraged to prescribe appropriate first-line agents before using alternative drugs.

Policies/Drugs Requiring Prior Authorization

This list is not all-inclusive and is changed periodically to reflect new drugs and/or clinical policy revisions.

For a complete list of drugs requiring prior authorization, including policies, visit horizonNJhealth.com or contact the Pharmacy department at **1-800-682-9094** to request a paper copy of prior authorization criteria.

- Acyclovir 5% Ointment (Zovirax)
- Admelog Solostar
- Age Limits Exceeded
- Antiretroviral Medications
- Asfotase alfa (Strensiq)
- Becaplermin Recombinant (Regranex)
- Biological Response Modifiers (Actemra, Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Simponi, Stelara)
- Botulinum Toxins
- Brand Name Medically Necessary
- Calcitonin gene-related peptide (CGRP) inhibitors
- Caplacizumab-yhdp (Cablivi)
- Colony Stimulating Factors (G-CSF & GM-CSF)
- Cryopyrin-Associated Periodic Syndromes (CAPS) Products
- Deflazacort (Emflaza)
- Dextromethorphan Hydrobromide and Quinidine Sulfate (Nuedexta)
- Dronabinol (Marinol)
- Drug Recall Policy
- Drug Utilization Review Program
- Dupilumab (Dupixent)

- Epoetin Alfa and Darbepoetin Alfa
- Esketamine (Spravato)
- Eteplirsen (Exondys 51
- Fabry Disease Products)
- Formulary System Maintenance
- Formulary System Management
- Gaucher Disease Products
- Golodirsen (Vyondys 53) and Viltolarsen (Viltepso)
- Gonadotropin Releasing Hormones Agonists and Antagonists
- Gout Products
- Growth Hormone Therapy
- Hepatitis C Treatment
- Hereditary Angioedema (HAE)
- Idursulfase (Elaprase)
- Imiquimod (Aldara)
- Infant Formula
- Intravenous (IV) Iron Therapy
- Investigational Drugs for the Treatment of COVID-19
- Lambert-Eaton Myasthenic Syndrome
- Lost/Stolen/Vacation/Drug Supply Requests
- Lofexidine (Lucemyra)
- Lubiprostone (Amitiza)
- Medication Adherence
- Member Communication
- Mental Health/Substance Use Disorder Medications
- Mepolizumab (Nucala) and Benralizumab (Faserna)
- Metformin Step Therapy
- Modafinil (Provigil)
- Nitroglycerin Ointment (Rectiv)
- Non-formulary Medication
- Nusinersen (Spinraza)
- Nutritional Supplements/Treatments
- Off-label Use of Prescription Drugs
- Omalizumab(Xolair)
- Onasemnogene abeparvovec-XIOI (Zolgensma)
- Oncology agents
- Penicillamine (Cuprimine) and Trientine (Syprine)
- Pharmacy Prior Authorization
- Pimecrolimus (Elidel), Tacrolimus (Protopic), and Crisaborole (Eucrisa)
- Practitioner Communication
- Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors
- Pulmonary Hypertension Agents
- Quantity Limits/Plan Limitations Exceeded
- Repository Corticotropin (H.P. Acthar Gel)
- Respiratory Syncytial Virus Infection Prophylaxis
- Rifaximin (Xifaxan)
- Rolapitant (Varubi)

- Smoking Cessation Products
- Sodium Hyaluronate Injections
- Step Therapy Process
- Stiripentol (Diacomit) and Cannabidiol solution (Epidiolex)
- Sublingual Immunotherapy
- Tasimelteon (Hetlioz)
- Testosterone Products
- Transthyretin-mediated Amyloidosis (ATTR) Products
- Urea Cycle Disorder Products
- Vaccines
- Voxelotor (Oxbryta)

To obtain prior authorization, or for more information, contact the Horizon NJ Health Pharmacy Department at **1-800-682-9094** and be prepared to provide relevant, clinical information that supports the medical necessity of the requested medication.

4.0 Hospital Services

Participating facilities must accept all Horizon NJ Health members who present themselves for admission in accordance with the agreement between Horizon NJ Health and the facility. Hospitals not participating in Horizon NJ Health programs should administer Emergent/Urgent care but refer members to their PCP or applicable specialist for admission or provision of services at in-network facilities.

4.1 Hospital Admissions

Physicians admit patients to their own service and follow patients during admission. All inpatient hospitalizations should be submitted through NaviNet within 24 hours of admission to initiate the review process.

Physicians must have admitting privileges to a Horizon NJ Health network hospital or facility for all age categories for which they are providing care. Hospital admissions for non-maternity related observation do not require a Horizon NJ Health authorization. Observations do not include Emergency Room (ER) observation areas or holding units.

Observation should be considered if the patient does not meet acute care criteria and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within 48 hours
- Treatment and/or procedures will require more than six hours of observation
- The clinical condition is changing and a discharge decision is expected within 48 hours
- Symptoms unresponsive to at least four hours of ER treatment
- For behavioral health this includes psychiatric and or substance use disorder diagnosis

4.2 Inpatient Services

Inpatient services provided to a member during a hospital stay are considered part of the precertification for the inpatient stay and procedure. These services include, but are not limited to:

- Professional component
- Therapeutic services
- Specialist services
- Diagnostic services
- Laboratory services
- Operating room and recovery room charges
- Registered bed charges

Horizon NJ Health will reimburse for contracted levels of care. If the level of care is not included in your contract, Horizon NJ Health will deny payment to the facility.

4.3 Hospital Maternity Observation Notification

Maternity observation visits do not require notification, this includes members receiving routine non-emergent non-stress tests (NST), ultrasound or fetal monitoring tests. This eliminates the need for physicians to contact Horizon NJ Health to request a billing claim number for billing purposes.

All maternity inpatient notice of admissions should be submitted through NaviNet within 24 hours of admission to initiate the review process.

In accordance with N.J.S.A. §30:4D-9.2 and the New Jersey Medicaid Managed Care Contract, Horizon NJ Health will deny early elective deliveries that are not medically indicated in accordance with established standards of clinical care as provided by the American College of Obstetricians and Gynecologists (ACOG).

For more information, contact Provider Services at **1-800-682-9091**.

4.4 Newborn Care

Horizon NJ Health assumes financial responsibility for services provided to newborns of mothers who are Horizon NJ Health members for the first 60 days after birth. However, these newborns are not automatically enrolled in Horizon NJ Health at birth. Refer to Section 2.5.1 for more information about newborn eligibility.

4.5 Emergency Care

Horizon NJ Health reimburses for emergency/urgent care services provided 24 hours a day, seven days a week. All ER care should be coordinated through the PCP. Members are advised to contact their PCP whenever an ER visit is initiated.

4.6 Emergency Services

Horizon NJ Health recognizes an emergency service as health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorder such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (and, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Members are advised to present at the nearest emergency facility and to notify the Member Services department or their PCP of their ER visit. This policy includes out-of-network services.

Emergency situations may include, but are not limited to:

- Severe pain of any kind
- Psychiatric disturbances
- Altered mental status (whether sustained or transient) for any reason
- Abrupt change in neurologic status (whether sustained or transient)
- Symptoms of substance use disorder
- Any and all complications of pregnancy
- Chest pain
- Acute allergic reactions
- Shortness of breath
- Abdominal pain (e.g., acute onset, severe)
- Multiple episodes of vomiting or diarrhea, any age
- Fever greater than 102.5 in any age group
- Fever greater than or equal to 100.4 in infants three months or younger
- Injuries with active bleeding
- Injuries with functional loss of any body part (including extremities, eyes, nose, mouth and ears)
- All patients arriving at the hospital by ambulance after an injury with any body part immobilized
- All patients arriving at the hospital by paramedic Ambulance

The emergency facility and PCP are responsible for educating members on the appropriate use of ER services when members present with non-life threatening conditions. A member enrolled with NJ FamilyCare C is responsible for a \$10 copayment for ER services, provided the member is not admitted into the hospital. The

hospital should issue a receipt to the member upon collection of a copayment. This receipt should include the hospital's name, address and phone number.

Horizon NJ Health covers emergency services that include:

1. Medical examination at an ER which is required by NJAC 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.
2. Examinations at an ER for suspected physical/child abuse and/or neglect.

A member enrolled with NJ FamilyCare D is responsible for a \$35 copayment for ER services, provided the member is not admitted into the hospital or the member is referred to the ER by the PCP for services that should have been rendered in the PCP's office. The hospital should issue a receipt to the member upon collection of a copayment. This receipt should include the hospital's name, address and phone number.

Emergency Dental Services

A dental emergency is a specific condition of the oral cavity or contiguous tissues that causes severe or intractable pain, and could compromise the life, health or safety of the member unless treated immediately.

Emergency symptoms may include the following:

- Severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction
- Pain resulting from injuries to the oral cavity and related structures
- Extensive, abnormal bleeding
- Fractures of the maxilla, mandible or related structures, as well as dislocation of the mandible

For dental emergencies, providers should avail themselves to treat members' dental emergencies no later than 48 hours, or earlier as the condition warrants. Members are instructed to first call their PCD to determine if the emergency warrants an office or clinic visit or an Emergency Room visit.

All general dentists and specialty care dentists must be available to Horizon NJ Health members 24 hours a day, seven days a week. General dentists and specialists should make arrangements with an answering service or direct members to another Horizon NJ Health dental provider or the Horizon NJ Health Nurse Line at **1-800-711-5952** before they are sent to the local hospital Emergency Room. Providers must respond to after-hours calls within 15 minutes for crisis situations; 45 minutes for non-emergent, symptomatic issues; and same day for asymptomatic concerns.

4.7 Hospital Transfer Policy

When members require hospitalization, it is Horizon NJ Health's policy to have the service rendered in a Horizon NJ Health participating hospital. In order to assure payment for emergency services and hospitalization, the physician must comply with this policy.

However, Horizon NJ Health recognizes that it may not be possible to follow this policy when members present at a medical facility due to a medical emergency. In cases where a Horizon NJ Health member needs to be transferred to a facility that does not have a contract with Horizon NJ Health, the hospital or attending provider must notify Horizon NJ Health's Utilization Management department for approval prior to the transfer, unless a true emergency situation arises.

In the event of an emergent situation, Horizon NJ Health requires notification of admission once the member is stabilized to receive a reference number and initiate the review process, as set forth in Section 8.3 Hospital Admissions. Please call Modivcare for all transportation authorizations at **1-866-527-9933**.

4.8 Out-of-State Hospitals

Horizon NJ Health requires an authorization for all out-of-state admissions with approval by the Utilization Management department, specifically the review and approval of the medical director or physician advisor. In the event of an emergent situation, Horizon NJ Health requires notification of admission once the member is stabilized to receive a reference number and initiate the review process, as set forth in Section 8.3 Hospital Admissions. All inpatient hospitalizations including behavioral health should be submitted through NaviNet within 24 hours of admission to initiate the review process.

If unable to submit through NaviNet, call:

Utilization Management Department
1-800-682-9094

4.9 Horizon NJ TotalCare (HMO D-SNP) Care Management

Horizon NJ TotalCare (HMO D-SNP) offers members a customized care management program designed to meet their individual needs. This plan allows the coordination of all care venues for members who are eligible for both Medicaid and Medicare.

It is available in all 21 counties. Providers who are participating in this program have an addendum to their contract or have a unique contract covering FIDE SNP. Each person enrolled in this program is assigned a Care Manager who will develop a plan of care with the member that is best suited to meet their needs. This includes information and health education to address health literacy in partnership with their primary care provider.

If you have questions about our Care Management program, call us at **1-888-621-5894 (TTY 711)** and select option **2**. Representatives are available weekdays from 8 a.m. to 5 p.m., ET.

Please review your Horizon NJ TotalCare (HMO D-SNP) member panel roster to obtain your patient's care manager's name and direct extension.

5.0 Primary Care Provider

5.1 The Role of the Primary Care Provider (PCP)

A Primary Care Provider (PCP) is a licensed physician or other licensed medical practitioner practicing in the area of Family Practice, General Practice, Internal Medicine, Geriatric Medicine or Pediatric Medicine.

The PCP has the responsibility of contacting each new member to schedule an appointment for a complete age/sex-specified baseline physical. This should be completed no later than 90 days after the effective date of enrollment for children under 21 years of age and no later than 180 days after initial enrollment for adults.

In instances in which a PCP has not conducted a visit with a member within 13 months, at its sole discretion, Horizon NJ Health may reassign that member to another PCP.

Clear and honest communication between you and your patients, our members, can help you and your patients make smart choices about their health. It is important that your patients are comfortable with you so they can be honest and upfront about their symptoms. Please encourage your patients to have an open dialogue with you. If a patient doesn't have any questions, make sure they understand their diagnosis, treatment and recovery.

Horizon NJ Total Care (HMO D-SNP) requests the PCP's ongoing participation to ensure that its members have comprehensive access to services and meaningful coordination of care. The PCP is responsible for:

- Reviewing the proposed care plan faxed (or accessed via NaviNet) to them from Horizon NJ Total Care (HMO D-SNP) for their patient
- Providing any necessary additional information about the member's care to ensure the care plan is complete and accurate
- Updating each care plan as needed by faxing to FIDE-SNP Care Management or updating in NaviNet
- Discussing the care plan with the Horizon NJ Total Care (HMO D-SNP) member for whom he or she provides care
- Communicating with the Interdisciplinary Care Team as requested to ensure optimal coordination of care
- Encouraging member participation in care management

For assistance from the Horizon NJ TotalCare (HMO D-SNP) Care Management Department, please call **1-888-621-5894 (TTY 711)**, Monday through Friday between the hours of 8:30 a.m. and 5 p.m.

The PCP is responsible for notifying members of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases by calling, or by arranging an appointment to discuss the result when it is deemed a face-to-face discussion may be necessary.

Within 10 business days of receipt of the results, the PCP must notify members of non-urgent or nonemergent laboratory and radiology results.

The PCP is responsible for supervising, coordinating and managing member health care by providing or authorizing the services needed to ensure positive health outcomes for each member on the panel.

This includes:

- Periodic communication with the member
- Providing health education and information
- Arranging for 24 hours a day, seven days a week, practice coverage
- Maintaining comprehensive medical records documenting all services provided to the enrollee, including periodic preventive and well-care services and providing appropriate and timely notice to members
- Delivering direct primary care services, as needed by the member

- Compliance with all adult and pediatric care protocols
- Education on the appropriate use of emergency services
- Maintaining continuity of members' health care

Members with Special Needs

The PCP supervising the care of those members with special needs has the additional responsibility to ensure a team approach to their care, when required, with an emphasis on the continuity and integration of medical care and, as needed, participating with Horizon NJ Health care management and specialty care management teams.

This includes methods for well-child care, health promotion, disease prevention and specialty care. The PCP is responsible for determining the urgency of a consultation with a specialist and, if urgent, shall arrange for the consultation appointment.

The PCP is responsible for providing or authorizing the services needed to ensure positive health outcomes for those members with special needs on their panel.

This includes:

- Overall clinical direction
- Serving as a central point of integration and coordination of covered services
- Providing health counseling and advice
- Diagnosing and treating covered conditions that do not require a referral to, and services of, a specialist
- Arranging for inpatient care, consultations and laboratory and radiological services
- Coordinating the findings of laboratories and consultants
- Interpreting such findings to the enrollee and the enrollee's family (or, where applicable, an authorized person)
- Upon enrollment, each member selects a PCP.

Members with special needs may select a PCP or request a specialist. The name and phone number of the PCP will appear on the member's Horizon NJ Health ID card.

Encounter Submission

PCPs must submit a CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters to the plan for each member encounter or office service, even if the service is capitated. Horizon NJ Health is required by the State of New Jersey to report encounter data for all services rendered to our members, including capitated and fee for service activities. Refer to Section 9.8 - Risk Assessment Program for more information.

All encounters must be received within 180 days of the date of service. PCP claims that are eligible for reimbursement will be denied for untimely filing if they are received after 180 days of the date of service.

Claims/encounters should be submitted to Horizon NJ Health at the following address.

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

5.2 PCP Reimbursement

5.2.1 Capitation

PCPs reimbursed via capitation will receive a fixed monthly payment (capitation), which is based on the age and gender of enrollees assigned to their panel. This payment is assigned on a per member/per month (pm/pm) basis and is calculated according to the number of days a member is assigned to the PCP during that month. With each capitation payment, Horizon NJ Health shall provide the provider with a list of members who have selected the physician as their PCP. PCPs receiving capitation payments have responsibilities to ensure:

- Member access
- Timely submission of encounters in appropriate format

Providers failing to do this may be removed from capitation at the sole discretion of Horizon NJ Health.

Capitated services include all examination, administrative and medical procedures performed by the PCP that are not specifically defined as reimbursed above capitation.

These services include, but are not limited to:

- Venipuncture
- X-ray services
- Laboratory services (including pregnancy testing)
- Gynecological examinations
- Family planning services

On or about the 15th of each month, Horizon NJ Health will issue a capitation check and capitation summary report of the amount of payment per member to the PCP.

Adjustments to capitation payments for members shall be subject to termination and eligibility requirements contained in the Medicaid contract. Horizon NJ Health shall limit capitation payment adjustments associated with retroactive terminations of members to two months' capitation payments.

If a member is added to a panel after the first of the month, Horizon NJ Health will prorate the capitation payment for that member and include the partial payment with the next capitation.

If a member is dual eligible (Medicare and Medicaid), the PCP will be paid on a fee for service basis in accordance with coordination of benefits rules.

5.2.2 Primary Care Billable Services

In addition to the monthly capitation, Horizon NJ Health will reimburse the PCP on a fee for service basis for the following:

- Immunizations (only the administration fee will be paid for standard immunizations provided by the VFC program for Plan A members)
- Inpatient hospital care
- Routine newborn care
- Simple repair of superficial wounds to scalp, neck, axillae, external genitalia, trunk and/or extremities
- Sigmoidoscopy
- Colposcopy
- Treatment of nail conditions
- Venipuncture services for lead screening
- Capillary blood specimen

- Nebulizer therapy
- Lead screening
- EPSDT services

5.2.3 Fee for Service

Horizon NJ Health will reimburse the PCP each time a panel member is seen. PCPs who are reimbursed on a fee for service basis will receive monthly member panel listings.

Services eligible for reimbursement are listed below.

- Office visits
- Immunizations (only the administration fee will be paid for standard immunizations provided by the VFC program)
- Inpatient hospital care
- Routine newborn care
- Simple repair of superficial wounds to scalp, neck, axillae, external genitalia, trunk and/or extremities
- Sigmoidoscopy
- Colposcopy
- Nebulizer therapy
- Treatment of nail conditions
- Intramuscular injection of antibiotics
- Electrocardiogram
- Venipuncture
- Allergy injections
- Maternity services (family practice physicians)

To ensure prompt reimbursement of your claim, be sure to:

- Submit a completed CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters.
- Submit EPSDT services on a CMS 1500 (HCFA 1500) form with EPSDT codes. Refer to Section 9.7 Early and Periodic Screening Diagnosis and Treatment (EPSDT) Information Missing or Incomplete for coding procedures.
- Verify that the standard CMS 1500 (HCFA 1500) form contains the following information:
 - Member’s full name
 - Member’s address
 - Member’s date of birth
 - Horizon NJ Health ID number
 - Diagnosis
 - Date of service
 - Physician’s Employer Identification Number
 - Taxonomy Code (mandatory)
 - Physician’s signature and physician/vendor number
 - Procedure code(s) – Current Procedural Terminology (CPT) and/or HCPCS
 - PCPs must submit a CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters to the plan for each member encounter or office service, even if the service is capitated. On a monthly basis, Horizon NJ Health is required to report all encounters to the State of New Jersey.

All claims must be received within 180 days of the date of service. If received after 180 days of the date of service, PCP claims eligible for reimbursement will be denied for untimely filing.

New Claims should be submitted to Horizon NJ Health at:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

Phone: 1-800-682-9091

Family planning claims should include the member's Social Security Number.

Providers who have claims questions or inquiries should contact Provider Services at **1-800-682-9091**.

Taxonomy codes must be provided on all claims. NOTE: IT IS VITAL THAT THE PROPER TAXONOMY CODE BE INCLUDED WHEN BILLING. WITHOUT THIS CODE CLAIMS PAYMENT WILL BE DENIED.

Red and White paper claims are the only claims that are accepted. Black and White, faxed, copied or any other versions of these paper claims cannot be processed.

Member Copayments for Primary Care Provider and Specialty Office Visits

Refer to Section 3 Benefit Overview of this Manual for member copayments specific to certain benefits.

5.3 EPSDT Coding and Reimbursement

The New Jersey Division of Health Services, Division of Medical Assistance and Health Services (DMAHS) will pay a \$10 incentive payment to Horizon NJ Health for a pass through to PCPs when an encounter record has a procedure code and diagnosis code as set forth below. EPSDT covers children from birth to their 21st birthday.

Important: Preventive visits are evaluation and management services. Physicians and health care professionals should not use additional evaluation and management codes in conjunction with these services.

For lead testing, please utilize the following CPT codes and modifiers:

36405 59	Venipuncture for lead screening for children under three years of age, scalp vein
36406 59	Venipuncture for lead screening for children under three years of age, other vein
36410 59	Venipuncture for lead screening for children three years of age or older
36415 59	Collection of venous blood by Venipuncture for lead screening for children 3 years and older
36416 59	Collection of capillary blood specimen for lead screening (finger, heel, and ear stick)
83655 52	Lead test (diagnosis code required)

Procedure Code Description

99460	Normal Newborn, Inpatient Care; History and Examination
99381	New Patient, Initial Preventive Medicine; infant (age under 1 year)
99382	New Patient, Initial Preventive Medicine; early childhood (age 1 - 4 years)
99383	New Patient, Initial Preventive Medicine; late childhood (age 5 - 11 years)
99384	New Patient, Initial Preventive Medicine; adolescent (age 12 - 17 years)
99385	New Patient, Initial Preventive Medicine; (age 18 – 39 years)
99391	Established Patient, Periodic Preventive Medicine; infant (age under 1 year)
99392	Established Patient, Periodic Preventive Medicine; early childhood (age 1 – 4 years)

- 99393 Established Patient, Periodic Preventive Medicine; late childhood (age 5 – 11 years)
- 99394 Established Patient, Periodic Preventive Medicine; adolescent (age 12 – 17 years)
- 99395 Established Patient, Periodic Preventive Medicine; (age 18 – 39 years)

Code ICD-10 Diagnoses

- Z00.00 Encounter for general adult medical examination without abnormal findings
- Z00.01 Encounter for general adult medical examination with abnormal findings
- Z00.110 Health examination for newborn under 8 days old
- Z00.111 Health examination for newborn 8 to 28 days old
- Z00.121 Encounter for routine child health examination with abnormal findings
- Z00.129 Encounter for routine child health examination without abnormal findings
- Z00.5 Encounter for examination of potential donor of organ and tissue
- Z00.6 Encounter for examination for normal comparison and control in clinical research program
- Z00.70 Encounter for examination for period of delayed growth in childhood without abnormal findings
- Z00.71 Encounter for examination for period of delayed growth in childhood with abnormal findings
- Z00.8 Encounter for other general examination
- Z02.0 Encounter for examination for admission to educational institution
- Z02.1 Encounter for pre-employment examination
- Z02.2 Encounter for examination for admission to residential institution
- Z02.3 Encounter for examination for recruitment to armed forces
- Z02.4 Encounter for examination for driving license
- Z02.5 Encounter for examination for participation in sport
- Z02.6 Encounter for examination for insurance purposes
- Z02.81 Encounter for paternity testing
- Z02.82 Encounter for adoption services
- Z02.83 Encounter for blood-alcohol and blood-drug test
- Z02.89 Encounter for other administrative examinations
- Z76.2 Encounter for health supervision and care of other healthy infant and child

5.3.1 EPSDT Worksheets

Horizon NJ Health, along with the other Medicaid health maintenance organizations (HMOs) in New Jersey and the New Jersey DMAHS, developed age-appropriate medical record tools for physicians to use for EPSDT visits.

These medical record tools are free of copyright and can be used by all Medicaid HMOs. The use of the medical record tools is not mandatory. It is up to each physician’s office whether to use the age-appropriate forms. A copy of the forms can be printed from the Horizon NJ Health website at horizonNJhealth.com.

6.0 Referrals

Primary Care Providers do not need to provide referrals for in-network specialist services. As a reminder, Horizon NJ Health members must:

- Use in-network doctors and health care providers for all services.
- Request authorization for out-of-network specialist services.

6.1 Out-of-Network Referrals

Occasionally, a member's needs cannot be provided through the Horizon NJ Health network of physicians, dentists and health care professionals. Physicians and dentists must contact the Utilization Management department for review of all out-of-network requests. The Utilization Management department, in collaboration with the recommendations of the PCP/PCD, will make every effort to locate an in-network specialty care physician or dentist specialist. Members who seek self-initiated care from a nonparticipating physician or a non-covered service will be responsible for the cost of the care.

Utilization Management Department

1-800-682-9094

Dental Utilization Management Department

1-800-682-9091

7.0 Specialty Care Physicians

7.1 The Role of the Specialty Care Physician

Specialty care physicians provide non-primary care services to patients. The specialty care physician must coordinate care through the PCP and obtain necessary precertification for hospital admissions or specified diagnostic testing and procedures. If a specialty care physician is scheduled to perform a procedure on a Horizon NJ Health member and, due to some unforeseen circumstance, is unable to perform the procedure, the specialty care physician must make reasonable efforts to find another Horizon NJ Health participating specialty care physician to conduct the procedure.

The specialty care physician may be asked to only consult and communicate with the PCP or consult and treat. A specialist acting as the PCP for a member with special needs has the responsibility for overall health coordination and assurance that the member receives all necessary specialty care and for providing or arranging all routine preventive care and health maintenance services, which may not customarily be provided by or be the responsibility of such a specialist. A request for a specialist to act as a PCP should be made through Horizon NJ Health's Member Services department at **1-800-682-9091**. Any claim filed for a procedure provided either as a PCP or specialist must include a taxonomy code. Without a taxonomy code the claim will be denied.

For members with special needs who are chronically ill or have complex health care needs, their traditional PCP will have the responsibility of providing primary care services and for overall coordination of care, including specialty care.

It is important for the specialty care physician to communicate regularly with the PCP regarding any specialty treatment. The specialist treating members with special needs, in conjunction with the PCP, must develop a team approach to care management. Clear and honest communication between you and your patients, our members, can help you and your patients make smart choices about their health. It is important that your patients are comfortable with you so they can be honest and upfront about their symptoms. Please encourage your patients to have an open dialogue with you. If a patient doesn't have any questions, make sure they understand their diagnosis, treatment and recovery.

Prior to rendering services, the specialty care physician should call Horizon NJ Health Provider Services to verify member eligibility. (See Section 2.0 Eligibility for more information on verifying eligibility at NaviNet.) Referrals are not required for specialty care, including long-term specialty care.

Horizon NJ Health specialty care physicians are also required to maintain the same office standards as the PCP. (See Section 12.17 Office Standards for more information.)

7.2 Specialty Care Reimbursement

The specialty care physician will be paid by fee for service. Horizon NJ Health reserves the right to modify the Horizon NJ Health fee schedule.

To ensure prompt reimbursement of your claim, be sure to:

- Verify that the standard CMS 1500 (HCFA 1500) form contains the following information:
 - Member's full name
 - Member's address
 - Member's date of birth
 - Horizon NJ Health ID number
 - Diagnosis
 - Date of service

- Physician’s employer identification number
- Physician’s signature and physician/vendor number
- Taxonomy code
- Procedure code(s) – CPT (Current Procedural Terminology), Health Care Financial Administration Common Procedure Coding System (HCPCS)

Completed claims should be submitted to:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

All claims must be received within 180 days of the date of service. Claims received after 180 days of the date of service will be denied for untimely filing.

8.0 Precertification

8.1 Prior Authorization Requirements

Horizon NJ Health has specific requirements for prior authorization and other medical management needs, as covered under the specific Medicaid benefit package. The prior authorization process evaluates the medical necessity of a procedure or course of treatment or DME and the appropriate location of service, prior to the delivery of services.

Use our Prior Authorization Procedure Search Tool, available 24/7, to determine if you need prior authorization before providing services to your Horizon NJ Health and Horizon NJ TotalCare (HMO D-SNP) patients. We collaborate with certain business partners to manage prior authorization reviews on our behalf. The tool will let you know when requests need to be submitted directly to these business partners.

Prior authorization must be obtained prior to an elective or nonemergent admission, including transfers to another facility or before outpatient services are rendered. Participating and nonparticipating facilities must submit online via NaviNet/Utilization Management Request Tool or phone request, a minimum of 14 calendar days prior to rendering services. Failure to notify Utilization Management (UM) prior to rendering care or service may result in services being delayed or denied.

In order to provide timely services to patients, when we are notified that care is needed for a Medicaid beneficiary in a county where we are unable to certify that we received a waiver of the network adequacy standards, we will initiate negotiations with nonparticipating providers of that service, and will provide timely authorization to ensure services can be provided to the beneficiary without delay and consistent with timeframes defined in the managed care contract for all routine and urgent services. Balance-billing of Medicaid beneficiaries is prohibited. Any copayments or other forms of cost sharing for services rendered under this paragraph are limited to the maximum amount allowed under State law for the Medicaid program.

Please refer to the Prior Authorization Procedure Search Tool at <https://www.horizonnjhealth.com/providers/resources/utilization-management/prior-authorization-search>.

8.2 Prior Authorization Process

Prior authorization must be obtained prior to an elective or non-urgent admission or outpatient service before services are rendered. The procedure for obtaining prior authorization is outlined below.

- The prior authorization process can take up to 14 calendar days for completion. Therefore, requests should be submitted online via the Utilization Management Request Tool or by calling **1-800-682-9094** as soon as possible to allow adequate time to respond to them. Staff is available during normal business hours (Monday - Friday 8 a.m.-5 p.m.) with on-call support staff available after hours to meet urgent requests. Staff identifies by name, title, and organization when initiating and returning calls regarding UM issues.
- For Behavioral Health services that require prior authorization, a request can be submitted electronically, by phone, fax, email or mail. Refer to Section 3.17 Behavioral Health for more information.

Requests for prior authorization must include:

- Member ID number
- Member's name, address and date of birth
- Specific clinical information, such as diagnosis and requested treatment along with supporting evidence
- Member's designated contact

Clinical information supporting the prior authorization request should be submitted with each request. Examples of supporting clinical information include, but are not limited to, history of presenting problem, clinical exam and diagnostic test results, operative and pathological reports, treatment plan, progress notes and consultations. If clinical information that supports the request is not provided with the request, the provider may be asked to furnish additional information for review by a Horizon NJ Health medical director.

The UM Department uses nationally recognized evidenced-based clinical criteria and Horizon NJ Health's medical policies during the prior authorization process. If criteria are met, the provider will receive notification through NaviNet. Providers can check real-time status through the NaviNet/Utilization Management Request Tool system with the ability to print the final outcome. See Section 11.4.5 Precertification and Authorization Criteria.

Members and providers are notified by mail of denials; this notification includes information about appeal rights. Prior authorizations are valid only for the dates requested. If you disagree with any Horizon NJ Health medical necessity decisions, please see Section 10.2 Utilization Management Appeals Process regarding appeal rights or call our UM Medical Appeals Department at **1-800-682-9094 x89606**.

Prior to providing care for services requiring prior authorization, the provider should verify that a prior authorization has been obtained. Providers may have to reschedule non-urgent services if prior authorization is required and has not been obtained.

Utilization Management Department

Medicaid: **1-800-682-9094**

FIDE-SNP: **1-888-621-5894**

Medical management decisions are subject to appeal through the Appeals Resolution Process. Horizon NJ Health UM decisions are benefit determinations only and do not constitute treatment recommendations or directives. Providers are solely responsible for making medical treatment decisions in consultation with their patients. Members may request a reconsideration of a benefit determination, in accordance with the procedure, as described in Section 10.2 Utilization Management Appeals Process.

8.2.1 MLTSS Prior Authorization Process

For MLTSS specific authorizations, when the Care Manager and member are in agreement with the plan of care, authorizations will be entered into the medical management system. Services are authorized exactly as written in the signed plan of care. If there are questions about authorizations, those questions are discussed with the MLTSS Care Manager prior to completing and signing the plan of care.

The MLTSS care management team will make all the necessary arrangements to ensure that services mandated via the plan of care are executed timely. Horizon NJ Health will make every attempt to arrange services with the provider chosen by the member. If the contacted provider cannot provide the service, the MLTSS care management team then will try to identify a provider who can provide the services. This process continues until a provider can be found to meet the expectations of the plan of care.

Once it is confirmed that the provider is able to provide the service, an authorization is created in the medical management system for that specific provider with the authorization limits/requirements listed in the plan of care. The provider is given an authorization number, the start and end date of the service, and the type of service that will need to be provided. An authorization letter with the above information is mailed to the provider.

8.2.2 Utilization Management Request Tool

Utilization Management Request Tool is an online authorization tool accessed through NaviNet that enables providers to submit authorization requests securely over the Internet. Providers are able to communicate directly

with Horizon NJ Health; checking the status of requests in real time and receiving notifications when requests are completed.

The main features in Utilization Management Request Tool include:

- Authorization requests with supporting clinical information
- Viewing status of authorization requests and review determination letters
- Requesting changes to a pended authorization

Providers can access Utilization Management Request Tool through NaviNet. Select Horizon NJ Health from the Plan Central page; mouse over Referrals and Authorization on the left navigation; then select Utilization Management Requests.

8.3 Hospital Admissions

All inpatient hospitalizations including maternity should be submitted through our online Utilization Management Request Tool Affiliate within 24 hours of admission to initiate the review process.

Providers can access the Utilization Management Request Tool through [NaviNet](#). Select *Horizon NJ Health* from the Plan Central page; mouse over *Referrals and Authorization* on the left navigation; then select *Utilization Management Requests*.

If you experience technical difficulties submitting via NaviNet, you can call **1-800-682-9094**, option **2**, to submit your request.

Horizon NJ Health conducts concurrent medical review (see Section 11.4.12 Concurrent Review) in order to approve an unplanned admission or review additional information received for elective and non-urgent admissions continued stay.

Denied services may be appealed. See Section 10.0 Grievances and Appeals Process for more information.

8.4 Ambulatory Surgical Center

Horizon NJ Health does not require physicians to obtain prior authorization from the UM Department for surgical procedures performed by a participating surgeon at an ambulatory surgical center (ASC) in the Horizon NJ Health network. Pain management procedures, cosmetic procedures, gastric banding adjustments and varicose vein surgery and other select procedures require prior authorization.

However, if the surgical procedure is performed at a hospital by an in-network or out-of-network provider, prior authorization must be obtained by calling or submitting online to the UM Department at least 14 calendar days in advance of the surgery. If the procedure cannot be performed at the participating ASC with which the physician is affiliated, the physician must obtain prior authorization prior to performing the surgical procedure. Horizon NJ Health will deny provider claims for payment if prior authorization is not obtained for surgical procedures performed at a facility other than a participating ASC and by a participating provider.

Horizon NJ Health encourages specialists to perform all medically necessary and appropriate surgical procedures at the freestanding ASC with which they are affiliated. If you are not affiliated with a center, we recommend that you obtain affiliation with a participating ASC. There are more than 40 ASCs in Horizon NJ Health's network. Please refer to the online Doctor & Hospital Finder at horizonNJhealth.com to view participating freestanding ASCs. To better service and accommodate our members and physicians, Horizon NJ Health is continually expanding our ASC network. Please feel free to contact Provider Services at **1-800-682-9091** with information regarding any freestanding ASC with which you are affiliated that is not participating with Horizon NJ Health.

8.5 Short Procedure Unit

Horizon NJ Health providers may utilize a Horizon NJ Health participating hospital short procedure unit (SPU) for a precertified, medically necessary procedure. The provider should conduct the request for prior authorization of a SPU or nonparticipating ASC by submitting through NaviNet. In the event that prior authorization has not been obtained due to an emergent situation, Horizon NJ Health must be notified within 24 hours.

If a request to utilize the SPU or nonparticipating ASC is denied by Horizon NJ Health, the facility will receive notification of the denial.

Horizon NJ Health requests that prior authorization for procedures performed at a hospital SPU or ASC is obtained 14 calendar days in advance of the surgery. Due to monthly changes in member eligibility, all procedures are pending verification of eligibility for the date of service requested. In those instances that a procedure performed in the SPU requires an inpatient admission, Horizon NJ Health must be notified within 24 hours by the facility submitting Notice of Admission through NaviNet to the UM Department.

8.6 Radiology

eviCore healthcare (eviCore) will provide Utilization Management programs for Radiation Therapy and Radiology/Cardiology for Horizon NJ Health and Horizon NJ TotalCare (HMO D-SNP) members. Horizon BCBSNJ is partnered with eviCore healthcare to manage Advanced Imaging Services for our members through Prior Authorizations/Medical Necessity Determinations (PA/MND) with physicians. eviCore helps to ensure our members receive appropriate radiology/imaging services, provides clinical consultation to our participating healthcare professionals and assists in the scheduling of radiology/imaging services. The Advanced Imaging Services included in this program are CT/CTA, MRI/MRA, PET and Nuclear Medicine studies (including Nuclear Cardiology).

Please note that eligibility and participation may vary based on line of business therefore, all providers should check eligibility and benefits prior to performing any services related to this program.

Prior authorization through eviCore does not apply to services that are performed in:

- Emergency room
- Inpatient
- 23-hour observation

Prior authorization applies to services that are:

- Outpatient
- Elective / Non-emergent

Prior authorization will be required for the following nonemergent outpatient radiology procedures:

- Cardiac Catheterization
- Cardiac Computed Tomography Angiography (CCTA)
- Cardiac Implantable Devices
- Cardiac Resynchronization Therapy (CRT) Pacemaker
- CT/CTA
- Echocardiography
- Implantable Cardioverter Defibrillator (ICD)
- Nuclear Cardiology/Nuclear Stress/MPI
- MRI/MRA
- Radiation Oncology Management for Radiation Therapy

- Pacemaker
- PET
- Select Non-Advanced Radiology Procedures
- Stress Echocardiography

Authorization is required for Horizon members enrolled in the following programs:

- Medicaid Managed Care
- NJ FamilyCare
- Horizon NJ TotalCare (HMO D-SNP)
- Managed Long Term Services & Supports (MLTSS)

Please refer to our [website](#) for services that require pre-authorization.

8.7 Behavioral Health Services

Participating providers must obtain prior authorization from Horizon NJ Health before rendering non-emergent services. Requests for services may be received via mail, fax, web or phone. Failure to comply may result in a denial or delay in reimbursement. Referrals are no longer required by Horizon NJ Health to receive services.

Horizon requires prior-authorization for all inpatient elective services and most ambulatory services, including but not limited to:

For Behavioral Health:

- Inpatient Psychiatric Treatment
- Residential Mental Health
- Partial Hospitalization (PHP)
- Partial Care
- Intensive Outpatient (IOP)
- Adult Mental Health Rehabilitation (AMHR) Group Homes and Apartments
- ABA Services/Applied Behavioral Analysis
- Developmental Individual Differences Relationship-based model (DIR)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Electroconvulsive Therapy (ECT)
- Medically Managed Detox (ASAM 4.0)
- Medically Monitored Detox (SUD ASAM 3.7D)
- Inpatient SUD Rehab (ASAM 3.7)
- Residential SUD (ASAM 3.5) Clinically Managed High Intensity Residential Services
- Residential SUD (ASAM 3.1) Clinically Managed Low- Intensity Residential Services
- Partial SUD (ASAM 2.5)
- IOP SUD (ASAM 2.1)
- Services by on-participating providers
- OP Specialty Services

All out of network providers will require a prior authorization for any level of care including outpatient levels of care.

For in-network Behavioral Health Providers, prior authorization is not required for the following services:

- In-network outpatient psychotherapy
- In-network outpatient psychiatric/medication management

- Medication assisted treatment – not including actual medication
- In-network outpatient treatment for substance use disorders
- In-network outpatient psychiatric/medication management for substance use disorders

Any MCO-covered behavioral health service provided by an out-of-network provider will require both a prior-authorization and a single-case agreement.

Providers have 180 days from date of service to submit an initial claim to the plan. Any requests for a post service review and prior-authorization after claims submission limits will not be approved.

For questions related to Behavioral Health prior authorizations, please contact Provider Services:

Medicaid: **1-800-682-9091**

DDD: **1-800-695-5612**

MLTSS: **1-855-777-0123**

FIDE-SNP: **1-800-543-5656**

9.0 Billing Guide

This guide is intended to offer hospitals, physicians and health care professionals the information required for Horizon NJ Health to accurately and efficiently process claims prepared by or for hospitals, physicians and health care professionals for medical services provided to members of our health plan. This section contains notes of interest highlighting billing information relevant to the topic detailed above them. The notes may be titled as follows:

IMPORTANT – Reminds the reader of claim submission problems that can be avoided. These errors can result in rejection, inaccurate claim payments or denials, usually because required information is missing, invalid, incomplete or inconsistent with standard billing practices.

Note: Reviews an associated piece of information, which clarifies or explains specific details about the service, but may not directly impact reimbursement. For example, place of service is required to determine eligibility for payment, but does not necessarily affect payment amount.

In the event of additional questions about Horizon NJ Health programs or policies, please review the entire Manual or contact the Provider Services at **1-800-682-9091**.

In order to comply with contractual obligations, regulatory requirements or state and federal law, Horizon NJ Health reserves the right, at any time, to modify or update information contained in this document. Notification will be posted at least 30 days prior to the effective date unless the effective date of a law or regulation does not permit this time frame. Hospitals, physicians and health care professionals may access the For Providers section of the Horizon NJ Health website at horizonNJhealth.com to check for updates on billing requirements and other policies and procedures relevant to reimbursements for services.

IMPORTANT – Horizon NJ Health, its subcontracted vendors or the State of New Jersey are responsible for payment for all services included in the member's benefit package. Services not included in the benefit package are reimbursable by the member only if the hospital, physician or health care professional notifies the member in writing and in advance of providing the service(s) of this obligation. Members should not be billed for any service covered under their benefit package. Should Horizon NJ Health require a copayment for any service or population group, an itemization of these items will be included in the benefit listing and will be available on the website. The practice of balance billing Medicaid/NJFC and FIDE-SNP beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance. A provider enrolled in the Medicaid/NJFC FFS program or in managed care is required to accept as **payment in full** the reimbursement rate established by the FFS program or managed care plan.

All costs related to the delivery of health care benefits to a Medicaid/NJFC eligible beneficiary, other than authorized cost sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third-party payer (if applicable). If 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.

9.1 Requirement for Filing Claims

9.1.1 General Requirements

Horizon NJ Health is a Medicaid managed care plan that is under contract with the New Jersey Department of Human Services. Horizon NJ Health will pay claims based only on eligible charges. Unless the provider contract states otherwise, claims will be paid on the lesser of billed charges or the contracted rate (Horizon NJ Health fee schedule). Claims submitted by nonparticipating Horizon NJ Health providers will be paid on the lesser of billed

charges or the Horizon NJ Health nonparticipating provider fee schedule. Consistent with CFR 42 Part § 447.45: the following definition shall apply to clean claims as used within the Horizon NJ Health Billing Guide:

“Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.”

Under the New Jersey Health Claims Authorization, Processing and Payment Act, claims must also meet the following criteria:

- a) the health care provider is eligible at the date of service
- b) the person who received the health care service was covered on the date of service
- c) the claim is for a service or supply covered under the health benefits plan
- d) the claim is submitted with all the information requested by the payor on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51)
- e) the payor has no reason to believe that the claim has been submitted fraudulently

Other requirements, such as timeliness of claims processing includes:

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. Horizon NJ Health shall pay all clean claims from hospitals, physicians and other health care professionals within 30 days of the date of receipt of EDI claims and within 40 days for paper claims. MLTSS claims will be paid within 15 days of the receipt of EDI claims and within 30 days for paper claims.

The time limitation does not apply to claims from providers under investigation for fraud or abuse. The date of receipt is the date Horizon NJ Health receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Horizon NJ Health is required to report all claims to the State of New Jersey for services provided to members through electronic media. Practitioners and facilities may not use a PO Box as an acceptable billing address. A physical street address must be used. In addition, when submitting ZIP codes anywhere on a claim, practitioners and facilities must use the full nine-digit format. Therefore, all billing addresses, whether submitted on paper or electronically, must contain a physical billing address. To have payments sent to a different address or PO Box, the pay-to provider name and address field on the 837-I and 837-P transaction must be used.

9.1.2 National Practitioner Identifier (NPI)

Horizon NJ Health requires all practitioners use their NPI numbers for all claim submissions. To ensure our systems properly identify you as an individual, group or facility, Horizon NJ Health requires you register the NPI with your taxonomy and tax identification numbers. Another requirement that will affect both timeliness and payment is the use of name differential on your W-9. Horizon NJ Health continues to accept the use of your provider identification numbers (legacy ID). The continued use of the legacy ID is recommended, as the claims processing system uses this number for adjudication and payment activities. Please make sure your name matches the name used on your W-9. Below are some helpful hints, which will facilitate accurate and consistent management of your claims.

- Physicians, facilities, and health care professionals are required to have an NPI. Please register for one if you have not already secured your NPI.
- Groups are not technically required to have an NPI, but are encouraged to have one as long as there is a legal entity associated with the business name and tax identification number. To register the group NPI

with Horizon NJ Health, we will need the W-9 for the business and all associated individual NPIs paid to that tax ID number.

- Facilities, including hospitals and groups chosen to subpart their type 2 NPI, will need to choose a master NPI if all of the registered numbers are under the same tax identification number. Designating a master NPI number will help Horizon NJ Health assign claims to the right location for payment purposes. A valid W-9 for the business and all associated individual NPIs that are paid to that tax ID number should be registered with Horizon NJ Health.
- Where an NPI number is shared among different locations using the same tax ID number, the Horizon NJ Health legacy ID is needed to distinguish where the claim payment should be sent.
- Nonparticipating practitioners and facilities are also required to adhere to the NPI requirements. To facilitate payment for claims, Horizon NJ Health encourages you to register your NPI with us in the same manner described above. To complete this task, please visit the “For Providers” section of horizonNJhealth.com and download our NPI Collection Form. Once completed, fax your forms and CMS documentation to Horizon NJ Health at **1-609-583-3004**.

9.1.3 Procedures for Claim Submission

Horizon NJ Health is required by state and federal regulations to capture and report specific data regarding services rendered to its members. All services rendered, including capitated encounters and fee-for-service claims, must be submitted on the CMS 1500 (HCFA1500) version 02/12 or UB-04 claims form, or via electronic submission in a HIPAA — compliant 837 or NCPDP format. Horizon NJ Health does not accept handwritten or stamped claims. These claims forms and electronic submissions must be consistent with the instructions provided by CMS requirements, as stated in the CMS Claims Manual, which can be accessed at cms.gov/Manuals/IOM/list.asp.

The hospital, physician and health care professional, to appropriately account for services rendered and to ensure timely processing of claims, must adhere to all billing requirements.

When data elements are missing, incomplete, invalid or coded incorrectly, Horizon NJ Health cannot process the claims.

- Claims for billable services provided to Horizon NJ Health members must be submitted by the hospital, physician or health care professional that performed the services.
- Professional services are not reimbursable to a hospital unless the hospital is specifically contracted for professional services. Horizon NJ Health policy is to reimburse these services only when billed on a CMS 1500.
- Claims filed with Horizon NJ Health are subject to the following procedures:
 - Verification that all required fields are completed on the claim
 - Verification that all diagnosis codes, modifiers and procedure codes are valid for the date of service
 - Verification of member’s eligibility for services under Horizon NJ Health during the time period in which services were provided
 - Verification that the services were provided by a participating or nonparticipating hospital, physician or health care professional that has received authorization to provide services to the eligible member
 - Verification that the hospital, physician or health care professional has been given approval for services that require prior authorization by Horizon NJ Health
- Horizon NJ Health is the “payor of last resort” on all claims submitted for members of its health plan. Hospitals, physicians and health care professionals must verify whether the member has Medicare

coverage or any other third party resources and, if so, provide documentation that the claim was first processed by this other insurer as appropriate.

IMPORTANT – Rejected claims are defined as claims with invalid or missing data elements, such as the tax ID number, that are returned to the submitter or EDI source without registration in the claim processing system. Since rejected claims are not registered in the claim processing system, the hospital, physician or health care professional must re-submit clean claims within 180 calendar days from the date of service. This guideline applies to claims submitted on paper or electronically. Rejected claims are different than denied claims, which are registered in the claim processing system, but do not meet requirements for payment under Horizon NJ Health guidelines.

Horizon NJ Health encourages all hospitals, physicians, and health care professionals to submit claims electronically. We utilize the TriZetto Provider Solutions (TTPS) Direct Data Entry (DDE) SimpleClaim system. All providers that previously used Emdeon to directly enter their Horizon NJ Health claims must switch to DDE SimpleClaim.

For more information on registering, please go to trizettoprovider.com/horizon-simpleclaim. If you have any further questions about registering with TTPS for DDE claim submission, please call TriZetto at **1-800-556-2231** or email ttpssupport@cognizant.com.

While Horizon NJ Health strongly encourages submitting claims via EDI, if a paper claim is necessary, please submit red and white paper claims only for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

Note: Out-of-state, non-Horizon NJ Health providers should send claims to their local Blue Cross Blue Shield Plan.

IMPORTANT – Requests for reimbursement for retail pharmacy and all outpatient drugs for persons designated as aged, blind or disabled should be submitted directly to the State of New Jersey.

IMPORTANT – Requests for reimbursement for behavioral health services for all enrollees, except the developmentally disabled, FIDE-SNP or MLTSS members, should be submitted directly to the State of New Jersey.

Note: Be sure to include the member's Medicaid ID number on all claims submitted to the State of New Jersey.

Note: Horizon NJ Health subcontracts with Davis Vision to provide and/or coordinate vision services for eligible members. All services, except ophthalmologic procedures, are coordinated and paid by Davis Vision. Please call **1-877-226-3729** for information about submitting invoices.

Note: Horizon NJ Health subcontracts with SKYGEN USA to provide and/or coordinate dental services for eligible members. Please call the Provider Call Center at **1-855-878-5368** for routine provider questions related to eligibility, claims, authorizations, credentialing, contracting, adding/changing provider data/locations, and fee schedules.

Note: Horizon NJ Health subcontracts with Laboratory Corporation of America, Inc. (Labcorp) for most routine and specialized laboratory services. Generally, Horizon NJ Health is responsible for payment of claims for PAT/STAT laboratory service provided in hospitals and ambulatory surgical centers. Horizon NJ Health will also

provide reimbursements for claims for laboratory services included on Labcorp's excluded test listing. An authorization is required for any test included on this listing; please submit claims to Horizon NJ Health as specified above. Unless otherwise specified within specific contractual arrangements, laboratory services should be referred to Labcorp.

9.1.4 Claim Filing Deadlines

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. COB claims must be submitted within 60 days from the date of the primary insurer's EOB.

Horizon NJ Health's Appeals Department utilizes specific criteria when reviewing valid proof of timely filing:

- Member's name
- Horizon NJ Health or Medicaid ID number
- Billed amount
- Date of service
- Billed/mailed date
- Address where the claim form was sent (Horizon NJ Health or insurance code)
- For EDI submissions, a 999 report indicating submission to the correct insurance code is required for consideration of timely submission.

For claims selected electronically:

- Submit an electronic data interchange (EDI) acceptance report. This must show that Horizon NJ Health or one of its affiliates received, accepted and/or acknowledged the claim submission.

Note: A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.

- The acceptance report must:
 1. Include the actual wording that indicates the claim was either "accepted," "received" and/or "acknowledged. (Abbreviations of those words are also acceptable.)
 2. Show the claim was accepted, received, and/or acknowledged within the timely filing period.

For paper claims:

1. The submission date must be within the timely filing period.
2. Certified mail receipts as valid proof of timely filing.
3. Only red and white paper claims can be processed.

Other valid proof of timely filing documentation

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating coverage termination prior to the date of service of the claim
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim

All of the above must include documentation that the claim is for the correct patient and the correct date of service. The date on the other carrier's payment correspondence starts the timely filing period for submission to

Horizon NJ Health. In order to be considered timely, the claim must be received by Horizon NJ Health within 60 days from the date on the other carrier's correspondence. Not including all of the information requested will result in a rejected inquiry or a delay in response. If the claim is received after the timely filing period, it will not meet timely filing criteria.

REFER TO SECTION 10 – Section 10.0 Complaint and Appeals Process for complete instructions of the submission time frames and procedures for administrative or medical appeals.

9.1.5 Filing Corrected Claims

For CMS 1500 (HCFA 1500) paper claims:

CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original Explanation of Payment (EOP), with the claim number of the most recently adjudicated claim for which the corrected claim is being submitted. Horizon NJ Health will reject any claims that are not submitted on red and white forms or that have any handwriting on them.

For UB-04 claims:

UB-04 claims should be submitted with the appropriate resubmission code in the third digit of the bill type (for corrected claim this will be 7), the claim number of the most recently adjudicated claim in Box 64 of the paper claim and a copy of the original EOP.

Send red and white paper corrected claims to:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

Correcting electronic HCFA 1500 claims:

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the claim number of the most recently adjudicated claim for which the corrected claim is being submitted.

Correcting electronic UB-04 claims:

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF *F8* with the claim number of the most recently adjudicated claim for which the corrected claim is being submitted.

Both paper and electronic claims must be submitted within 365 calendar days from the initial date of service.

Retracted Claim (HCAPP) Exception:

Claim was previously submitted and paid, but retracted through HCAPP.

If a corrected claim is received within 60 days from the date of the retraction, it will bypass timely filing. Corrected claim must be submitted with the appropriate resubmission code.

9.2 Claim Forms (Paper)

Horizon NJ Health requires that all hospitals, physicians and health care professionals use the standard CMS 1500 (HCFA 1500) or UB-04 claim forms to report services, which are reimbursable or capitated. The CMS 1500

(HCFA 1500) claim form must be completed for all professional medical services. The UB-04 claim form must be completed for all facility claims. When services are rendered by MLTSS providers, facilities should file a UB-04 form, and nonfacilities should use the CMS 1500. **Horizon NJ Health does not accept handwritten or black and white claims.**

9.2.1 CMS 1500 (HCFA 1500) Claim Form (Paper Submissions) (Paper Submission)

The CMS 1500 (HCFA 1500) Paper Submissions claim form must be used to bill all professional services to Horizon NJ Health. Horizon NJ Health only accepts form version 02/12. The National Uniform Claim Committee (NUCC) created the CMS 1500 form (version 02/12) to accommodate coding changes for ICD-10. There are two significant changes on the revised CMS 1500, the claim form used to submit paper claims to Medicare and the required claim form to submit paper claims to Horizon NJ Health.

The CMS 1500 Form (version 02/12) gives physicians the ability to:

- Identify whether they are using ICD-9-CM or ICD-10-CM codes.
- Include up to 12 codes in the diagnosis field (the limit on the 08/05 version is four codes in the diagnosis field).
- Include information that will improve the accuracy of the data reported, such as being able to identify the role of the provider and specific dates of illness.
- Align paper copy claim submissions with the ASC X12 Health Care Claim: Professional (837P) transaction.

CMS has advised providers to use the following process to assure clean claims submission. All information must be:

- Aligned within the data fields.
- On an original red ink on white paper claim 02/12 version form.
- Typed. Do not print, handwrite or stamp any extraneous data on the form.
- In black ink.
- In large, dark font, such as PICA or ARIAL 10-, 11- or 12-point type.
- In capital letters.

More information about Administrative Simplification and Compliance Act (ASCA) exceptions can be found in Chapter 24 of the “Medicare Claims Processing Manual,” which is available on the CMS website at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912>.

Required Fields for CMS 1500 (HCFA 1500) Claim Form

This section will provide the list of required fields for Horizon NJ Health; however, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

Place of Service Codes Code Description

- 11 Office
- 12 Home
- 19 Off Campus - Outpatient Hospital
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital

- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Residential Treatment Center
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Use Disorder Treatment Center
- 56 Psychiatric Residential Treatment Center
- 60 Mass Immunization Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End-Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

Type of Service Codes Code Description

- 1 Medical Services
- 2 Surgery
- 3 Consultations
- 4 Radiology (total component)
- 5 Laboratory (total component)
- 6 Radiation Therapy (total component)
- 7 Anesthesia
- 8 Assistant Surgery
- 9 Other (e.g., prosthetic eyewear, contacts, ambulance)
- D DME
- F ASC

Required and Conditional Field Indicator

IMPORTANT – An authorization number and/or referral number must be included in box #23 on a CMS 1500 (HCFA 1500) claim form or box #63 on a UB-04 form. The required fields that must be completed for the standard CMS 1500 (HCFA 1500) or UB-04 claim forms are in the respective claim form areas. If the field is required without exception, an “R” (required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

9.2.2 The UB-04 (CMS 1450) Claim Form (Paper)

The UB-04 (CMS 1450) claim form must be used to bill all facility services to Horizon NJ Health. This section will provide the list of required fields for Horizon NJ Health. However, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

Type of Bill Codes Code Description

111 Hospital/Inpatient (Part A)/Admit through Discharge

Code Description

112 Hospital/Inpatient (Part A)/Interim – First Claim
113 Hospital/Inpatient (Part A)/Interim – Continuing Claims
114 Hospital/Inpatient (Part A)/Interim – Last Claim
115 Hospital/Inpatient (Part A)/Late Charge Only
117 Hospital/Inpatient (Part A)/Replacement of Prior Claim
121 Hospital/Hospital Based or Inpatient (Part B)/Admit Through Discharge
131 Hospital/Outpatient/Admit Through Discharge
211 Skilled Nursing/Inpatient (Part A)/Admit Through Discharge
212 Skilled Nursing/Inpatient (Part A)/Interim – First Claim
213 Skilled Nursing/Inpatient (Part A)/Interim – Continuing Claims
214 Skilled Nursing/Inpatient (Part A)/Interim – Last Claim
321 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge
322 Hospice Interim – First Claim
323 Hospice Interim -- Continuing Claim
324 Hospice Interim – Final Claim
331 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge
711 Clinic/Rural Health Clinic (RHC)/Admit Through Discharge
721 Clinic/Independent Renal Dialysis Facility/Admit through Discharge
731 Clinic/FQHC/Admit Through Discharge
831 Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge

Type of Admission Codes Code Description

1 Emergency
2 Urgent
3 Elective

Patient Status Codes Code Description

01 Discharged to Home or Self Care (routine discharge)
02 Discharged/Transferred to Another Short-Term General Hospital
03 Discharged/Transferred to SNF
04 Discharged/Transferred to ICF
05 Discharged/Transferred to Another Type of Institution (including distinct parts) or Referred for Outpatient Services to Another Institution
06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
07 Left Against Medical Advice
08 Discharged/Transferred to Home Under Care of an IV Drug Therapy Provider
09 Admitted as an Inpatient to this Hospital

- 20 Expired (or did not recover – Christian Science Patient)
- 30 Still Patient or Expected to Return for Outpatient Services
- 40 Expired at Home (hospice claims only)
- 41 Expired in a Medical Facility, such as Hospital, SNF, ICF or Freestanding Hospice (hospice claims only)
- 42 Expired – Place Unknown (hospice claims only)
- 50 Hospice – Home
- 51 Hospice – Medical Facility

Commonly Used Revenue Codes Code Description

- 100 – 129 Room and Board Charges
- 130 – 249 Semi-private; Private; Ward, Nursery, Subacute, ICU, CCU
- 250 – 259 Pharmacy
- 260 – 269 IV Therapy
- 270 – 279 Medical/Surgical Supplies & Devices
- 280 – 289 Oncology
- 290 – 299 Durable Medical Equipment (DME)
- 300 – 319 Laboratory/Laboratory Pathological
- 320 – 339 Radiology Diagnostic/Therapeutic
- 340 – 349 Nuclear Medicine
- 350 – 359 CT Scan
- 360 – 369 Operating Room Services
- 370 – 379 Anesthesia
- 410 – 449 Therapy Services
- 450 – 459 Emergency Codes
- 540 – 548 Ambulance Services
- 720 – 729 Labor and Delivery
- 730 – 750 Outpatient Surgery
- 800 – 880 Radiology
- 900 – 919 Psychiatric/Psychological
- 920 – 999 Nuclear Medicine

Required and Conditional Field Indicator

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the services rendered to Horizon NJ Health members.

9.2.3 Taxonomy Codes

Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique ten-character alphanumeric code that enables providers to identify their specialty at the claim level.

Taxonomy codes are assigned at both the individual provider and organizational provider level. Taxonomy codes have three distinct levels: Level I is Provider Type, Level II is Classification, and Level III is the Area of Specialization. Examples and discussion of taxonomy codes can be found at

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Find-Your-Taxonomy-Code>.

For paper UB04 institutional claims, the taxonomy code should be placed in box 81 and should be submitted with the “B3” qualifier. For CMS-1500 professional claims, the taxonomy code should be identified with the qualifier

“ZZ” in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level. Claims that do not contain these codes cannot be processed.

CMS 1500 (08-05) Professional Claim Form (for enumerated providers)

Billing Provider NPI Field 33a
Billing Provider TIN Field 25
Referring Provider NPI Field 17b
Rendering Provider NPI Field 24j
Service Facility Location NPI Field 32a

IMPORTANT – Make sure that your claim software supports the revised 1500 claim form (08-05). Reference the 1500 Reference Instruction Manual at Nucc.org for specific details on completing this form.

UB-04 Paper Institutional Claim Form (for enumerated providers)

Billing Provider NPI Locator 56
Billing Provider TIN Locator 05
Billing Provider Taxonomy Code Locator 81
Attending Provider NPI Locator 76
Operating Provider NPI Locator 77
Other Provider NPI Locator 78-79

9.3 Procedures for Electronic Submission – Electronic Data Interchange (EDI)

IMPORTANT – Effective **January 1, 2017**, registered providers must include their taxonomy code, tax identification number, and NPI on all claims. Atypical providers, as defined by CMS, must submit their taxonomy code and their tax identification number.

IMPORTANT – All claims submitted electronically must be in a HIPAA compliant 837 or NCPDP format. Electronic data interchange (EDI) allows faster, more efficient and cost-effective claim submission for hospitals, physicians and health care professionals. EDI, performed in accordance with nationally recognized standards, supports the industry’s efforts to reduce overhead administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

Note: EDI Technical Support Team is available during regular business hours, 8 a.m. through 5 p.m., Monday through Friday, and can be reached at **1-888-334-9242**.

9.3.1 Hardware/Software Requirements

There are many different products that can be used to bill electronically. Hospitals, physicians and health care professionals should send EDI claims to Horizon NJ Health EDI Gateway through direct submission or through another clearinghouse/vendor using payor number **22326**.

Contracting with Horizon NJ Health EDI Gateway and Other Electronic Vendors

If you are a hospital, physician or health care professional interested in submitting claims electronically to Horizon NJ Health, You may also choose to contract with another EDI clearinghouse or submit directly to Horizon NJ Health EDI Gateway.

Contacting the EDI Technical Support Group

Hospitals, physicians and health care professionals interested in sending claims to Horizon NJ Health electronically may contact the EDI Technical Support Group for information and assistance.

Once Horizon NJ Health is notified of the intent to submit claims through EDI, the organization's contact will receive a complete list of ID numbers for Horizon NJ Health hospitals, physicians and health care professionals, the electronic payor number, Horizon-specific edits, and any other information needed to initiate electronic billing with Horizon NJ Health.

Transmission Requirements

Once the material is received, proceed as follows:

- Read over the materials carefully
- Transmission can begin upon receipt of ID numbers for Horizon NJ Health individual hospitals, physicians and health care professionals

Contact EDI Technical Support to answer any questions you may have. If you wish to receive confirmation to begin electronic submission, EDI Technical Support will notify you on the effective day for EDI claim submission.

After registration, contact your system vendor and/or Horizon to inform them that you are now going to submit production claims electronically to Horizon NJ Health. You will be asked for the electronic payor address and the Horizon-specific edits included in your Horizon NJ Health documentation.

Note: Contact EDI Technical Support at **1-888-334-9242** to notify them of your intention to begin EDI transmissions.

9.3.2 Specific Data Record Requirements

EDI claims should be submitted according to HIPAA standards. These standards can be found in the Implementation Guides written by the Designated Standard Maintenance Organizations (DSMOs) responsible for each transaction. Additional information can be found at x12.org.

9.3.3 Electronic Claim Flow Description

All electronic claims sent to Horizon NJ Health must use the payor number **22326**. The claims can be submitted directly or through another EDI clearinghouse or vendor. Once Horizon receives the transmitted claims, they are validated with Horizon NJ Health-specific requirements. Claims not meeting the syntax and business level validations are rejected and a report is sent to the sender. The name of this report can vary, based on the physician's contract with their intermediate EDI vendor or clearinghouse.

Hospitals, physicians and health care professionals are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from clearinghouses must be reviewed and validated against transmittal records daily.

9.3.4 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Horizon NJ Health must first pass Horizon NJ Health-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Horizon NJ Health. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the rejection notices (the functional acknowledgements to each transaction set and the unprocessed claim report) received from your vendor or clearinghouse in order to identify and resubmit these claims accurately.

Common Rejections

- Missing or invalid member ID
- Claims with missing or invalid batch level records
- Claim records with missing or invalid required fields
- Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
- Claims without or that have invalid hospital, physician or health care professional National Provider Identifier (NPI) numbers whenever applicable. Per federal requirements, atypical providers are excluded
- No physical billing address on file
- No taxonomy code
- NDC code not being billed for J and Q codes with the correct NDC unit of measure and the NDC unit dispensed (MLTSS)
- The PPCN field must be populated with the original claim number when billing a corrected claim (MLTSS)

Note: Hospital, physician or health care professional identification number validation is not performed at the clearinghouse. Claims will be rejected if the hospital, physician or healthcare professional number fields are empty.

9.3.5 Submitting Corrected Claims (Frequency 7) vs. Voided Claims (Frequency 8)

Providers using electronic data interchange (EDI) can submit corrected claims electronically rather than via paper to Horizon NJ Health.

A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. These claims should be submitted with a frequency 7 and are subject to timely filing guidelines for corrected claim submissions (365 days from the date of service/discharge date).

Note: The member/provider information for corrected claims must remain the same and should reflect changes to the dates of service, modifiers, add on of additional charges/services, etc.

A voided claim is defined as a claim that was submitted in error for any of the following reasons: incorrect/invalid member ID, incorrect/invalid provider NPI, claims submitted on the incorrect claim form such as UB04 vs. CMS 1500. These claims should be submitted with a frequency 8 and are subject to timely filing guidelines for original claim submissions (180 days from the date of service/discharge date).

Note: Voided claims are those sent erroneously and act as a void/cancellation of a prior claim submission.

- Use “5” for late charges, “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Use “8” for a voided claim utilizing bill type in loop 2300, CLM05-03 (837P). For both corrected and voided claim submissions, include the claim number of the most recently adjudicated claim in segment REF01=F8 and REF02=the claim number of the most recently adjudicated claim; no dashes or spaces.
- Include the Horizon NJ Health claim number in order to submit your claim with the 5, 7 or 8.
- Bill all services, not just the services that need corrections.
- Do use this indicator for claims that were previously processed (approved or denied).
- Do not use this indicator for claims that contained errors and were not processed (such as claims that did not appear on a remittance advice; i.e., rejected up front).
- Do not submit corrected claims electronically and via paper at the same time.
- Please note that either a written or stamped note stating that any claim is a corrected claim will result in that claim being returned for correction.

9.3.6 Electronic Billing Inquires

Please direct inquiries as follows:

Action

- If you would like to be authorized to transmit electronic claims
- If you have specific EDI technical questions
- If you have general EDI questions or questions on where to enter required data

Contact

- EDI Technical Support at **1-888-334-9242**

Action

- If you have questions about your claims transmissions or status reports

Contact

Your System Vendor or call EDI Technical Support at **1-888-334-9242**

Action

- If you have questions about your claim status (receipt or completion dates)
- If you have questions about claims that are reported on the Remittance Advice
- If you need to know a provider ID number

Contact

- To check a claim status, log on to NaviNet.net and access the Horizon NJ Health plan central page. Access the “Claim Status Inquiry” option under Workflows for this Plan.
- You can submit a request to have a claim investigated by clicking the “Investigate” button in the Claim Status Details screen.
- Your provider ID number can be found by accessing your profile in our online directory. Visit HorizonNJHealth.com/findadoctor.

Action

- If you would like to update provider location, practice name, tax ID number, physical billing address or payment address information
- For questions about changing or verifying provider information

Contact

Details on how to submit changes to your information can be found at HorizonNJhealth.com/demographicupdates.

Provider Services: 1-800-682-9091

9.4 Common Coding Requirements

9.4.1 Diagnosis Codes

All claims must include the proper ICD-10-CM diagnostic code.

The Centers for Medicare and Medicaid Services (CMS) provides specific guidelines to aid in standardizing U.S. coding practices. The guidelines for outpatient facilities, physician offices and ancillary care are summarized below:

- Identify each service, procedure or supply with an ICD-10-CM code to describe the diagnosis, symptom, complaint, condition or problem.
- Identify services or visits for circumstances other than disease or injury, such as follow-up care after chemotherapy, with V codes provided for this purpose.
- Code the primary diagnosis first, followed by the secondary, tertiary and so on. Code any coexisting conditions that affect the treatment of the patient. Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity. Carry the numerical code to the fourth or fifth digit when available. Remember, there are only approximately 100 valid three-digit codes; all other ICD-10-CM codes require additional digits.
- Code a chronic diagnosis, when it is applicable to the patient's treatment.
- When only ancillary services are provided, list the appropriate V code first and the problem second. For example, if a patient is receiving only ancillary therapeutic services, such as physical therapy, use the V code first, followed by the code for the condition.
- For surgical procedures, code the diagnosis applicable to the procedure. If, after the procedure has been done, the condition necessitating the surgery is more specifically identified, or even determined to be different than the preoperative diagnosis, code the most specific diagnosis determined to be the reason for the surgery.

Horizon NJ Health has adopted these diagnosis guidelines for its health plan and recommends that hospitals, physicians and health care professionals remain informed about these requirements through updated ICD-10-CM coding manuals. Both the State of New Jersey and the HIPAA transaction code sets require the use of a diagnosis code on all claims. To ensure that diagnosis codes are accurate, use the appropriate codes from the most recent ICD-10-CM coding manuals. Using deleted or incorrect codes will result in inability to process your claim or payment delays.

9.4.2 Procedure Codes

Common Procedure Terminology

CPT is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. It was developed and is updated and published annually by the American Medical Association (AMA). CPT codes communicate to physicians, health care professionals, patients and payors the procedures performed during a medical encounter. Accurate coding is crucial for proper reimbursement from payors and compliance with government regulations.

The AMA revises and publishes the CPT Book on an annual basis. Appendix B of CPT always consists of a summary of additions, deletions and revisions to the current edition. Of these three types of changes, only the

descriptions of revised codes appear in Appendix B, so you must refer to the manual itself to look at the descriptors of the new codes.

All physicians and health care professionals must use the appropriate procedure codes from the most recent HCPCS and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to enrollees.

9.4.3 Modifiers

Modifiers are used to report that the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide for coding consistency and editing for Level I (Common Procedure Terminology Codes) and Level II (Healthcare Common Procedure Coding System).

Sometimes, CPT codes require the addition of two-digit modifiers. CPT modifiers allow you to show that a service was altered in some way from the stated CPT Book description. Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is very important to know how to use modifiers correctly.

Modifiers can indicate:

- A service or procedure has both a professional and a technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred

Use the appropriate modifier from the most recent HCPCS and CPT coding manuals. Using deleted or incorrect codes and failing to use a modifier can result in denials, incorrect payments or claim payment delays.

IMPORTANT – Modifiers should not be used for multiple evaluation and management events unless the activity occurs at separate times on the same day. The Evaluation and Management Services Guide from CMS will be used by Horizon NJ Health to determine the appropriateness of coding submitted by physicians and health care professions, including the use of modifiers.

For more information on the Evaluation and Management Services Guide, please visit the Medicare Learning Network (MLN) at cms.gov/MLNGenInfo.

Note: These modifiers are subject to change. Consult the current CPT or HCPCS publications for the most up-to-date modifier list.

9.4.4 Units

The number of units or times a particular service is performed must be accurately indicated on all claims. When spanning dates of services, the number of units must match the count of the actual days within the spanned dates. If services were performed intermittently throughout the spanned dates of services, each date must be listed separately on the bill or an itemized statement must be submitted along with the claim.

When billing for loaded mileage, exact mileage must be identified on the claim. When billing for observation, units are equivalent to hours. All anesthesia providers are required to indicate the true amount of minutes in the days/units field of the claim form when billing for services.

IMPORTANT – The number of units and the service dates must be coordinated in order to obtain the most accurate reimbursement for the services billed. Services performed once (one date of service) must be indicated with a “1” in the unit’s field.

9.4.5 Other Coding

Use the appropriate coding as indicated in the official guides for the CMS 1500 and UB-04 claim forms or HIPAA-compliant electronic transaction sets when completing additional fields such as bill type, place of service and type of service. Incorrect coding can cause under- or over-payments or claim payment delays.

9.4.6 Taxonomy Codes

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level.

9.4.7 Pharmacy (HCPC Codes)

When billing for all “J” and “Q” codes via revenue codes, the appropriate National Drug Codes (NDC) number, metric units, unit of measure, and revenue code must be submitted as well. Failure to submit the NDC number, metric units, unit of measure, and revenue code along with the “J” or “Q” code will result in the claim being rejected. This guideline applies to all claims.

9.4.8 Vaccine Administration Services

When billing for the administration of vaccines, only one initial administration code can be reported per day, regardless of vaccine administration method. For example: CPT codes 90460 (18 years and younger), 90471 and 90473 are initial administration codes and cannot be billed on the same date. When billing multiple vaccine administration codes, please report as multiple units on one line. For example, if you have 3 units of one vaccine administration code, please bill the code on one line with 3 units.

9.5 Common Causes of Claim Processing Delays, Rejections or Denials

- Authorization number invalid or missing
- Billed charges missing or incomplete
- Claim information does not match authorization
- Coordination of benefits (COB) information missing or incomplete
- Diagnosis code missing 4th or 5th digit
- Diagnosis, procedure or modifier codes invalid or missing
- DRG codes missing or invalid
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information missing or incomplete
- Eligibility/enrollment is not valid on DOS
- Employer identification number (EIN) missing or invalid
- Explanation of benefits (EOB) missing or incomplete
- Hospital, physician or health care professional identification number missing or invalid
- Illegible claim information
- Incomplete forms
- Payor or other insurer information missing or incomplete
- Place of service code missing or invalid
- Procedure/service code does not match authorization
- Physician name missing or invalid
- Revenue codes missing or invalid
- Spanning dates of service do not match the listed days/units
- Signature missing
- Third-party liability (TPL) information missing or incomplete

- Type of service code missing or invalid
- When billing urgent care center claims, Horizon NJ Health reimburses facilities only and not the individual providers. Urgent care centers are reimbursed at an all-inclusive case rate.

9.5.1 Newborn Claim Information Missing or Invalid

All newborns receive an individual member number. Please check the Electronic Medicaid Eligibility Verification System (EMEVS) for the Medicaid number and include it when the claim is billed. Always include the first and last name of the mother and baby on the claim. If the baby has not been named, insert “Girl” or “Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

IMPORTANT – The claim for baby must include the baby’s date of birth.

IMPORTANT – On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith A, Baby Girl Smith B, etc.

9.5.2 Attachments Missing from Original Claim

Hospitals, physicians and health care professionals are required to submit an invoice for implantable and other insurance EOBs if they are denied. If these items are not submitted with the claim or are submitted separately (EDI and paper), incorrect payment or denials may occur.

Adjustments to these payments or denials should be submitted as corrected claims not as a resubmission of the original claim. Please submit to the correspondence address below:

**Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406**

Signed consent forms for sterilization are required for payment under federal requirements. (See Section 3.3 Family Planning.) These forms should be submitted to the address below:

**Horizon NJ Health
PO Box 24078
Newark, NJ 07101-0406**

Signed receipt of information form, FD-189 must be submitted during the request for prior authorization for hysterectomies.

9.5.3 Claims and Clinical Editing

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have spearheaded a correct coding initiative that intends to establish norms for coding medical services. Medicaid programs are required to apply National Correct Coding Institute (NCCI) edits to physician and outpatient hospital claims. Services deemed to be a part of a more complex service as defined by the NCCI will be re-bundled or denied as established by current criteria set by CMS in its claims processing manual. Horizon NJ Health also uses the CMS Claims Processing Manual as a guide to managing payments for services provided to its members, including the medically unlikely edits (MUE) subset and redundant edits. CMS publishes the majority of existing MUEs on the CMS website at [cms.gov/nationalCorrectCodInitEd/](https://www.cms.gov/nationalCorrectCodInitEd/).

Horizon NJ Health continues to enhance its software used to adjudicate medical, professional and hospital outpatient claims. Horizon NJ Health uses Change Healthcare, ClaimsXten and other nationally recognized

software. These are clinically-based editing solution, that helps ensure that our code and claim editing rules are accurate and consistent with standard business practices and ensures that the claim editing system is transparent to all participating providers, and that claim payments are accurate and consistent with standard business practices and medical policies. The editing process is applied to all claims submitted to Horizon NJ Health by physicians, health care professionals and hospitals.

9.6 Coordination of Benefits

Integrated care is a best practice model. Horizon NJ Health members benefit from collaboration because it improves the safety and efficacy of services to support better outcomes. Coordination of health care is essential to improve health outcomes, especially for those with chronic illnesses. Any services provided to a Horizon NJ Health member are reviewed against benefits provided for that same individual under other insurance carriers with whom the member has coverage. Horizon NJ Health, as a managed care program for Medicaid and NJ FamilyCare members in New Jersey, is the “payor of last resort” on claims for services provided to members also covered by Medicare, employee health plans or other third-party medical insurance. Payors, which are primary to Horizon NJ Health, include (but are not limited to):

- Private health insurance, including assignable indemnity contracts
- Health maintenance organizations (HMOs)
- Public health programs, such as Medicare
- Profit and nonprofit health plans
- Self-insured plans
- No-fault automobile medical insurance
- Liability insurance
- Workers’ compensation
- Long-term care insurance
- Other liable third parties

In cases where another insurer, including Medicare fee for service, is deemed responsible for payment, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s explanation of benefits or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and will not exceed the normal Horizon NJ Health benefits, which would have been payable had no other insurance existed. Hospitals, physicians and health care professionals should not file a claim with Horizon NJ Health until they receive the EOB from the member’s other insurance carrier(s). Make sure you follow that insurer’s administrative requirements, standard claim submission policies and forms.

Upon receipt of payment, submit applicable claims to Horizon NJ Health for payment of deductibles and coinsurance amounts. Horizon NJ Health reimburses after coordination of benefits and only up to the primary contracted rate for the service. The claim, PCP referral and primary insurer’s explanation of benefits (EOBs) must be submitted within 60 days of the date of the other carrier’s correspondence or 180 days from the date of service, whichever is later. When preparing the claim, include a complete record of the original charges and primary (or additional) payor’s payment as well as the amount due from the secondary or subsequent payor.

Submit all pages of the primary (or additional) insurer’s EOB to avoid delays in completing claims due to missing information or coding and message descriptions. This information ensures accurate coordination of benefits. With the exception of Medicare, Horizon NJ Health’s same notification policies that are routinely applied and required must be followed for any claims to be considered for payment. In the case of Medicare as the primary insurer, practitioners and facilities are advised to follow Horizon NJ Health’s procedures, as some services may be exhausted or not covered by Medicare.

IMPORTANT – All coordination of benefit (COB) claims must be submitted with a copy of the EOB from the primary insurer. If the primary insurance claim has been paid, the COB claim can be submitted through EDI transmission. If the primary insurance claim has been denied, a paper copy of the primary explanation of payment should be sent. Submit paper claims for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health
 Claims Processing Department
 PO Box 24078
 Newark, NJ 07101-0406**

When seeking reimbursement from Horizon NJ Health as secondary insurer where Medicare is an enrollee’s primary source of insurance, you must use one of the following processes. When you provide services to a member who has other coverage, you must bill the member’s primary insurer directly. Be sure to follow that insurer’s claims submission policies. You must then submit a claim and the primary insurer’s explanation of benefits (EOB) to Horizon NJ Health within 60 days of the date of the EOB or within 180 days of the date of service, whichever is later. Alternatively, secondary/coordination of benefits (COB) claims may be submitted electronically, utilizing the following COB loops:

Loop	Description	Reported Data
2320	Other Subscriber Information	Name of Primary Insurance
2330A	Other Subscriber Name	Name of Subscriber*
2330B	Other Payer Name	Payment Date from Other Insurance
2340	Line Adjudication Information	Other Insurance Payment

Note: Although a primary insurer may have unique coding specific to their business, providers must bill with valid ICD-10-CM, CPT-4 and HCPCS codes. Unique or invalid codes specific to other insurers will cause claim processing delays or denials.

IMPORTANT – The hospital, physician or health care professional may not submit billed charges to Horizon NJ Health that are different than charges submitted to other insurers for the same services. The submitted bill must contain the exact billed amounts by procedure line as is reflected on the primary or additional insurer’s EOB.

IMPORTANT – The primary or additional insurer’s EOB must include member name, billed amounts, paid amounts, adjustments, coinsurance amounts, deductibles, copayments and all associated messages and notes. Incomplete information may result in a claim processing delay or denial.

9.6.1 Medicare

When both Medicare and Medicaid cover a member and the service is a benefit of both programs, the claim must first be filed with Medicare. Hospitals, physicians and health care professionals should not file a claim with Horizon NJ Health until they receive the Medicare EOB. Upon receipt of payment, submit the claim along with a copy of the Medicare EOB to Horizon NJ Health within 60 days of the date of the Medicare EOB or 180 days from the date of service, whichever is later.

Medicare primary members have no prior authorization requirements and are not required to be seen by a participating Horizon NJ Health hospital, physician or health care professional, unless Medicare does not cover the service. When Horizon NJ Health, by default, becomes the primary payor, the hospital, physician or health care professional must comply with all coverage requirements indicated by Horizon NJ Health to be considered for payment. Horizon NJ Health advises that services to members covered by Medicare and Medicaid be reported despite the fact that authorization is not required. This will avoid delays in claims payment for services that Horizon NJ Health must cover.

Medicare-eligible services denied by Medicare due to failure to comply with medical, administrative or filing requirements will not be covered by Horizon NJ Health.

Note: When Medicare is primary and the procedure...

- is covered by Medicare, an authorization is not required by Horizon NJ Health, even if one is normally required by Horizon NJ Health. Reporting these services to Horizon NJ Health is advised.
- is not covered by Medicare, an authorization is required by Horizon NJ Health if one is normally required by Horizon NJ Health.

IMPORTANT – The hospital, physician or health care professional may re-bill for services originally denied by Medicare when Medicare overturns the denial. The hospital, physician or health care professional must submit the re-bill within 60 days of the date of Medicare’s EOB or 180 days from the date of service, whichever is later.

9.6.2 Other Third-Party Medical Insurance

Members covered by a primary insurer including Medicare should be instructed to notify Horizon NJ Health of their primary coverage. Claims submitted to Horizon NJ Health as the secondary or tertiary insurer are subject to eligibility and benefit coverage. To receive payment for a claim submitted to Horizon NJ Health as the secondary or tertiary insurer, the hospital, physician or health care professional must submit a copy of the primary insurer’s EOB or denial letter along with the claim to Horizon NJ Health.

NOTE – Submit claims to Horizon NJ Health within 60 days of the date of the primary insurer’s remittance and/or EOB or 180 days from the date of service, whichever is later. Participating hospitals, physicians or health care professionals may not bill Horizon NJ Health members for deductibles and coinsurance or balances above our allowable fees. Medicaid is the “payor of last resort;” therefore, the payments received from the primary insurer and/or Horizon NJ Health must be considered payment in full. Members are not to be billed for any Horizon NJ Health covered service. If the service is not covered by the other insurer or Horizon NJ Health, there must be prior written agreement to bill the member for these non-covered services.

REFER TO – Section 10.0 Grievances and Appeals Process, for complete instructions of the submission time frames and procedures for administrative or medical appeals.

IMPORTANT – If there is any possibility that the services provided will not be covered by the primary insurer, the hospitals, physicians or health care professionals should obtain the appropriate referrals or prior authorizations needed to obtain coverage under Horizon NJ Health. Failure to do so may result in denial for payment.

IMPORTANT – If you provide services to a member who is ill or injured as the result of a third party action, you must notify Horizon NJ Health of this information. In the event that this information is determined after the claim is submitted and/or resolved, you are still required to inform Horizon NJ Health. This includes recording the information about the injury or condition on the claim and notifying Horizon NJ Health of any lawsuits or legal action in relation to the injury or condition.

IMPORTANT – When completing the CMS 1500 (HCFA 1500) claim form, be sure to complete #7 on the form.

Motor Vehicle Accidents

Motor vehicle accident-related claims should be submitted to the primary carrier prior to being submitted to Horizon NJ Health. If benefits exhaust or are unavailable, the claim may be submitted to Horizon NJ Health along with an explanation of benefits or a denial letter in order to be considered for payment. In all cases, Horizon NJ Health’s referral, prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim or 180 days from the date of service, whichever is later. Upon receipt of an EOB from the primary carrier, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer.

Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

In all cases, Horizon NJ Health's prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

IMPORTANT – When preparing the claim, all information relating to the accident must be included on the claim. This includes diagnosis codes, accident indicators and occurrence codes (UB-04 claim forms) where appropriate. Additionally, if a primary insurer has made payment for services, the insurer's EOB must be included when submitting the claim for payment.

Workers' Compensation

Workers' compensation covers any injury that is the result of a work-related accident. If Horizon NJ Health is aware of a workers' compensation carrier, Horizon NJ Health will reject the hospital, physician or health care professional's claim and direct that the claim be submitted first to the primary workers' compensation carrier. If insurance coverage is not available at the time the claim is submitted or the workers' compensation carrier ceases to provide coverage, the claim will be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim.

9.6.3 Reimbursement

Medicare

If a member has Medicaid and Medicare coverage, the hospital, physician or health care professional may bill for charges Medicare applied to the deductible or coinsurance, or both. Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

Note: Horizon NJ Health considers the deductible, coinsurance and copayments a component of the total primary care capitation for primary care reimbursement for services, which are capitated. If your primary care contact is for fee-for-service reimbursement, please first bill the primary carrier and then bill Horizon NJ Health with the carrier(s) EOB.

IMPORTANT – Bills submitted to the secondary insurer must exactly match the services and amount billed to the primary insurer. This information, along with the primary insurer's EOB, is necessary to complete an accurate COB. Incomplete information could result in processing delays or denials.

Other Third-Party Medical Insurance

Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's explanation of benefits or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually

agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

Guidelines on Billing Mileage for Member Transportation Services

Horizon NJ Health members shall be transported to and from medical appointments in a manner that results in the accrual of the least number of miles. Mileage is measured by odometer from the place of departure or the point at which the member enters the vehicle to the destination or point at which the member exits the vehicle. At no time shall the transportation provider's base location be used when calculating mileage.

For MLTSS Services, professionals may bill Horizon NJ Health for these services without submission of a primary insurer's EOB.

NOTE – If a service is covered by Medicare Advantage, please supply the resulting EOB.

IMPORTANT – If billing for room and board only at a SNF, reimbursement will be considered without submission of Medicare EOB.

9.6.4 Services That Do Not Require A Primary Insurer EOB

Services Not Covered by Traditional Medicare

- Hearing aids
- Diapers/Under-pads/Incontinence items
- EPSDT
- Personal care assistants (Medicare FFS only)
- Medical day care (Medicare FFS only)
- Private Duty Nursing

Physician and health care professionals may bill Horizon NJ Health for these services without submission of a primary insurer's EOB.

Note: If a service is covered by Medicare Advantage, please supply the resulting EOB.

IMPORTANT – If billing for room and board only at a skilled nursing facility, reimbursement will be considered without submission of Medicare EOB.

Other Third-Party Medical Insurance

An EOB or notice of refusal must be submitted with all commercial and Medicare Advantage insurers' claims. Claims with primary payment can be submitted via EDI.

9.6.5 Denials from Primary Insurers

If the primary insurer denies payment to the hospital, physician or health care professional based on coverage exclusion, non-coverage, benefit exhaustion or non-compliance with administrative guidelines, the physician must submit a copy of the EOB or notice of refusal. The EOB or notice of refusal must include an explanation of the reason for the denial. Services denied by the primary insurer and billed to Horizon NJ Health without an explanation of the denial from the primary insurer will be denied payment.

Services denied by the primary insurer for non-compliance with medical or administrative guidelines may be submitted to the secondary with a copy of the EOB or notice of refusal and a copy of the final appeal denial letter or notice of refusal. Medical and/or administrative denials will not be considered without receipt of the final appeal denial letter.

IMPORTANT – Horizon NJ Health will document receipt of notices that the member’s primary carrier does not cover a service or that the service is exhausted. No additional notices will be required until the anniversary date of the member’s policy with that other insurer. Annually, on or after the anniversary date, the hospital, physician or health care professional must provide notice again that the service is exhausted or not covered by the primary carrier.

Note: The hospital, physician or health care professional must file a claim with the primary insurer within the appropriate timely filing deadlines and according to appropriate filing requirements. Failure to submit medical and administrative denial information from a primary insurer could result in processing delays or denials.

IMPORTANT – Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim.

9.7 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT claims are paid based on the periodicity schedule. The biological component of immunizations is only paid where the Vaccines for Children (VFC) program does not offer the biological or the supply is not available. Administration of VFC-sponsored immunizations is paid on a per-visit basis; therefore, multiple shots given in a single visit will result in a per-vaccine administration payment. Physicians and health care professionals are encouraged to use combination immunizations when available.

The following CPT codes and modifiers should be used when conducting lead screening:

36405 59	Venipuncture for lead screening for children under three years of age, scalp vein
36406 59	Venipuncture for lead screening for children under three years of age, other vein
36410 59	Venipuncture for lead screening for children three years of age or older
36415 59	Collection of venous blood by Venipuncture for lead screening for children 3 years and older
36416 59	Collection of capillary blood specimen for lead screening (finger, heel, and ear stick)
83655 52	Lead test (diagnosis code required)

Horizon NJ Health sends quarterly EPSDT underutilization reports to physicians, identifying members whose EPSDT services are overdue. Compliance with using the EP modifier will increase the accuracy of these reports.

For more information on The NJFC Directory of Dentists Treating Children under the Age of 6, formerly known as NJ Smiles, see Appendix D, Section C of this Manual.

9.8 Risk Assessment Program

Horizon NJ Health is required by the State of New Jersey to report encounter data for all services rendered to our members, including capitated and fee-for-service activities. All physicians, hospitals and health care professionals are required to submit timely, accurate and complete encounter data. This is required even when the member is covered by another insurer.

Health care resource consumption in chronic disease can be very high. The State of New Jersey is using a risk adjustment payment model in an attempt to fairly distribute Medicaid funds in proportion to the severity of illness. Horizon NJ Health is required to submit encounter data to the State of New Jersey as an estimate of the prevalence of disease in the population we serve.

It is paramount that accurate data be gathered on the prevalence of illness of Horizon NJ Health members. This leads to accurate, severity-adjusted payment from the State to the health plan and, ultimately, the provider.

For example: Not only should members seek medical care for acute conditions, they should also visit their provider for chronic conditions, such as diabetes or hypertension. Moreover, if a member visits for an acute issue and a chronic issue is relevant or discussed, we ask that this is documented in both the records and the encounter claim form.

For further information, please call Horizon NJ Health’s Risk Adjustment nurse **at 1-800-682-9094, x89625**.

All services must be submitted on the CMS 1500 (HCFA 1500) or the UB-04 claim form, or via electronic submission in a HIPAA-compliant 837I, 837P or NCPDP format. Horizon NJ Health is required to submit this data in a HIPAA standard file format to the State. Any coded field or data element contained in a HIPAA transaction must adhere to the national set of codes, including medical services and diagnosis. Due to the requirement to submit all services to the State, all requirements for EDI transactions are also applied to paper claims.

The State of New Jersey will reject encounter data if it does not meet their processing criteria. In some instances, Horizon NJ Health will be required to reverse payment already made to the provider if the encounter does not meet the State’s criteria. A complete list of all possible encounter rejections can be obtained by going to njmmis.com. Under the Information section, select Edit Codes, then Encounter Edits. The following are some causes for rejections:

Facility Services

- NPI – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider, Attending Provider, Operating Provider and Other Provider fields, if applicable. The NPI is required by the State of New Jersey’s Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement.
- Type of Bill – The bill type must be consistent with the type of service rendered with applicable revenue codes and corresponding HCPCS. Common bill types are listed in Section 9.2.2 of this manual.
- Statement Covers Period – Any practitioner billing for services must ensure that the dates of service are within the time period indicated in the Statement Covers Period stated on the claim. If a date of service is outside the dates placed in the From/Through field, the encounter will be rejected.
- Principle Procedure Date – Any practitioner billing for surgical services must ensure that the dates of service are within the time period indicated in the Statement Covers Period indicated on the claim. If the Principle Procedure date or Other Procedure date field is outside the dates reported in the Statement Covers Period, the encounter will be rejected.
- Revenue Codes – All revenue codes billed must be valid for the type of claim being billed.
- Laboratory Services – When billing revenue codes 300-319, the corresponding HCPCS or CPT codes must be billed.
- Physician Administered Drug – All services are required to report units of measure for all drugs, including their corresponding NDC code when billing with “J” or “Q” codes. The corresponding 11 digit NDC code must be reported along with the correct unit of measure:

A. NDC units are based upon the numeric quantity administered to the patient and the unit of measure.

UOM	Description	Guidelines
F2	International unit	International units will mainly be used when billing for Factor VIII-Antihemophilic Factors

UOM	Description	Guidelines
GR	Gram	Grams are usually used when an ointment, cream, inhaler, or bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing.
ML	Milliliter	If a drug is supplied in a vial in liquid form, bill in millimeters.
UN	Unit	If a drug is supplied in a vial in powder form, and must be reconstituted before administration, bill each vial (unit/each) used.

NDC Units

Submit the decimal quantity administered and the units of measurement on the claim. If reporting a partial unit, use a decimal point.

- GR0.025
- ML2.5
- UN3.0

The quantity should be eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. Do not zero fill, leave remaining positions blank. The following are some examples:

- 1234.56
- 2
- 12345678.123

Paper Claim Requirements

CMS 1500 form:

- Enter the NDC in the shaded area of the service lines in Field 24
- The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information.
- Submit the NDC code in the red-shaded portion of the detail line item starting in positions 01.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N412345678901).

UB-04 form:

- Field 42: Revenue code
- Field 43: NDC 11 digit number, Unit of Measurement

Qualifier and Unit Quantity

- Field 44: HCPCS code

For EDI claims:

LOOP	Segment	Element Name	Information
2410	LIN	02	Product or Service ID Qualifier If billing for a national drug code (NDC), enter N4.
2410	LIN	03	If billing for drugs, include the NDC. LIN**N4*1234567890

LOOP	Segment	Element Name	Information
2410	CTP	04	Quantity If an NDC was submitted in LIN03, include the quantity for the NDC billed.
2410	CTP	05-1	Unit or Basis for Measurement Code If an NDC was submitted in LIN03, include the unit or basis for measurement code for the NDC billed. F2 - International unit GR - Gram ML - Milliliter UN - Unit Sample - CTP****3*UN
2410	REF	01	VY: Link Sequence Number, XZ : Prescription Number Link Sequence # (to report components for compound drug)
2410	REF	02	Link Sequence Number or Prescription Number Sample - REF01*VY*123456

Claims cannot be paid by Horizon NJ Health without this information.

For additional information on the valid NDC codes, unit and units of measure, please refer to the NJ Medicaid website at njmmis.com/ndcLookup.aspx.

Professional Services

- NPI – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider and Service Facility Location if applicable. The NPI is required by the State of New Jersey’s Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement. Providers are prohibited from billing under the NPI number of a different provider.
- Transportation Services – When billing for transportation services, a valid origin and destination modifier are required. Horizon NJ Health members shall be transported to and from medical appointments in a manner that results in the accrual of the least number of miles. Mileage is measured by odometer from the place of departure or the point at which the member enters the vehicle to the destination or point at which the member exits the vehicle. At no time shall the transportation provider’s base location be used when calculating mileage. The CMS-1500 claim form should be completed by choosing modifiers that appropriately support the member’s place of departure and destination locations.
- Procedure Codes – All codes are to be in HIPAA-compliant format. The use of CPT Level III codes (local codes) is no longer valid.
- Diagnosis Codes – All diagnosis codes must be reported and coded to the 7th digit, if available.
- Retroactive Terminations – Horizon NJ Health participates in the Medicaid and NJ FamilyCare programs. Our members must maintain eligibility in order to receive services. There may be times when a member’s eligibility is retroactively terminated, as determined by the Medicaid/NJ FamilyCare program. This retroactivity will result in an encounter rejection. Horizon NJ Health is required to reverse payment already made to the physician, hospital and health care professional.
- Medical Claims for Fluoride Varnish – Providers should use the following procedure and diagnosis codes when submitting medical claims for fluoride varnish applications:
 - 99188
 - Z41.9 (ICD-10)

9.9 Remittance Advice Documentation

Overview of Payment Summary Page

Horizon NJ Health provides a comprehensive summary of financial information and activity on the Remittance Advice (RA).

The body of the RA contains claim detail and the Payment Summary page indicates whether the physician/payee has a positive (+) or negative (-) balance.

Many hospitals, physicians or health care professionals have requested ongoing notification of overpayments and negative payee balances in relation to claim adjudication activities, capitation payments, or accounts payable adjustments. The Payment Summary page displays this information as “rolling balances” of overpaid amounts that are owed to Horizon NJ Health. The “rolling balance” is updated on each RA after current claim payments and other adjustments have been applied.

Providers may also register for Electronic Funds Transfer (EFT) to receive payments. [Review information and instructions for enrolling in EFT](#). Note that if you register for EFT, you must also register for ERA or else you will not receive RAs.

If, after reviewing the RA, you have questions or want to request a reconsideration, go to [NaviNet.net](#). If your concerns are still not resolved, contact Provider Services at **1-800-682-9091** for assistance. MLTSS Providers can call MLTSS Provider Services at **1-855-777-0123**.

These explanation codes represent the current set of codes that are returned to the hospital, physician or health care professional on the RA. Please review the following list before calling the Physician & Health Care Hotline for questions about RA codes. If an electronic RA is requested, it will be submitted in the HIPAA-compliant 835 format. The explanation codes do not apply to an electronic RA transaction.

Cost Share/Patient Pay Liability (PPL) for MLTSS Services

Long-term care providers (i.e., Specialty Care Nursing Facilities, Nursing Facilities and Assisted Living Facilities) collect the Cost Share/PPL monthly from a Medicaid beneficiary and/or their designee to offset the cost of long-term care. Individuals living in the community will pay Cost Share/PPL directly to the State of New Jersey with the exception of Program for All-inclusive Care for the Elderly (PACE) participants. Refer to DMAHS for more information.

9.10 Labcorp Testing/Professional Relations Representatives Billing

Some tests are not available via Labcorp and must be completed at a hospital or clinical setting and billed accordingly. Some of these tests cannot be performed in hospitals and will require prior authorization. Please contact Labcorp Customer Service for more information on tests that are not available via Labcorp.

Labcorp Customer Service
1-800-631-5250

Information about testing not available through Labcorp is also available at [genetests.org](#).

9.11 Out-of-State Medicaid Claims for Blue Cross and Blue Shield Association Plans

State Medicaid agencies contract with Blue Cross and/or Blue Shield Plans as Managed Care Organizations (MCOs) to provide comprehensive Medicaid benefits on a risk basis. Both federal and state regulations guide these relationships, but the eligible population, covered benefits and specific rules regarding each state’s Medicaid program may differ from state to state. Many state Medicaid programs require providers to enroll as Medicaid

providers with that state’s Medicaid agency before payment can be issued. In other cases, a state Medicaid program will accept a provider’s Medicaid enrollment in the state where the provider practices.

Medicaid Reimbursement and Billing

Claims for all Horizon NJ Health Medicaid members should be submitted to your local BCBS Plan. If you are contracted with Horizon NJ Health, your Medicaid rates will only apply for services provided to Horizon NJ Health members. These rates do not apply to services provided to out-of-state Medicaid members. When you provide services to a Medicaid member from another state, you must accept that state’s Medicaid allowance (less any member responsibility such as copayments) as payment in full. Please note that billing out-of-state Medicaid members for any amounts in excess of the Medicaid-allowed amount for Medicaid-covered services is specifically prohibited by federal regulations (42 CFR 447.15).

Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements. Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. As a reminder, applicable Medicaid claims submitted without these data elements will be denied.

Provider Enrollment Requirements

As indicated above, some states require that out-of-state providers enroll in their state’s Medicaid program in order to be reimbursed. Some of these states may accept a provider’s Medicaid enrollment in the state where they practice to fulfill this requirement. If you are required to enroll in another state’s Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state’s Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local BCBS plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

[9.12 Claim overpayment: Payment return policy](#)

The Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, requires providers to return overpayments to Horizon NJ Health within 60 days of self-identifying the overpayment.

Instructions for reporting/returning overpayments

Please send details of the overpayment, including claim ID(s) along with payment, to:

**Horizon NJ Health
Claims Services
PO Box 24077
Newark, NJ 07101-0406**

10.0 Grievance and Appeals Process

Utilization Management Appeal Process: Service Denial/Limitation/Reduction/Termination based on Medical Necessity

You, the Provider, and the member should receive a notification letter within two business days of any decision to deny, reduce, or terminate a service or benefit. If you or the member disagrees with our decision, with the member's written permission, you (or the member) can challenge our decision by requesting an appeal. Our UM committee, nor its utilization review agent, will not take any action with respect to a member or a health care provider that is intended to penalize or discourage the member or the member's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, we will not take any punitive action against a provider who requests an expedited resolution or supports a member's appeal. See the summary below for the timeframes to request an appeal. For the dental appeals process, please refer to page D-11, Section J. For the MLTSS Appeal Process, please refer to Appendix B, Section B of this manual.

Stages	Timeframe for Member/Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached	FamilyCare Plan Type
<p>Internal Appeal The Internal Appeal is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.</p>	60 calendar days from date on initial notification/denial letter	<ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within ten calendar days of the date on the notification letter, whichever is later 	30 calendar days or less from health plan's receipt of the appeal request	A/ABP B C D
<p>External/IURO Appeal The External/IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO).</p>	60 calendar days from date on Internal Appeal notification letter	<ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within ten calendar days of the date on the Internal Appeal notification letter, whichever is later 	45 calendar days or less from IURO's decision to review the case	A/ABP B C D
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	<p>Whichever is the latest of the following:</p> <ul style="list-style-type: none"> • On or before the last day of the current authorization; or • Within ten calendar days of the date on the Internal Appeal notification letter, or • Within ten calendar days of the date on the External/IURO appeal decision notification letter 	A final decision will be reached within 90 calendar days of the Fair Hearing request.	A/ABP only

10.1 Initial Adverse Determination

If Horizon NJ Health decides to deny the member's initial request for a service, or to reduce or stop an ongoing service that the member has been receiving for a while, this decision is also known as an adverse determination. We will tell you and the member about this decision as soon as we can, often by phone. The member will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you (with the member's written permission) or the member can challenge the decision by requesting an appeal. You or the member can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call us at Provider Services at **1-800-682-9094 x89606** from weekdays 8 a.m. to 5 p.m. or Member Services at **1-800-682-9090 (TTY 711)**. Please remember that if your appeal is requested orally, you or the member will need to follow up by sending a written, signed letter confirming the appeal request as soon as you can. Written appeal requests should be mailed to the following address:

**Horizon NJ Health
Member/Provider Correspondence
PO Box 10196
Newark, NJ 07101-0406**

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

10.2 Internal Appeal

The first stage of the appeal process is a formal internal appeal to Horizon NJ Health (called an Internal Appeal). The member's case will be reviewed by a doctor or another health care professional, selected by Horizon NJ Health who has expertise in the area of medical knowledge appropriate for the member's case. We will be careful to choose someone who was not involved in making the original decision about the member's care. We must make a decision about the appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If the appeal is denied, the member will receive a written letter from us explaining our decision. The letter will also include information about the member's right to an External Independent Utilization Review Organization (IURO) Appeal, and/or their right to a Medicaid State Fair Hearing, and how to request these types of further appeal.

Expedited (fast) Appeals

The member has the option of requesting an expedited (fast) appeal if they feel that their health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about the appeal. Also, if you, the provider, informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize the member's life or health, or their ability to fully recover from their current condition attain, we must make a decision about your appeal within 72 hours.

10.3 External (IURO) Appeal

If the Internal Appeal is not decided in the member's favor, you (with the member's written consent) or the member can request an External (IURO) Appeal by completing the External Appeal Application form. A copy of the External Appeal Application form will be sent to the member with the letter that tells them about the outcome of the Internal Appeal. You or the member must mail the completed form to the following address within **60 calendar days** of the date on the Internal Appeal outcome letter:

**New Jersey Department of Banking and Insurance
Consumer Protection Services, Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329**

You may also fax the completed form to **1-609-633-0807**, or send it by email to ihcap@dobi.nj.gov. If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call Provider Services at **1-800-682-9094 x89606** from weekdays 8 a.m. to 5 p.m. or Member Services at **1-800-682-9090 (TTY 711)** to request a copy.

External (IURO) Appeals are not conducted by Horizon NJ Health. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either Horizon NJ Health or the State of New Jersey. The IURO will assign the case to an independent physician, who will review the case and make a decision. If the IURO decides to accept the case for review, they will make their decision within 45 calendar days (or sooner, if the member's medical condition makes it necessary).

You or the member can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or the member should fax a completed copy of the External Appeal Application form to the Department of Banking and Insurance at **1-609-633-0807**, and ask for an expedited appeal on the form in Section V, Summary of Appeal. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about the appeal *within 48 hours*.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance's at **1-888-393-1062**, option **3**.

Note: There are some services that the IURO will not review. If the letter the member receives about the outcome of the appeal does not include information about the member's option to request an External (IURO) review, this is probably the reason. However, if you have questions about your options, call Provider Services at **1-800-682-9094 x89606** from weekdays 8 a.m. to 5 p.m. or Member Services at **1-800-682-9090 (TTY 711)**.

The External (IURO) Appeal is optional. You, or the member, do not need to request an External (IURO) appeal before you request a Medicaid State Fair Hearing. Once the Internal Appeal is finished, the member has the following options for requesting an External (IURO) Appeal and/or a Medicaid State Fair Hearing:

- The member request an External (IURO) Appeal, wait for the IURO's decision, and **then** request a Medicaid State Fair Hearing, if the IURO did not decide in their favor.
- The member requests an External (IURO) Appeal **and** a Medicaid State Fair Hearing **at the same time** (just keep in mind that you make these two requests to different government agencies).
- The member requests a Medicaid State Fair Hearing without requesting an External (IURO) Appeal.

Note: **Medicaid Fair Hearings are only available to NJ FamilyCare Plan A and ABP members.**

10.4 Medicaid State Fair Hearing

The member has the option to request a Medicaid State Fair Hearing after the Internal Appeal is finished (and Horizon NJ Health has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. The member has up to **120 calendar days** from the date on the Internal Appeal outcome letter to request a Medicaid State Fair Hearing. The member can request a Medicaid State Fair Hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712

If the member makes an expedited (fast) Medicaid State Fair Hearing request, and they meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Note: The deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter explaining the outcome of your Internal Appeal. This is true even if the member requests an External (IURO) Appeal in the meantime. The 120 day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of the Internal Appeal, **not** the External (IURO) Appeal.

Continuation of Benefits

If you, or the member, are asking for an appeal because Horizon NJ Health is stopping or reducing a service or a course of treatment that the member already has been receiving, you can have the member's services/benefits continue during the appeal process. We will automatically continue to provide the service(s) while the appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (acting on the member's behalf with their written consent) or the member file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, **whichever is later**.

The services will not continue automatically during a Medicaid State Fair Hearing. If you want the member's services to continue during a Medicaid State Fair Hearing, you or the member must request that ***in writing*** when you request a Fair Hearing, and make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; or within
- 10 calendar days of the date on the letter informing the member of the outcome of the External (IURO) Appeal, if you requested one; **or**
- On or before the final day of the original authorization, **whichever is later**.

Note: **If you ask to have the member's services continue during a Medicaid State Fair Hearing and the final decision is not in the member's favor, the member may be required to pay for the cost of their continued services.**

If you have any questions about the appeal process, you can contact our Utilization Management Department by calling **1-800-682-9094 x89606**.

10.5 Claim Appeal Process

This section describes procedures through which participating and nonparticipating physicians, facilities and health care professionals have a right to a written appeal of disputes relating to payment of claims, as defined below. As always, Horizon NJ Health's procedures are intended to provide our physicians, facilities and health care professionals with a prompt, fair and full investigation and resolution of claim issues. All of our delegated vendors will also adhere to our existing policies and procedures. The procedure includes a Stage Two external Alternative Dispute Resolution (ADR) option for claim payments that physicians, facilities and health care

professionals continue to dispute after pursuing their appeal through Horizon NJ Health’s Stage One internal appeals process.

Common Appeal Reasons

No Referral or Authorization: Referral or authorization was provided by PCP or Horizon NJ Health prior to providing the service to the member.

Untimely Filing: Claim was filed within the required 180 days from the date of service.

Payment Discrepancy: The amount paid was inconsistent with the contracted rate or the established Horizon NJ Health fee schedule.

Not Member’s PCP: Physician or other health care practitioner was the member’s PCP on the date of service and/or covering for a physician or other health care practitioner on the date of service.

Member Not Enrolled: The member was enrolled in the Medical Assistance on the date of service, as evidenced by valid source documentation.

Lack of Explanation of Benefit (EOB): Third-party liability information has been provided to show the member is not eligible for other coverage or has reached their benefit limit.

Claims Editing Discrepancy: Physician, facility or other health care practitioner disagrees with the edits applied to the claim.

Incorrect Denial: The denial code on the claim is not accurate. No physician, facility or health care professional who exercises the right to file an appeal under this procedure shall be terminated or otherwise penalized for filing and pursuing such an appeal.

When a physician, facility or health care professional is dissatisfied with a claim payment, including determinations, prompt payment or no payment made by Horizon NJ Health, he/she may file a claim appeal, as described herein. **All claim appeals must be initiated on the applicable appeal application form created by the Department of Banking and Insurance. The appeal must be received by Horizon NJ Health within 90 calendar days following receipt by the physician, facility or health care professional of the payer’s claim determination.**

To file a claim appeal, a physician or health care professional must send the appeal application form, which is available at horizonNJhealth.com/for-providers, and any supporting documentation to Horizon NJ Health using one of the following methods:

**Mail: Horizon NJ Health
Claim Appeals
PO Box 63000
Newark, NJ 07101-8064**

Fax: 1-973-522-4678

IMPORTANT – Supporting documentation, e.g., proof of timely filing, may be submitted. Please follow all appropriate procedures as defined in this manual before submitting an appeal.

Note: Corrected claims should be sent to Horizon NJ Health, Claim Processing Department, PO Box 24078, Newark, NJ 07101-0406. These claims should not be submitted through the appeals process.

Stage One

A Horizon NJ Health employee who serves as an appeal resolution analyst shall review all claim appeals. Appeals resolution analysts are personnel of Horizon NJ Health who are not responsible on a day-to-day basis for the payment of claims. The appeal resolution analyst shall review all submitted documentation and confer with all necessary Horizon NJ Health departments, given the nature of the claim appeal. Upon review by the appeal resolution analyst, a decision will be rendered. The appeals resolution analyst will render a final determination with written notification that will be sent to the physician, facility or health care professional within 30 calendar days of the date of Horizon NJ Health's receipt of the claim appeal request. The appeal decision will be sent to the contact that is documented on the Department of Banking and Insurance's Claim Appeal Application Form. Horizon NJ Health has established a binding and non-appealable external alternative dispute resolution (ADR) mechanism that involves arbitration and, in some cases, mediation, for physicians, facilities or health care professionals who remain dissatisfied following their pursuit of an appeal through the Stage One internal claim appeal process. These mechanisms are described below.

Stage Two - Alternative Dispute Resolution (ADR)

All adverse decisions made by a claim appeal reviewer may be appealed by the physician or health care professional through an independent, binding ADR process. Arbitration must be initiated on or before the 90th calendar day following receipt of the determination of an internal appeal. Disputes must be in the amount of \$1,000 or more. Physicians and health care professionals may aggregate claims to reach the \$1,000 minimum under circumstances in which the same claim issue is involved.

The Department of Banking and Insurance (DOBI) awarded the independent arbitration organization contract to MAXIMUS, Inc. Parties with claims eligible for arbitration may complete an application accessible online at njpica.maximus.com and submit the application, together with required review and arbitration fees, to the Program for Independent Claims Payment Arbitration (PICPA).

Participating and nonparticipating physicians or health care professionals may initiate the above binding and non-appealable external ADR review of an adverse decision of a physician or health care professional claim appeal review **after** the Stage One internal appeal by filing a request for external ADR review with the written findings from the Stage One determination within 90 calendar days from the date of the claim appeals reviewer's written decision to the following address:

MAXIMUS, Inc.
Attn: New Jersey PICPA
3750 Monroe Ave.
Suite 705
Pittsford, NY 14534

Fax: 1-585-869-3388

External appeals must be initiated through MAXIMUS, Inc., and not through Horizon NJ Health. Further information regarding PICPA, can be found on MAXIMUS's website at njpica.maximus.com or on the DOBI website at state.nj.us/dobi/index.html.

Additional Review

Notwithstanding of the above, physicians have the right, at any time and regarding any issue, to seek assistance from the following:

**New Jersey Department of Health and Senior Services
Office of Managed Care
PO Box 367
Trenton, NJ 08625-0367**

Or

**New Jersey Department of Banking and Insurance
Division of Enforcement and Consumer Protection
PO Box 329
Trenton, NJ 08625-0329**

If members need assistance in completing forms and taking other procedural steps related to a grievance or appeal, they can contact Member Services at **1-800-682-9090** (TTY 711).

11.0 Service Departments

Horizon NJ Health is available to assist you in providing health care services to our members. This section describes each of the service departments by function.

11.1 Provider Contracting & Strategy

A Provider Contracting & Strategy Department representative is available to visit your office and/or facility to provide orientation and training on Horizon NJ Health policies and administrative procedures. Provider, Contracting & Strategy responsibilities include identifying network needs, assisting in recruitment of additional physicians and participating in the educational process of physicians on a day-to-day basis.

For a list of Provider Relations Representatives, visit horizonNJhealth.com/PCSstaff.

11.2 Provider Services Phone Number

The Provider Services Phone Number is available to furnish general information about policies, administrative procedures, eligibility, member benefits, member care, billing, claims and capitation inquiries, coordination of benefits and other services available for members.

Provider Services: 1-800-682-9091
Monday through Friday, 8 a.m. to 5 p.m.

11.3 Member Services Department

The Member Services department provides information to members regarding eligible services. Members should be referred to this department to address any questions about their eligibility and/or benefits. Bilingual representatives are available.

Member Services Department
1-800-682-9090 (TTY 711)
24 hours a day, seven days a week

11.3.1 MLTSS Member Services

Horizon NJ Health cares about making sure that members in the MLTSS program have the information they need to make informed decisions and have someone they can speak to if they have any issues or questions. Member services are available to MLTSS members 24 hours a day, seven days a week.

Member Services will:

- Internally represent the interests of MLTSS members and assist them in understanding the MLTSS Services versus Plan Benefit
- Provide education to members, families, and providers on issues related to the MLTSS program
- Assist members in navigating Horizon NJ Health's MLTSS system
- Be a resource for members by providing information, making referrals to other staff members, and resolving issues if possible

MLTSS Member Services can be reached 24 hours a day, seven days a week at **1-844-444-4410 (TTY 711)**.

11.3.2 Provider Contact Numbers for MLTSS Services

Nursing Facilities

Provider contact number for when a resident that is auto-assigned or has self-selected the MCO and needs a NJ Choice Assessment performed; also to assist with issues in assigning or administering hospice services:

1-844-444-4410

Home and Community-Based Services
For any member issues: **1-844-444-4410**

Claims, Eligibility and Enrollment Issues for all MLTSS Providers: **1-855-777-0123**

11.4 Utilization Management Department

The Utilization Management (UM) Department coordinates hospital admissions, precertification, discharge planning and home care services. This department also assists physicians in managing the services provided to members.

Horizon NJ Health's UM program oversees the prompt, efficient delivery of quality health care services and evaluates the appropriateness of medical resources utilized by our members.

Prior authorization, concurrent review, discharge planners and care managers are available to coordinate care for members with complex medical and/or social problems, as well as to educate members about covered services and the utilization management process. The primary method for submitting Prior authorizations and Notice of Admission requests is through NaviNet.

Utilization Management Department
1-800-682-9094
Monday through Friday, 8 a.m. to 5 p.m.

Or

Medical On Call/After Hours and Weekends: 1-888-223-3072
Behavioral Health Utilization Management 24/7: 1-800-682-9094

11.4.1 UM Ethical Standards

Horizon NJ Health adheres to the following principles in the conduct of the UM program:

- UM decisions made are based solely on the necessity and appropriateness of care and service within the parameter of the member's Medicaid benefit.
- Horizon NJ Health does not compensate those responsible for making UM decisions in a manner that provides incentive to deny or approve coverage for medically necessary and appropriate covered services.
- Horizon NJ Health does not offer its employees performing UM review incentives to encourage denials of coverage or service that are medically necessary, and does not provide financial incentives to hospitals, physicians and other health care professionals to withhold covered health care services that are medically necessary and appropriate.

11.4.2 Retrospective Review

When a retrospective review is required in instances in which an admission and discharge occur over a weekend, Horizon NJ Health will accept the clinical review within three business days of discharge and for prior authorizations including outpatient medical and behavioral health within six business days. For behavioral health, this includes the following levels of care and Outpatient services, but are not limited to: Intensive Outpatient, Partial Hospital, Partial Care and ABA services.

The hospital must submit the request for a retrospective review through NaviNet and select Post Service event classification area of the authorization main screen. Horizon NJ Health has up to 30 days to review retrospective requests. Providers can utilize NaviNet to review authorization status.

In extenuating circumstances related to eligibility verification/exhaustion of primary benefit, such inquiries will be reviewed on a case-by-case basis and require supporting documentation.

11.4.3 Staffing Qualifications

The Utilization Management Department consists of licensed nursing professionals with the minimum of two years clinical experience. We also employ non-clinical, administrative support personnel and licensed practical nurses (LPNs). The Utilization Management Department also consists of a team of Medical Directors that support review and determination of medical necessity. All authorizations including behavioral health are sent to the Medical Directors when utilization criteria is not met. Staff is identified by name, title and organization name when initiating and returning calls regarding UM related inquiries.

For behavioral health providers:

Behavioral Health Licensed Clinical professionals include Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Marriage and Family Counselors (LMFTs), Licensed Clinical Psychologists, (PhD/PsyD.) and Board Certified Behavioral Analysts (BCBAs).

11.4.4 Precertification and Authorization Criteria

Prior authorizations and/or authorizations of all medical services are conducted using one of the following Horizon NJ Health approved approaches:

- MCG Care guidelines-Evidence-Based Criteria: clinical decision support to review and determine medical necessity
- Horizon NJ Health Uniform Medical Policies (UMP) are developed and approved by the Medical Policy Committee and the Quality Improvement committee at Horizon BCBSNJ
- Evidence-based peer reviewed current medical literature
- ASAM- American Society of Addiction Medicine Comprehensive Guidelines for addiction conditions.
- Centers for Medicare/Medicaid Services (CMS) - Local and National coverage determinations (LCD/NCD) Medicare guidance to determine what items or services may be covered.

Information about the above criteria is available on the Horizon NJ Health website at horizonNJhealth.com. Providers can obtain a copy of the benefit provisions and the guideline protocols.

Horizon NJ Health medical directors are available to discuss clinical determinations with the treating provider. They can be contacted at **1-800-682-9094 x89469**.

We have a TTY and language line services that are available to members, at no cost. During their office visit, members who require this service can ask their provider to call Horizon NJ Health Provider Services at **1-800-682-9091 (TTY 711)**, Monday through Friday, from 8 a.m. to 5 p.m. After hours, members can ask their provider to call Horizon NJ Health Member Services at **1-800-682-9090 (TTY 711)**.

11.4.5 Patient Hospital Generic Quality Improvement Guideline Screens

The Quality Management Department annually reviews data and, monitors the quality of care through the application of the following types of inpatient screens and reports, implemented by the UM nursing staff.

Criteria for quality referral:

- Surgical or invasive procedures
- Product or device events
- Patient protection events
- Care management events
- Environmental events

- Radiologic events
- Potential criminal events
- Other

11.4.6 Neonatal Utilization Management Program

The Neonatal Utilization Management (UM) program is for all neonates admitted to the neonatal intensive care unit (NICU). The program is designed to ensure that Horizon NJ Health neonatal members have access to high-quality, evidenced-based care throughout the first year of life.

The goal of the Neonatal UM program is to work collaboratively with the facilities, providers and Horizon NJ Health's Case Managers from admission to the NICU through discharge to the next level of care.

11.4.7 Emergency Services

If a medical emergency leads to a hospital admission, the Horizon NJ Health UM Department must be notified by the hospital or physician within 24 hours of the admission to initiate the review process, as set forth in Section 8.3 Hospital Admissions.

Horizon NJ Health recognizes an emergency service as a health care service required to treat a medical condition. Examples of an emergency include, but are not limited to: severe pain, psychiatric disturbances and/or symptoms of substance use disorder. In addition, serious impairment to bodily functions such as a dysfunction of a body organ or part. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child. Members are advised to present at the nearest emergency facility and to notify the Member Services department or their PCP of their emergency room visit. This policy includes out-of-network services.

Horizon NJ Health covers emergency services that include:

1. Medical examination at an ER which is required by NJAC 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.
2. Examinations at an ER for suspected physical/child abuse and/or neglect.

11.4.8 Utilization Review and Reports

Horizon NJ Health produces reports for analysis that focus on the review and detection of over- and underutilization. The reports provide a mechanism to monitor and identify deviations of patterns of treatment from established standards, baselines or norms. These reports profile utilization of facilities, physicians and enrollees and compare them against experience and norms for comparable entities. Physicians are notified of this information via profiles, newsletters, drug utilization review and UM committee.

11.4.9 Discharge Planning

The main objective of the Discharge Planning program is to ensure appropriate and timely discharge from a hospital to a more appropriate level and setting of care. When a member is hospitalized and it has been determined that they may be in need of special assistance at the time of discharge, case managers make the appropriate contacts with Social Services and community service groups and lend assistance in the overall transition.

Medical review programs and protocols are in place to effectively control both in- and out-of-network utilization. All out-of-network utilization is reviewed when a physician contacts UM to receive preadmission authorization. Utilization management clinical staff assist the caller in securing appropriate in-network services when available within geographic access.

Both primary and specialty physicians play an important role in each of the utilization review programs. In coordinating care, Horizon NJ Health's network physicians must drive this process and work directly with health services staff in the coordination of medical services.

For Behavioral Health, all psychiatric inpatient admissions are referred to our Follow up after hospitalization (FUH) team to assist the member with discharge planning and aftercare support. The FUH program is designed to provide the member with additional resources they may need to assure appropriate aftercare services are available to them within seven days of discharge.

Post-Acute Facility

As part of discharge planning from an acute care setting, post-acute facility clinicians are available to review and determine the need for rehabilitation services. All prior authorization for post-acute care must be submitted through our Utilization Management Request Tool, NaviNet or by calling **1-844-243-3450**, option **1** for FIDE SNP, and call **1-800-682-9091 x89104** for Medicaid to initiate the review process.

Please call Modivcare for all transportation authorizations at **1-866-527-9933**.

11.4.10 Drug Utilization Review

Horizon NJ Health has a comprehensive, concurrent and retrospective Drug Utilization Review (DUR) program. Horizon NJ Health systematically obtains and analyzes drug utilization data from contracted physicians. Physicians are required to submit such data under their contract. The objective of the data analysis is to profile patterns of drug usage by physician and member (physician profile, frequency of drug, type, usage, cost, trend, volume, etc.) This data is used in both the Quality Improvement and UM programs.

Concurrent DUR utilizes innovative information technology to proactively warn the dispensing pharmacist of potential drug misadventures. The Clinical Decision Support System (CDSS) checks all incoming prescriptions, compares them to patient demographics and checks for potential clinical conflicts that may result if the prescription is dispensed, such as drug-drug interactions, drug-allergy conflicts, drug-disease conflicts, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, underutilization, overutilization, clinical abuse/misuse, drug-age conflicts, drug- gender conflicts, duration of therapy and drug-pregnancy conflicts.

11.4.11 Concurrent Review

MCG Health guidelines are Evidence-Based Criteria, Horizon NJ Health uses to support clinical decisions during the review and determination of medical necessity.

For substance use disorder, Horizon NJ Health utilizes ASAM the American Society of Addiction Medicine criteria.

The need for hospital admission or continued stay is based on the patient's present condition, underlying medical condition and the nature of the services provided. For surgical requests, the need for post-operative care and the potential for complications are also considered. When a request does not meet criteria, it is referred to a medical director for a medical necessity determination.

Horizon NJ Health medical directors are available to speak with providers for peer to peer requests regarding UM determinations. They can be reached at **1-800-682-9094, x89469**.

All inpatient requests will be monitored on an ongoing basis by a Horizon NJ Health concurrent review coordinator. Concurrent review will be performed by licensed RN, LPNs and Behavioral Health Clinicians including LCSW, LMFT, LPC, BCBA's, PhD/PsyD. They are supported by Horizon NJ Health medical directors,

who will determine and document the medical need for continued stay in a facility and/or initiate appropriate discharge planning.

Notification of all Horizon NJ Health inpatient admissions is required within 24 hours of admission. Daily concurrent review is required for some inpatient admissions based on contractual arrangements. Critical clinical information is required to conduct concurrent review. Examples of critical elements include, but are not limited to; history of presenting problem, clinical exam and diagnostic test results, operative and pathological reports, treatment plan, progress notes and consultations, and the requested level of care. The determination will be provided to the facility within 24 hours of receipt of clinical information.

If Horizon NJ Health requests additional information to approve or deny an authorization, a response is required within 72 hours from the time that a request for additional information is made.

Daily communication is faxed to the hospital UM Department via the Daily Hospital Log with determination.

For Behavioral Health, verbal notification of a UM decision is provided via telephone by licensed UM staff post decision within 24 hours, and in writing within 72 hours.

11.4.12 Second Opinion

Horizon NJ Health utilizes a combination of Milliman Care Guidelines criteria as a resource for second opinion determinations, and medical director review for all elective surgical procedures and for the treatment of serious medical conditions, such as cancer.

Members may request a second opinion from a specialty care provider for any medical condition by contacting their PCP, who is responsible for the medical management of the patient's care.

If Horizon NJ Health receives a request for a second opinion, the UM team will utilize a combination of MCG Health Guidelines and refer all second opinion requests to the medical director for review and determination.

Requests for second opinions with nonparticipating providers undergo the same type of review as other requests involving nonparticipating providers. Information about members' rights to dental second opinions is available on page D-1 of this Manual.

11.5 Pharmacy Department

The Pharmacy Department reviews requests for medications requiring prior authorization. The Pharmacy Department is available to assist physicians in managing pharmaceutical services provided to members. Questions pertaining to the formulary or prior authorizations can be directed to the Pharmacy Department at **1-800-682-9094**, weekdays, 8 a.m. to 5 p.m. ET, and Saturday, 8 a.m. to 4:30 p.m. ET.

11.6 Quality Management Department

The Quality Management Department assists physicians by ensuring that Horizon NJ Health members receive the highest standard of health care. If you identify a quality of care issue, please contact Provider Services at **1-800-682-9091**, Monday through Friday, 8 a.m. to 5 p.m.

11.7 MLTSS

Horizon NJ Health's Managed Long Term Services and Supports (MLTSS) benefits focus on preventive in-home, medically appropriate care, offering a comprehensive menu of service options across beneficiary groups or care settings in the home, an alternate community setting like assisted living or in a nursing facility. Services offered range from assisted living services to home-delivered meals to home and vehicle modifications to lawn care.

11.8 Horizon NJ TotalCare (HMO D-SNP) Care Management

Horizon NJ Total Care (HMO D-SNP) requests the PCP's ongoing participation to ensure that FIDE-SNP members have comprehensive access to services and meaningful coordination of care. The PCP is responsible for:

- Reviewing the proposed care plan faxed (or accessed via NaviNet) to them from Horizon NJ Total Care (HMO D-SNP) for their patient
- Providing any necessary additional information about the member's care to ensure the care plan is complete and accurate
- Updating each care plan as needed by faxing to FIDE-SNP Care Management or updating in NaviNet
- Discussing the care plan with the Horizon NJ TotalCare (HMO D-SNP) member for whom he or she provides care
- Communicating with the Interdisciplinary Care Team as requested to ensure optimal coordination of care
- Encouraging member participation in care management

If you have questions about our Care Management program, call us at **1-888-621-5894 (TTY 711)**, option 2. Representatives are available Monday through Friday from 8 a.m. to 5 p.m., ET.

12.0 Horizon NJ Health Policies and Procedures

12.1 Member Rights and Responsibilities

All members have the following rights:

1. To have access to a PCP or a backup doctor, 24 hours a day, 365 days a year, for urgent care
2. To obtain a current directory of doctors within the network
3. To have a choice of specialists
4. To have a second opinion
5. To receive care from an out-of-network provider when a participating Horizon NJ Health provider is not available
6. If a member has a chronic disability, to be referred to specialists who are experienced in treating their disability
7. To have a doctor make the decision to deny or limit a member's coverage
8. To have no "gag rules" in Horizon NJ Health. That means doctors are free to discuss all medical treatment options even if the services are not covered
9. To know how Horizon NJ Health pays its doctors, so a member will know if there are financial incentives or disincentives tied to medical decisions
10. To be free from inappropriate balance billing
11. To be treated with respect and with recognition of their dignity and right to privacy at all times
12. To receive care without regard to race, color, religion, sex, age or national origin
13. To participate with their doctor in making decisions about their health care
14. To information and open discussion about the member's own medical condition, and the right to choose from different ways of treating their condition, regardless of cost or benefit coverage
15. To have the member's medical condition explained to a family member or guardian if the member is unable to understand, and have it documented in the member's medical records
16. To refuse medical treatment with an understanding of the results of refusal
17. To call 911 in a potential life-threatening situation – without prior approval from Horizon NJ Health
18. To have Horizon NJ Health pay for a medical screening exam in the emergency room to determine whether an emergency medical condition exists
19. To postpartum stays in the hospital no less than 48 hours for a normal vaginal delivery and no less than 96 hours following a cesarean section
20. To receive up to 120 days of continued coverage – if medically necessary - from a doctor who has been terminated by Horizon NJ Health including:
 - Up to six months after surgery
 - Six weeks after childbirth
 - One year of psychological or oncologic treatment— No coverage may be continued if the doctor is terminated for cause.
21. To timely notification of changes to the member's benefits or the status of their provider
22. To make an advance directive about medical care. Federal law requires providers to ask about a member's advance directive
23. To receive information about Horizon NJ Health, its services, doctors and providers, and the member's rights and responsibilities
24. To offer suggestions for changes in policy and procedure, including the member's rights and responsibilities
25. To have access to a member's own medical records – at no charge to the member
26. To privacy of the member's medical information and records
27. To refuse the release of personal information (except when required or permitted by law)

28. To be informed in writing if Horizon NJ Health decides to end a member's membership
29. To tell Horizon NJ Health when a member no longer wishes to be a member
30. To appeal a decision to deny or limit coverage, first within Horizon NJ Health and then through an independent organization
31. To appeal any Horizon NJ Health decision, the care it provides, benefits or membership
32. To make a complaint about the organization or the care provided in the member's primary language
33. To know that a member or their doctor cannot be penalized for filing a complaint or appeal
34. To contact the Department of Banking and Insurance or the Department of Human Services whenever the member is not satisfied with Horizon NJ Health's resolution of a complaint or appeal
35. To give consent and make informed decisions about treatment of a member's minor dependents
36. Horizon NJ Health will provide care for members younger than 18 years old following all laws and treatment and will be at the request of the minor's parent(s) or other person(s) who have legal responsibility for the minor's medical care. Under certain circumstances, New Jersey law allows minors to make health care decisions for themselves. Horizon NJ Health will allow treatment without parental consent in the following cases:
 - Minors who go to an emergency room for treatment and that treatment is determined to be medically necessary.
 - Minors who want family planning services, maternity care or sexually transmitted diseases (STD) services.
 - Minors 14 years or older presenting themselves for drug/alcohol or mental health services. Services will be rendered as medically necessary without parental consent.

For a member to receive information in their preferred method of communication (in a language other than English) or to speak to an interpreter, at no cost to the member, members can call Member Services at **1-800-682-9090 (TTY 711)**, 24 hours a day, seven days a week.

All members have the following responsibilities:

1. To treat health care providers with same respect and kindness in which the member expects to be treated
2. To talk openly and honestly, and seek care regularly from a doctor
3. To abide by Horizon NJ Health's rules for medical care
4. To give information to a doctor and Horizon NJ Health in order for them to provide care
5. To ask questions of their doctor(s) so that the member can understand their health problems and the care they are receiving, and participate in developing mutually agreed-upon treatment goals
6. To follow their doctor's advice that was agreed upon, or to consider the results if they choose not to
7. To keep appointments and call in advance if an appointment must be cancelled
8. To read all the Horizon NJ Health materials and follow the rules of membership
9. To follow the proper steps when making grievances about care
10. To take advantage of educational opportunities to learn about health issues
11. To pay any copayments and/or premiums, when applicable
12. To inform the Health Benefits coordinator and Horizon NJ Health about any doctors the member is currently seeing at the time of enrollment

Additional information on member rights is available at: [HorizonBlue.com/Medicare](https://www.horizonblue.com/medicare). Information on members' rights to dental second opinions is available in Appendix D of this Manual.

12.1.1 MLTSS Member Rights and Responsibilities

In addition to the rights a traditional Horizon NJ Health member has, an MLTSS member has the right to:

1. Ask for and receive information on the choice of services and providers available to you

2. Have access to and choice of qualified service providers
3. Be told about all of their rights before receiving chosen and approved services
4. Get services no matter what their race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability
5. Have access to all services that are best for their health and welfare
6. Make the right decisions after being made to understand the risks and possible effects of the decisions made.
7. Make decisions about their own care needs
8. Help develop and change their own plan of care
9. Ask for changes in services at any time, including to add, increase, decrease or discontinue them
10. Ask for and receive from their Care Manager a list of names and duties of any providers assigned to provide services to them under the plan of care
11. Receive support and direction from their Care Manager to resolve concerns about their care needs and/or grievances about services or providers
12. Be told about a list of resident rights, and receive a copy in writing, upon admission to an institution or community residential setting
13. Be told of all the covered/required services they are entitled to, required by and/or offered by the institutional or residential setting, and of any charges not covered by Horizon NJ Health while in the facility
14. Not to be discharged or transferred out of a facility unless it is medically necessary; to protect their welfare and safety as well as the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice, to pay the facility from available income as reported on the statement of available income for Medicaid payment
15. Have Horizon NJ Health protect and promote all their rights
16. Have all rights and responsibilities outlined here shared with their authorized representative or court-appointed legal guardian

Along with rights come responsibilities. Here are some of the key responsibilities for MLTSS members:

1. Provide all health and treatment-related information, including but not limited to, medication, circumstances, living arrangements, and informal and formal supports, to the Care Manager to identify care needs and develop a plan of care
2. Understand their health care needs and work with their Care Manager to develop or change goals and services
3. Work with their Care Manager to develop and/or revise their plan of care to facilitate timely authorization and delivery of services
4. Ask questions when they need more information
5. Understand the risks that come with their decisions about care
6. Understand that Horizon NJ Health does not provide 24-hour/seven-day-a-week care management services, and that they will need to work with family and friends to safeguard against potential risks
7. Develop an emergency backup plan for care and services with their Care Manager
8. Report any major changes about their health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager
9. Notify their Care Manager should any problems occur or if they are not pleased with the services being provided
10. Pay their room and board in a nursing facility or community residential setting, and their cost share on time each month (if applicable)
11. Treat service workers and care providers with dignity and respect

12. Keep all Horizon NJ Health documents, such as their plan of care, emergency backup plan, etc., for their personal records and future reference
13. Follow Horizon NJ Health's rules and/or those rules of institutional or community residential settings

12.2 Member Non-Compliance

Please call Member Services when a member does not abide by the member responsibilities, continues with disruptive behavior at the physician's practice or refuses to comply with the recommended treatment program. Member Services will contact the member to discuss their responsibilities as a Horizon NJ Health member and seek to find a resolution to the situation.

Member Services
1-800-682-9090 (TTY 711)
24 hours, seven days a week

A healthy relationship between a provider and a member is important. If the provider believes that he/she cannot have this with a member, the provider may ask that the member receive treatment from another provider. Other circumstances in which a provider may request that a member be changed to another provider include:

- Inability to solve conflicts between the member and their PCP
- If a member fails to comply with health care instructions, where such non-compliance prevents the physician from safely or ethically proceeding with the member's health care services
- If a member has taken legal action against the provider

12.3 Horizon NJ Health Policies and Procedures

Because Horizon NJ Health's policies and procedures are intended to comply with federal and state requirements for the Medical Assistance program, providers are responsible for abiding by federal and state laws, regulations and program requirements, including the provisions of the contract between Horizon HMO and the New Jersey Department of Human Services.

12.4 Medically Necessary Services

The Division of Medical Assistance and Health Services (DMAHS), through regulation N.J.A.C. 10:74-1.4, defines medically necessary services as set forth below:

Medically necessary services are services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, when appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter (whether or not they are ordinarily covered services for all other Medicaid enrollees) are appropriate for the age and health status of the individual, and that the service will aid the overall physical and mental growth and development of the individual, and the service will assist in achieving or maintaining functional capacity. The Health Claims Authorization, Processing and Payment Act (HCAPPA) defines medical necessity or medically necessary as follows:

“Medical necessity” or “medically necessary” means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance with the “generally accepted standards of medical practice”; clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the covered person’s illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person’s illness, injury or disease.

Horizon NJ Health believes that the DMAHS definition, which we are mandated to use by the State Contract and N.J.A.C. 10:74-1.4, incorporates the language and principles of the HCAPPA definition (as indicated in the underscored language). Therefore, Horizon NJ Health’s Utilization Management (UM) program will function under the definitions in the same way as it has previously, utilizing the language from DMAHS found at NJAC 10:74 - 1.4. Furthermore, our medical policies and UM criteria used to help us reach decisions about medical necessity for coverage purposes reflect compliance with both definitions.

12.5 Clinical Practice Guidelines

Clinical practice guidelines are initiated and then re-evaluated biannually by Horizon NJ Health or more frequently in the event that new scientific evidence or national standards are published or such national guidelines change during the time period between biannual reviews. References to these guidelines are available on the Horizon NJ Health website, horizonNJhealth.com, or Appendix A of this manual.

12.6 Confidentiality Statement

The physician and health care professional agree and understand that all information, records, data and data elements collected and maintained for the operation of the physician and health care professional, Horizon NJ Health and the Department of Human Services of the State of New Jersey and pertaining to Horizon NJ Health members, shall be protected from unauthorized disclosure, in accordance with the provisions of 42 CFR Part 1396 (a)(7) (Section 1902 (a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7, and any and all applicable State and Federal laws and regulations. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of the provider agreement with Horizon NJ Health including the Department of Health and Human Services and to such others as may be authorized by Division of Medical Assistance and Health Services (DMAHS) in accordance with applicable law. For Horizon NJ Health members who are eligible through the Division of Child Protection and Permanency, records must be kept in accordance with the provision under N.J.S.A. 9:6-8.10a and 9:6-8.40, and any and all applicable State and Federal laws and regulations, consistent with the need to protect the members’ confidentiality.

12.6.1 Enrollee-Specific Information

With respect to any identifiable information concerning Horizon NJ Health members that is obtained by the physician, it: (a) shall not use any such information for any purpose other than carrying out the express terms of the provider agreement with Horizon NJ Health; (b) shall promptly transmit to Horizon NJ Health and DMAHS all requests for disclosure of such information; (c) shall not disclose, except as otherwise specifically permitted by Horizon NJ Health, any such information to any party other than DMAHS without Horizon NJ Health or DMAHS's prior written authorization specifying that the information is releasable under Title 42 CFR, Section 431, 300et seq.; and (d) shall, at the expiration or termination of the provider agreement with Horizon NJ Health, return all such information to Horizon NJ Health and/or DMAHS or maintain such information according to written procedures set by DMAHS for this purpose.

12.6.2 Employees

The physician and health care professional shall instruct their employees to keep confidential information concerning the business of Horizon NJ Health or DMAHS, its financial affairs, its relations with members and its employees, as well as any other information that may be specifically classified as confidential by law.

Medical records and management information data concerning Medicaid beneficiaries enrolled pursuant to the provider agreement with Horizon NJ Health shall be confidential and disclosed to other persons within the provider's organization only as necessary to provide medical care and quality peer or grievance review of medical care under the terms of the provider agreement with Horizon NJ Health.

The provisions of this section shall survive the termination of the provider agreement with Horizon NJ Health and shall bind the provider, so long as the physician and health care professional maintain any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

12.7 Affirmative Statement

The physician and health care professional are encouraged to freely communicate with members regarding available treatment options, including medication treatment that may or may not be a covered benefit under Horizon NJ Health.

Horizon NJ Health distributes a statement to providers and employees who make utilization management (UM) decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Horizon NJ Health does not specifically reward providers or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

12.8 Non-Discrimination Statement

The physician and health care professional shall comply with the following requirements regarding non-discrimination:

- The physician and health care professional shall accept assignment of a Horizon NJ Health member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental handicap, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

- ADA Compliance. In providing health care services, the physician and health care professional shall not directly or indirectly, through contractual, licensing or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are “qualified individuals with a disability” covered by the provisions of the ADA.
- A “qualified individual with a disability” is defined as an individual with a disability who, with or without reasonable modifications to rules, policies or practices; the removal of architectural, communication or transportation barriers; or the provision of auxiliary aids and services, meets the essential eligibility requirements for the recipient of services or the participation in programs or activities provided by a public entity.
- Horizon NJ Health shall submit a written certification to DMAHS that it is conversant with the requirements of the ADA, is in compliance with the law, and has assessed its physician and health care professional network, and certifies that the providers meet ADA requirements to the best of the physician’s and health care professional’s knowledge. The physician and health care professional warrant that they will hold the State harmless and indemnify the State from any liability, which may be imposed upon the State as a result of any failure of the physician and health care professional to be in compliance with the Act. Where applicable, the physician and health care professional must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.
- The physician and health care professional shall not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the physician and health care professional, or the eligible person’s actuarial class or pre-existing medical/health conditions.
- The provider shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a grievance/appeal.
- The physician and health care professional shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations or orders that prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion or national origin or ancestry. There shall be no discrimination against any employee engaged in the work required to produce the services covered by the provider agreement, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.
- Horizon NJ Health, the physician and health care professional shall not discriminate with respect to participation, reimbursement or indemnification as to any physician and health care professional, who is acting within the scope of the physician’s license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit Horizon NJ Health from including the physician and health care professional, only to the extent necessary to meet the needs of the organization’s members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.
- Scope. This non-discrimination provision shall apply to, but not be limited to, the following: recruitment, hiring, employment upgrading, demotion, transfer, layoff or termination, rates of pay or other forms of compensation and selection for training, including apprenticeship included in PL 1975, Chapter 127.

- Grievances. The physician and health care professional agree that copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation or physical or mental handicap shall be forwarded to DMAHS for review and appropriate action within three business days of receipt by the physician and health care professional.

Cultural Competency

Physicians shall demonstrate cultural competency in the following ways:

- Assess members and document in the medical record the presence or absence of cultural and/or language barriers to care
- Seek information from members, families and/or community resources to assist in servicing and responding to the needs and preferences of culturally and ethnically diverse members and families
- Display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of members and families
- Provide magazines, brochures and other printed materials that reflect diverse cultures in waiting areas
- Understand that folk and religious beliefs may influence how families respond to illness, disease, death and their reaction and approach to a child born differently-abled
- Understand that the family unit can be defined differently by different cultures
- Whenever possible, seek to employ bilingual staff or trained personnel to serve as interpreters
- Understand that a member and/or family's limitation in English proficiency is in no way a reflection of their level of intellectual functioning

12.9 Indemnification and Hold Harmless

As required by the New Jersey Medicaid program, at all times during the term of the agreement between Horizon NJ Health and the physician or health care professional, the physician or health care professional shall indemnify, defend and hold the State of New Jersey and members harmless from and against all claims, damages, causes of action, cost or expense, including reasonable attorney's fees, to the extent such actions were caused by any negligent act or other wrongful conduct by the physician or health care professional or physician's or health care professional's employee(s) arising with respect to the physician's services to members.

Billing Members

The provider agrees that under no circumstances (including, but not limited to, nonpayment by Horizon NJ Health, insolvency of the managed care plan or breach of agreement) will the provider bill, charge or seek compensation, remuneration or reimbursement from or have recourse against enrollees, or persons acting on their behalf, for covered services, except for applicable copayments as designated by Horizon NJ Health. However, a provider may charge DMAHS for Medicaid services not included in Horizon NJ Health's benefits package under this contract on a New Jersey Medicaid fee-for-service basis.

The provider may charge members when they seek care on their own for non-covered services. The provider is required to notify the member in writing before the service is rendered and receive the member's agreement to pay for all or part of the provider's charges. The provider agrees that this provision shall survive the termination of agreement with Horizon NJ Health regardless of the reason for termination, including insolvency of Horizon HMO or Horizon NJ Health, and shall be constructed to be for the benefit of Horizon HMO and the members. The provider agrees that this obligation supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider and the members, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services, provided under the terms and conditions of this continuation of benefits provision.

12.10 Credentialing

The use of thorough screening of credentialing criteria is an important step in maintaining the quality of the Horizon NJ Health provider network. Providers may not treat members until credentialing and acceptance to the Horizon NJ Health network is completed. In cases where treatment is provided without appropriate credentialing claims will be denied and other actions, if appropriate, may be taken. Providers should refer to their contracts for specific guidance.

Horizon NJ Health also uses strict standards for the credentialing of its physician, other health care professionals, facilities and hospitals. Evaluation of a credentialing application includes review of the following credentialing requirements for facilities and hospitals:

- Accreditation
- Current state licensure
- Medicare/Medicaid certification
- Medicare/Medicaid sanction activity
- Professional liability coverage (malpractice)
- Satisfactory history of malpractice claims and settlements

Evaluation of a credentialing application includes review of the following credentialing requirements for physicians and other health care professionals.

- CAQH or paper application, including attestation and disclosure questions
- Work history, including an explanation for gaps greater than six months (credentialing requirement only)
- Education/training (credentialing requirement only)
- Full, unrestricted admitting privileges at a Horizon NJ Health contracted hospital or a completed Continuity of Care Coverage Agreement
- State License
- New Jersey Controlled Dangerous Substance (CDS) certificate
- Drug Enforcement Administration (DEA) certificate
- Board certification for specialty
- Certificate of Insurance with a minimum of \$1M per occurrence and \$3M per aggregate
- Satisfactory inquiry of National Practitioner Data Bank (NPDB)
- Satisfactory inquiry of Department of Treasury, Division of Property Management (Treasury website)
- Statement of Collaboration, as applicable

Updates to all credentialing information must be reported as changes occur. Incomplete credentialing applications will result in delays in privileging and can impact claim payment.

12.11 Recredentialing

Recredentialing of physicians and providers will be conducted by Horizon NJ Health every three years. We will let you know when it is time for you to be recredentialed. We encourage you to routinely update your CAQH profile with current documents and demographic information, including your credentialing contact. This will allow us to seamlessly complete the recredentialing process without delay. If you receive notification that additional information is required it is imperative that you respond to these requests timely to avoid termination from the Horizon NJ Health Network.

All credentialing criteria except where noted is reviewed at the time of recredentialing, as well as the following:

- Correspondence between the medical management program and the physician

- Actions of the utilization and quality improvement committees
- Economic and medical utilization data
- Compliance with Horizon NJ Health policies and procedures
- Patient satisfaction or complaint response information
- Other pertinent data

Recommendations will be made to the medical director if any change in participation status is deemed necessary.

12.12 Subrogation

With respect to subrogation, Horizon NJ Health follows applicable law, regulatory requirements and the State Contract. As further detailed herein, providers must notify Horizon NJ Health Provider Services, at **1-800-682-9091**, upon learning that a third party may be responsible for paying for the provider's services. Such circumstances include, but are not limited to, (1) when a member has become ill or has been injured as a result of an act or omission of a third party or (2) when a member has initiated, or may initiate, a legal cause of action for damages against a third party in connection with the member's illness or injury.

12.13 Treatment of Minors Policy

Physicians and health care professionals agree to comply with Horizon NJ Health's Medical Treatment of Minors Policy, which provides that the medical treatment of minors will be rendered in accordance with applicable law; and, to the extent required, treatment will be in accordance with the wishes of parent(s) or other person(s) having legal responsibility for the minor's medical care.

Under certain circumstances, New Jersey law authorizes minors to make health care decisions on their own behalf. Horizon NJ Health will not deny access to medical care in the following situations:

- Minors presenting themselves for family planning services, maternity care or STD (sexually transmitted diseases) services
- Minors 14 years or older presenting themselves for drug/alcohol or mental health treatment

12.14 Americans with Disabilities Act

All physicians and health care professionals agree to comply with the Americans with Disabilities Act of 1990 (ADA), all amendments to that act and all regulations promulgated thereunder.

Horizon NJ Health is required by the State of New Jersey to conduct a formal ADA physician survey. Horizon NJ Health also conducts a special needs survey. If you have not completed either survey, please do so at your earliest convenience.

The surveys will provide handicap accessibility information regarding your practice facility or business location and information regarding your experience in treating members with special facility or business needs. Your responses will provide helpful information to special needs members, their families and caretakers, including other physicians who might require this information.

You will find ADA survey and special needs survey forms on the Horizon NJ Health website at horizonNJhealth.com. Please follow the directions below to complete the surveys. The surveys will take approximately 10 minutes to complete.

ADA Provider Survey

- Read the survey thoroughly
- Answer each question appropriately
- Sign and date the survey

- Please use black or blue ink

Note: If you have 15 or fewer employees at your location, please complete only questions 1-4 (a-g) and sign Statement II on page 6 of the survey.

Special Needs Survey

- Read the survey thoroughly
- Answer each question appropriately
- Sign and date the survey
- Please use black or blue ink

The surveys are considered complete once you have recorded your responses to all applicable questions, and signed and dated both surveys. Providers specializing in the treatment of members with developmental disabilities must have adequate support staff to meet the needs of these patients.

Once you have completed and signed the ADA provider survey and the special needs survey, please submit the completed form using our Data Submission Template process. Details on how to submit the form and other changes to your provider information can be found at HorizonNJhealth.com/demographicupdates.

You also have the option to mail the forms to the following address:

**Horizon BCBSNJ
3 Penn Plaza East
Mail Station PP 14 C
Newark, NJ 07105**

The following website and phone number for the Department of Justice offer a source of clarification with regard to ADA compliance:

ada.gov
1-800-514-0301

If you have any questions regarding this survey, you may call Provider Services at **1-800-682-9091**.

12.15 Domestic Violence Reporting

The health care provider is a primary source in identifying members who may have been subjected to domestic violence. Domestic violence includes both abuse and battery. Abuse is a pattern of coercive control that one person exercises over another. Battery is a behavior that physically harms, arouses fear, prevents a partner from doing what they wish or forces them to behave in ways they do not want.

State law requires the reporting of child abuse. Reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Immediately report any suspected child abuse or neglect to the Division of Child Protection and Permanency at **1-877-NJABUSE (877-652-2873)**. Calls can be received 24 hours a day, seven days a week.

The physician is responsible to report suspected cases of elder or partner abuse, neglect or exploitation that occurs in the community. Immediately report any suspected elder or partner abuse to the State's Department of Adult Protective Services at **1-609-588-6501**.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to \$1,000 or imprisonment up to six months.

To help identify domestic violence, the following questions have been developed by the Family Violence Prevention Fund. A complete copy of the guidelines can be found at futureswithoutviolence.org.

Domestic Violence Screening Tools

Framing Questions:

- Because violence is so common in many people's lives, I've begun to ask all my patients about it.
- I'm concerned that your symptoms may have been caused by someone hurting you.
- I don't know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

Direct Verbal Questions:

- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner/husband?
- Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
- Do you feel controlled or isolated by your partner?
- Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?

For History Intake Forms/New Patient Questionnaires

Option 1:

- Have you ever been hurt or threatened by your boyfriend/husband/partner?
-OR-
- Have you ever been hit, kicked, slapped, pushed or shoved by your spouse/partner?
-OR-
- Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?
-AND-
- Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

- Are you currently or have you ever been in a relationship in which you were physically hurt, threatened or made to feel afraid?

Option 3:

- Have you ever been forced or pressured to have sex when you did not want to?
- Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

12.15.1 Reporting Abuse, Neglect or Exploitation

All members have the right to be free from exploitation, fraud and abuse. Providers, including Care Managers, are required to report suspected abuse, neglect or exploitation of any:

- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner/husband?

Adult Protective Services

The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports may be made to those County APS offices or to:

The Public Awareness, Information, Assistance & Outreach Unit 1-800-792-8820

Child Protective Services

The New Jersey Division of Child Protection and Permanency (DCP&P) handles all reports of child abuse and neglect, including those occurring in institutional settings such as child care centers, schools, foster homes and residential treatment centers. These must be reported to the State Central Registry (SCR):

Child Abuse Hotline (SCR)
24-Hour Toll-Free Hotline: 1-877 NJ ABUSE (1-877-652-2873)
TTY: 1-800-835-5510

Facility-Based Complaints and Investigation

Office of the Ombudsman for the Institutionalized Elderly investigates claims of abuse and neglect of people age 60 and older living in nursing facilities and other long-term health care facilities, such as assisted living facilities.

24-Hour Toll-Free Hotline: 1-877-582-6995
Email: ombudsman@advocate.state.nj.us
Fax: 1-609-943-3479

Write: The Office of the Ombudsman
PO Box 852
Trenton, NJ 08625-0852

NJ Division of Health Facilities Evaluation and Licensing investigates all complaints against health care facilities, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute and long-term care facilities.

24-Hour Toll-Free Hotline: 1-800-792-9770

Write: New Jersey Department of Human Services
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625-0367

12.15.2 Defining Critical Incidents

The Centers for Medicare and Medicaid Services (CMS), as well as the State of New Jersey, requires that measures be employed to protect the health and welfare of Horizon NJ Health MLTSS members. This includes guidelines for reporting critical incidents. Per the state of New Jersey, critical incidents include but are not limited to the following situations:

- Unexpected Death of a Member
- Media involvement\Potential Media involvement
- Physical abuse\seclusion\restraints\physical\chemi
- Psychological\Verbal abuse

- Sexual Abuse or Suspected Sexual Abuse
- Fall resulting in the need for medical treatment
- Medical emerg resulting in need for medical tx
- Medication Error
- Psych emerg resulting in the need for medical tx
- Severe Injury or Fall
- Suicide attempt resulting in need for medical tx
- Neglect\Mistreatment, caregiver(paid or unpaid)
- Neglect\Mistreatment, self
- Neglect\Mistreatment, other
- Exploitation, financial
- Exploitation, theft
- Exploitation, destruction of property
- Exploitation, other
- Theft with Law Enforcement Involvement
- Failed Back Up Plan
- Elopement or Wandering
- Inaccessible for Initial On-Site Meeting
- Unable to Contact
- Inappropriate Provider Conduct
- Cancellation of Utilities
- Eviction or Loss of Home
- Facility Closure
- Natural Disaster
- Operational breakdown
- Other

12.15.3 Reporting Requirements for Critical Incidents

MLTSS providers with suspicion or evidence of critical incidents must report them to Horizon NJ Health. Upon discovery of a Critical Incident, providers are to take steps to prevent further harm to members and promptly respond to these members' needs. These steps may include reporting potential violations of criminal law to law enforcement authorities.

For MLTSS members, providers are responsible for reporting Critical Incidents to Horizon NJ Health, within **one business day** of discovery by faxing the “Critical Incident Reporting Guide” form to **1-609-583-3003**. The reporting form can be found online at horizonNJhealth.com/criticalincidentreportingguide. Horizon NJ Health’s Critical Incident Team will subsequently contact/follow up with the provider as warranted, and has a dedicated fax to receive subsequent Provider Investigation Findings and Resolution summaries from providers to ensure incidents are resolved promptly through appropriate referrals and corrective action. The Horizon NJ Health MLTSS Critical Incident Team will notify the State of New Jersey of any critical incidents via a state-specified web-based system.

MLTSS providers who have reported critical incidents are required to independently conduct an internal critical incident investigation and submit a report on their findings to Horizon NJ Health. The report should be submitted no longer than 15 calendar days after the date of the incident or discovery of its occurrence. Under extenuating circumstances, but only with the approval of Horizon NJ Health, the report can be submitted within 30 calendar days after the date of the Incident.

12.16 HIV Testing and Education of Pregnant Women

According to Chapter 174 of the Public Laws of 1995, the law states that a provider or other health care practitioner, who is the primary care giver for a pregnant woman or a woman seeking treatment within four weeks of giving birth, must counsel that woman about HIV and AIDS, discuss the benefits of being tested for HIV and offer the option of being tested. The member may reject the option of being tested, without prejudice. In addition, counseling and education regarding prenatal transmission of HIV to both mother and her newborn should be made available during pregnancy.

12.17 Office Standards

As part of the Quality Management Program, Horizon NJ Health has adopted specific primary care physician/specialist office care standards. These standards are in compliance with the standards of the Department of Human Services, Division of Medical Assistance and Health Services, for providing service to Horizon NJ Health members.

Office standards include:

- Medical records are filed systematically
- Medical records are stored in a secure manner
- Only authorized persons have access to medical records
- Patient information is not viewable to non-office personnel
- Medical records are internally organized
- Systems are in place for covering physicians, so they have access to medical records
- Process for documentation of missed appointments exists
- There is a policy/procedure, process or workflow to provide family planning to minors

Periodically, office personnel are trained about confidentiality and HIPAA regulations.

12.18 Appointment Scheduling Standards

Horizon NJ Health has adopted the following appointment scheduling standards to ensure timely access to quality medical care. Physicians will be advised of these standards through this Manual and by participating in physician orientation programs. Compliance with these standards will be audited by periodic on-site review of physician offices and/or “secret shopper” phone calls.

Type of Care	Access Standard
Routine Care Non-symptomatic office visits shall include but not be limited to: Well/preventative care appointments such as annual gynecological exams or pediatric and adult immunization visits.	Within 28 days
Emergency Services	Immediately upon presentation at a service delivery site
Urgent Care An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life threatening.	Within 24 hours
Symptomatic Acute Care A non-urgent, symptomatic office visit is an encounter with a health care provider associated with	Within 72 hours

the presentation of medical signs, but not requiring immediate attention.	
Specialist Referrals A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's PCP. Emergency appointments must be provided within 24 hours of referral.	Within four weeks or shorter as medically indicated
Urgent Specialty Care	Within 24 hours of referral
Baseline Physicals for New Adult Enrollees	Within 180 calendar days of initial enrollment
Baseline Physicals for New Children Enrollees and Adult Clients of DDD	Within 90 days of initial enrollment, or in accordance with EPSDT guidelines
Prenatal Care	Enrollees shall be seen within the following timeframes: a. Three weeks of a positive pregnancy test (home or laboratory) b. Three calendar days of identification of high risk c. Seven days of request in first and second trimester d. Three calendar days of first request in third trimester
Routine Physicals For routine physicals needed for school, camp, work or similar	Within four weeks
Lab and Radiology Services	Three weeks for routine appointments; 48 hours for urgent care
Waiting Time in Office	Less than 45 minutes

For Dental Appointments

- Emergency dental treatment: no later than 48 hours or earlier, as condition warrants
- Urgent care appointments: within three days of referral
- Routine non-symptomatic appointment: within 30 days of referral
- Wait time in office: less than 45 minutes

For Behavioral Health (mental health and substance use disorder) Appointments (Clients of the Division of Developmental Disabilities, MLTSS and FIDE-SNP only)

- Emergency services: immediately upon presentation at a facility
- Urgent care: within 24 hours
- Routine care: within ten days of request
- Waiting time in office: less than 45 minutes

12.19 Medical Record-Keeping Standards

Horizon NJ Health has adopted medical record-keeping standards based on state and federal regulations, as well as the guidelines of national accrediting agencies (i.e., NCQA, URAC). Compliance with these standards will be audited through periodic on-site review of physician offices and chart sampling. Horizon NJ Health has the right to request and review medical records in connection with services provided to our members. Upon request, providers shall provide copies of the medical records within the time frame set forth.

The standards are as follows:

- Each page in the record contains the patient's name and/or ID number.
- Personal/biographical data include address, employer, home and work phone numbers, marital status and emergency contact name and phone number.
- All entries in the medical record contain author's identification. Author identification may be a handwritten signature, unique electronic identifier, initials or a stamped signature. All practitioners, including solo practitioners, are required to adhere to this standard.
- All entries are dated.
- The record is legible to someone other than the writer and office personnel. A second surveyor will examine any record judged to be illegible by the initial surveyor.
- Significant illnesses and medical conditions are indicated in the medical record.
- Documentation shows reason of visit (i.e., chief complaint).
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, it is appropriately noted in the record.
- Past medical history (for patients seen three or more times) is easily identified and include serious accidents, operations and illnesses and sexual activity information (e.g., age, number of partners). For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illness.
- The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting grievances.
- For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substance use disorder (for patients seen three or more times).
- There is documentation of mammography services for women aged 50 to 74 every two years. After discussion with their provider, women at high risk may choose to begin screening at 40 to 49 years of age.
- There is documentation of a discussion with a health care provider for men aged 55 to 69 on periodic prostate cancer screening for male enrollees.
- There is documentation of appropriate colorectal screening test for all enrollees aged 45 to 75.
- Documentation of colorectal screening includes one of the following tests:
 - Annual fecal occult blood test (FOBT)
 - Flexible sigmoidoscopy (FSIG) once every five years
 - Colonoscopy once every 10 years
 - CT Colonography once every five years
 - FIT-DNA (Fecal Immunochemical Test-DNA) every three years
- Abbreviations and symbols must be appropriate.
- Laboratory and other studies are ordered, as appropriate, signed and the results discussed with the patient.
- The treatment plans are consistent with the diagnosis.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed. Missed or canceled appointments must be documented, as well as follow-up outreach.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- There must be documentation for follow-up for missed appointments for EPSDT exams. Appropriate and reasonable outreach shall be documented and must consist of a minimum of three attempts to reach the enrollee.
- If a consultant is requested, there is a note from the consultant in the record and this note is initialed by the physician to indicate that the consult was reviewed.
- Consultation, laboratory and imaging reports filed in the chart are initialed by the physician who ordered them to signify review. Review and signature by professionals, other than the ordering physician such as

RNs, LPNs, PAs and medical assistants, do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of provider review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans and the results were shared with the patient.

- Immunizations are documented for pediatric members (ages 20 years and under).
- Body mass index (BMI) for members 20 years and older is documented, as well as BMI percentile for members younger than 20 years of age.
- Discharge summaries are included as part of the medical records for hospital admissions, which occur while the patient is enrolled in the plan.
- Cultural/language/visual/auditory and religious factors affecting care are noted in the medical record. If no barriers to care are identified, a notation indicating this should be included in the record.
- For members age 18 years and older, the medical record shall document whether or not the member has executed an advance directive (e.g., living will or durable power of attorney for health care).
- Medical records must be protected against loss, destruction or unauthorized use and retained for at least ten years following the member's most recent service or until the member reaches age 23. If an audit, investigation, litigation or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later.

12.20 Reporting of Urgent/Emergent Lab/X-Ray Results

- All providers will notify members of laboratory and/or radiology results within 24 hours of receipt in urgent or emergent cases.
- Providers may arrange an appointment to discuss results when it is deemed face-to-face discussion with the member may be necessary or appropriate. Urgent/emergent appointment standards must be followed.
- Rapid strep test results must be available to the member within 24 hours of the test.

Definitions:

Urgent care – treatment of a condition that is potentially harmful to a patient's health and for which his/her physician determined that it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration

Urgent lab/radiology result – a laboratory or radiology result that warrants urgent care

Emergent care – services that are necessary to evaluate or stabilize an emergency medical condition

Emergent lab/radiology result – a lab or radiology result that necessitates emergent care

Emergency dental condition – an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including: severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction, uncontrolled bleeding due to tissue laceration, oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible. These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Emergency medical condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (and with respect to a pregnant woman, her unborn child) in serious jeopardy, serious impairment to bodily functions or any bodily organ or part

Member – an enrolled participant in Horizon NJ Health related to Managed Medicaid programs and NJ FamilyCare

Provider – a participating physician, network hospital or other health care professional or entity who has a contractual arrangement with Horizon NJ Health related to the Managed Medicaid or NJ FamilyCare programs

12.21 Advance Directives

Horizon NJ Health requires that network providers and health care practitioners comply with all federal and state regulations related to advance directives.

In summary, the Federal Patient Self-Determination Act (Part 489, Subpart 1) requires that hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home-care, providers of personal care services and hospices maintain written policies and procedures concerning advance directives with respect to individuals receiving medical care, ages 18 years and older. Written information must be provided to individuals regarding the provider's written policies and the individual's rights related to advance directives. Additionally, the individual's medical record must include documentation indicating whether or not the individual has executed an advance directive.

The New Jersey Administrative Code (13:35-6-6.5-1-ix) requires that health care professionals, regulated by the Board of Medical Examiners, must document the presence or absence of any advance directive for health care for an adult or emancipated minor and associated pertinent information. Documented inquiry shall be made on the routine intake history form for all new patients. The treating doctor shall also make and document a specific inquiry of a patient in appropriate circumstances, such as when providing treatment for a significant illness, when an emergency has occurred presenting an imminent threat to life, or when surgery is anticipated with the use of general anesthesia.

For the purposes of this Manual, an advance directive means a written instruction that relates to the provision of health care when the individual is incapacitated. All physicians agree to comply with New Jersey law respecting advance directives and not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care publishes a guideline for members on advance directives. This document can be found on the Horizon NJ Health website at horizonNJhealth.com.

12.22 Coverage Arrangements

PCPs and specialty care physicians are required to make arrangements for practice coverage when they are away from the office. A Horizon NJ Health participating provider of the same or similar specialty should provide coverage.

12.23 After-Hours Coverage

All primary care and specialty care physicians must be available to Horizon NJ Health members 24 hours a day, seven days a week, as stated in the contractual agreement. PCPs and specialists should make arrangements via an answering service during off-hours. If an answering machine is used, a forwarding phone number to connect with a physician must be given. Instructions for Emergency Room (ER) care in life-threatening situations are acceptable. Instructions for emergency room care in place of contact with a physician when there is no life-threatening emergency (e.g., sore throat, pain in ear, etc.) are unacceptable.

A telephone response should be considered acceptable/unacceptable based on the following criteria:

- Acceptable:

- An active provider response, such as: phone is answered by PCP, office staff, answering service or voicemail with instructions for contacting the provider
- The answering service:
 - Connects the caller directly to the provider/practitioner
 - Contacts the PCP on behalf of the caller and the provider/practitioner returns the call
 - Provides the phone number where the PCP/covering provider/practitioner can be reached
 - The provider/practitioner's answering machine message provides a phone number to contact the PCP/covering provider/practitioner
- Unacceptable:
 - The answering service:
 - Leaves a message for the provider/practitioner on the PCP/covering provider/practitioner's answering machine
 - Responds in an unprofessional manner
 - The provider/practitioner's answering machine message:
 - Instructs the caller to go to the ER, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider/practitioner for non-emergent situations
 - Instructs the caller to leave a message for the provider/practitioner
 - No answer
 - Listed number no longer in service
 - Provider/practitioner is no longer participating in our network
 - On hold for longer than five minutes
 - Refuses to provide information for survey
 - Phone lines are persistently busy despite multiple attempts to contact the provider/practitioner

Response Time

The physician shall respond to after-hours phone calls, including those from special needs members, regarding medical care within the following time frames: 15 minutes for crisis situations, 45 minutes for non-emergent, symptomatic issues and the same day for non-symptomatic concerns.

If a PCP or specialist is identified as non-compliant, education regarding the 24-hour standards is provided by the Provider Contracting & Servicing Department. The PCP or specialist will be re-audited within 30 to 60 days. If this does not produce a favorable outcome, Horizon NJ Health will implement the corrective action plan, as outlined below:

1. A certified letter will be mailed to the PCP or specialist by the Horizon NJ Health Quality Management Department reviewing the contractual obligation to provide after-hours coverage. The PCP or specialist will have two weeks (10 business days) to respond to Horizon NJ Health with an improvement action.
2. A Professional Service representative will re-audit the PCP or specialist during non-office hours and within 30 days of receipt of the certified letter to verify that a new procedure has been implemented.
3. If a satisfactory improvement action procedure has been implemented, a letter, signed by the Quality Management Department will be sent to the PCP and specialist thanking him/her for his/her cooperation.
4. If a satisfactory procedure is not implemented, a detailed report on the case will be forwarded to the Quality Management Department for review and further investigation.

For more information about the Horizon NJ Health corrective action plan, contact Provider Services at **1-800-682-9091**.

Office Practice Standards for PCPs/Specialists

Maximum Number of Intermediate/Limited Patient Encounters

- Four per hour (adults and children)

12.24 Notification of Open/Closed Status

A PCP may make a change in the status of his or her practice so that it is open, limited or closed for enrollment of new Horizon NJ Health members. As a provider, you must notify Provider Services in writing 90 days in advance of your intent to limit your panel size. Failure to comply with this standard can result in provider removal from the network and reassignment of all members. Horizon NJ Health will process your request for limiting or closing your panel size once you have met a minimum of 50 Horizon NJ Health members. If a closed panel is reduced to less than 50 Horizon NJ Health members, it will be automatically reopened until the minimum is met again. The closing or limiting of your panel shall not close your office to the assignment of members who, prior to becoming Horizon NJ Health members, had been your existing patients.

Your change in status must apply to all members. No individual exceptions will be permitted once a selection of open or closed status is made. Requests should be mailed to:

**Horizon BCBSNJ Provider Files
3 Penn Plaza East, PP-14C
Newark, NJ 07105-2200**

12.25 Change in Address

Information on how to update participating physician or provider changes to phone numbers, practice locations, billing address, tax ID or any operational changes, such as business hours can be found at horizonNJhealth.com/demographicupdates.

12.26 Workers' Compensation

Workers' compensation covers any injury or illness that is the result of a work-related accident. Employers purchase the insurance. You should always bill the workers' compensation carrier for work-related illnesses or injuries.

Payment will not be made for services provided to a member for any injury, condition or disease if payment is available under workers' compensation laws.

12.27 Financial Disclosure

If you have annual revenues from Horizon NJ Health in excess of \$25,000, you agree to cooperate with Horizon NJ Health in the disclosure of significant business transactions between you and Horizon NJ Health. Transactions to be reported include any sale, exchange or leasing of property, any furnishing for consideration of goods, services or facilities (but not employee salaries) and any loans or extensions of credit.

12.28 Coordination of Benefits

Any services provided to a Horizon NJ Health member are reviewed against benefits provided for that same individual under other insurance carriers with whom the member has coverage. Horizon NJ Health, as a managed care program for Medicaid and NJ FamilyCare members in New Jersey, is the "payor of last resort" on claims for services provided to members also covered by Medicare, employee health plans or other third party medical insurance. Payors that are primary to Horizon NJ Health include (but are not limited to):

- Private health insurance, including assignable indemnity contracts
- Health Maintenance Organizations (HMOs)
- Traditional Medicare
- Medicare Advantage
- For-profit and non-profit health plans
- Self-insured plans
- No-fault automobile medical insurance
- Liability insurance
- Workers' Compensation
- Long Term Care insurance
- Other liable third parties

In cases where another payor is deemed responsible for payment, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's explanation of benefits (EOB) or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed. When you provide services to a member who has any other coverage, bill the member's primary insurer directly. Make sure that you follow that insurer's standard claim submission policies and forms.

Upon receipt of payment and/or an EOB, submit applicable claims to Horizon NJ Health for consideration of deductibles, copayments and coinsurance amounts. Horizon NJ Health reimburses after coordination of benefits (COB) and only up to the primary contracted rate for the service. The claim and the primary insurer's EOBs must be submitted within 60 days of that EOB or within 365 days of the dates of service, whichever is later.

When preparing the claim, include a complete record of the original charges and primary (or additional) payor's payment as well as the amount due from the secondary or subsequent payor. Submit all pages of the primary (or additional) insurer's EOB to avoid delays in completing claims due to missing information or coding and message descriptions. This information ensures accurate COB.

With the exception of Medicare, Horizon NJ Health's notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

IMPORTANT – All COB claims must be submitted with a copy of the EOB from the primary insurer.

Submit COB claims for all medical services to Horizon NJ Health at the following address:

Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406
Phone: 1-800-682-9091

Note: Although a primary insurer may have unique coding specific to their business, providers must bill with valid ICD-10-CM, CPT-4 and HCPCS codes. Unique or invalid codes specific to other insurers will cause claim processing delays or denials.

IMPORTANT – The hospital, physician or health care professional may not submit billed charges to Horizon NJ Health that are different than charges submitted to other insurers for the same services. The submitted bill must contain the exact billed amounts by procedure line as is reflected on the primary or additional insurer's EOB.

IMPORTANT – The primary or additional insurer’s EOB must include member name, billed amounts, paid amounts, adjustments, coinsurance, deductibles, copayment amounts and all associated messages and notes. Incomplete information may result in a claim processing delay or denial.

12.29 Corrective Action

Horizon NJ Health is committed to working cooperatively with participating physicians to resolve any identified areas of non-compliance with administrative or quality standards. In order to prevent and avoid such non-compliance, all attempts will be made to educate our physicians on our policies and procedures.

Steps in the corrective action process include, but are not limited to, the following:

- Physician notification of Horizon NJ Health standards and clinical practice guidelines. (See Appendix A Preventive and Clinical Guidelines.)
- Physician is monitored against these guidelines.
- Administrative or quality of care issues are identified by Horizon NJ Health staff and reviewed by the medical director.
- Medical director identifies deficiencies, which need to be reviewed by the Peer Review Committee (hereafter identified as the “committee.”)
- If the committee or medical director identifies a concern, the provider is notified and given the opportunity to respond before a final determination is made.

The Corrective Action Program contains important safeguards for the physician to ensure that all decisions are made fairly, with the goal of improving quality of care and service to our members.

12.30 Sanctions and Appeals of Sanctions

It is the goal of Horizon NJ Health to resolve identified provider deficiencies in a fair manner, which allows an opportunity for physician education and fair due process, where indicated. When noncompliance significantly affects the quality of care provided to the member, Horizon NJ Health may impose sanctions through the Corrective Action Program. Sanctions will only be imposed after a thorough review of the issue.

Severity Levels of Sanctions

Level Zero – No Quality of Care issue identified

- Clinical - No quality of care issue identified.
- Administrative - No evidence of failure to comply with documented administrative policies, procedures, and/or contractual obligations of Horizon.

Level 1 – Quality of care issue identified that leads to potential harm to the member or unborn child

- Clinical - Deviation from standards and guidelines of medical practice resulting in potential harm to the member or unborn child. Examples include but are not limited to:
 - Prescription/Medications errors
 - Delays in treatment
 - Inadequate documentation where potential harm to the member could have occurred
- Administrative – Failure to comply with documented administrative policies, procedures, and/or contractual obligations of Horizon which pose a potential harm to the member or unborn child. Examples include but are not limited to:
 - Failed site evaluation
 - Failure to comply with Horizon’s request for medical record documentation
 - Failure to comply with Horizon’s licensing, credentialing, and/or re-credentialing policies

- Failure to implement and complete an agreed upon corrective action plan addressing a quality of care sanction

Level 2 – Quality of care issue identified that leads to actual harm to the member or unborn child

- Clinical – Deviation from standards and guidelines of medical practice, resulting in actual harm to the member or unborn child. Examples include but are not limited to:
 - Modification of a procedure/treatment which resulted in the need for additional or extended care
 - Negligent professional behavior
 - A documented pattern of complaints about the quality of care provided
 - Failure to implement a documented corrective action plan
- Administrative – Failure to comply with documented administrative policies, procedures, and/or contractual obligations of Horizon which pose an actual harm to the member or unborn child. Examples include but are not limited to:
 - A provider failing to make him/herself available or failing to meet the ‘on-call’ requirement of their contract

Level 3 – Identification of a Serious Reportable Event (aka - “Never Events”) as identified by the National Quality Forum (qualityforum.org/Topics/SREs/List_of_SREs.aspx#sre7)

- Clinical – Identification of events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable. Examples include but are not limited to:
 - Wrong site surgery
 - Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
 - Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
- Administrative - Failure to comply with documented administrative policies, procedures, and/or contractual obligations of Horizon which results in a member or unborn child experiencing a Serious Reportable Event. Examples include but are not limited to:
 - A provider refusing to evaluate a member
 - An Emergency Medical Treatment and Labor Act (EMTALA) violation

Sanctions and Appeal Process

1. The Quality Peer Review Committee (QPRC) will send the provider a letter outlining the decision and committee recommendations, including an action plan, if applicable. Actions that can be taken related to identified deficiencies include, but are not limited to:
 - Individual physician education
 - Educational seminars
 - Request for a corrective action plan
 - Site visit
 - Freezing of patient panel and/or incentive payment
 - Termination from the physician network
2. Following the QPRC determination, the file is forwarded to the Quality Management Department and a copy of the resolution letter is placed in the file. If the provider does not respond within 30 days from the initial QPRC determination, a copy of the resolution letter is forwarded to Horizon BCBSNJ’s

Credentialing Department to place in the provider's credentialing file. The requested corrective action plan(s) are tracked for receipt.

3. A corrective action plan, if requested, is due within 30 days of receipt of our letter. When the plan is received, it will be reviewed by a medical director and forwarded to the next QPRC meeting. The QPRC determines if the plan is accepted. If it is accepted, the plan will be placed in the file and the case closed. If the plan is not accepted, a committee member or designee will contact the provider, either by phone or mail, to identify the areas of concern and await a response, which is due within 30 days. If no plan is received within 30 days, the case will be brought back to the QPRC for further action.
4. If the provider does not agree with the determination of the QPRC regarding a Level One, Level Two, or Level Three Sanction, the provider may appeal the decision in writing to the Quality Management Department within 30 days of receipt of the determination to request a hearing.

Severity Levels of Sanctions

Level Zero: No quality of care or service issue and/or no evidence of failure to comply with documented administrative policies and procedures.

Level One: Includes failure to comply with documented administrative policies and procedures of, and contractual obligations with, Horizon NJ Health (i.e., EPSDT, Case Management, Quality Management, Claims, Recipient Restriction, Pharmacy, Provider Services and Grievances).

Examples include but are not limited to:

- Failed site evaluation
- Failed medical record review
- Failure to precertify procedures
- Failure to comply with complaint protocol

Level Two: Will be imposed upon providers who have greater than five occurrences of Level One sanctions or for activities that are documented quality of care concerns.

Examples include but are not limited to:

- Documented pattern of member complaints
- Grossly negligent professional behavior
- Quality of care and/or service concerns Sanctions and Appeal Process

1. The Quality Peer Review Committee (QPRC) will send the provider a letter outlining the decision and committee recommendations, including an action plan, if applicable. Actions that can be taken related to identified deficiencies include, but are not limited to:
 - Individual physician education
 - Educational seminars
 - Request for a corrective action plan
 - Site visit
 - Freezing of patient panel and/or incentive payment
 - Termination from the physician network
2. Following the QPRC determination, the file is forwarded to the Quality Management Department and a copy of the resolution letter is placed in the file. If the provider does not respond within 30 days from the initial QPRC determination, a copy of the resolution letter is forwarded to Horizon BCBSNJ's Credentialing Department to place in the provider's credentialing file. The requested corrective action plan(s) are tracked for receipt.

3. A corrective action plan, if requested, is due within 30 days of receipt of our letter. When the plan is received, it will be reviewed by a medical director and forwarded to the next QPRC meeting. The QPRC determines if the plan is accepted. If it is accepted, the plan will be placed in the file and the case closed.
4. If the plan is not accepted, a committee member will contact the provider, either by phone or mail, to identify the areas of concern and await a response, which is due within 30 days. If no plan is received within 30 days, the case will be brought back to the QPRC for further action.
5. If the provider does not agree with the determination of the QPRC regarding a Level One, Level Two or Level Three Sanction the provider may appeal the decision in writing to the Quality Management Department within 30 days of receipt of the determination to request a hearing.
6. A Hearing Committee shall be established to preside over the hearing, which shall take place within 30 days. The committee shall consist of at least three people, at least one of whom must be a clinical peer in the same or substantially similar discipline and specialty as the provider. This peer may not be an employee of Horizon NJ Health, but shall be a participating provider who is not otherwise involved in the plan management. If the health care professional consents, the hearing may be conducted by conference phone or any means of communication by which all persons participating in the hearing are able to hear each other. The decision of the committee shall be by majority vote. The First Level Appeal Hearing Committee shall conduct a hearing, as described in Section 5, and issue its decision, as described in Section 11, with the exception that no further appeal rights following the First Level Appeal shall be available, as described. As such, the decision reached through this First Level Appeal process shall be final.
7. If applicable, after the close of the First Level Hearing, the provider is notified of the hearing committee's decision within 30 days. If the provider does not respond within 30 days to the First Level Hearing determination, a copy of the resolution letter is forwarded to Horizon BCBSNJ's Credentialing Department to place in the provider's credentialing file. If formal sanctioning proceedings are implemented and the outcome is not in favor of the provider, the National Practitioner Data Bank may need to be notified depending on the severity of the deficiency and the associated sanction. If the hearing involved an administrative action, the corrective action officer or designee may also need to be notified.

12.31 Termination

Specialty groups, primary care, specialty care physicians and providers must notify Horizon NJ Health 90 days prior to their intent to terminate their contract. Written notifications, including the reason for termination, must be sent by certified mail to:

**Horizon NJ Health
Provider Contracting and Strategy
1700 American Blvd.
Pennington, NJ 08534**

Horizon NJ Health will notify members of the physician termination at least 30 days prior to the termination date. Contractual obligations with Horizon NJ Health and New Jersey HMO regulations require that physicians provide continuity of care for patients for up to 120 days after termination when it is medically necessary, as determined by Horizon NJ Health, for the member to continue treatment by the terminated provider, except as set forth below:

- **Pregnancy** – services shall continue through postpartum evaluation up to six weeks after delivery.
- **Postoperative** – services shall continue up to six months after termination date.
- **Oncological or psychiatric treatment** – services shall continue up to one year after termination date.

Continuity of care services rendered after termination require prior authorization (except in the cases of pregnancy, as set forth above) and will be paid at the contract rate, except for care provided by primary care physicians under a capitation agreement. Primary care physicians are not entitled to capitation payments after the termination date and will be paid at the Horizon NJ Health fee schedule. Any capitation payments remitted to the physician after the termination date must be refunded to Horizon NJ Health.

13.0 Horizon NJ Health Programs

13.1 Quality Improvement Program

Horizon NJ Health's QI Program is designed to produce prospective, concurrent, and retrospective analyses of the plan's activities in order to improve the quality of care and service members receive. The Contracted practitioners/providers shall cooperate with the collection and evaluation of data and participate in Horizon NJ Health's quality improvement activities. Performance data may be used for quality improvement activities. The specific goals of the QI Program are to ensure that Horizon NJ Health is:

- Providing health care that is medically necessary with an emphasis on the promotion of health in an safe, effective and efficient manner
- Assessing the appropriateness and timeliness of the care and services being provided
- Promoting members' ability to maintain themselves in the least restrictive, most integrative setting of their choice
- Optimizing care delivery for members with special and/or complex care needs
- Identifying members' needs and coordinating care to address the needs of the member
- Focusing on the quality of medical care and services provided to all members
- Working to identify and reduce potential health care disparities within its membership by gender, race, ethnicity, primary language, and disability status
- Striving to improve member and provider satisfaction
- Maintaining oversight of delegated entities
- Maintaining oversight of the credentialing and recredentialing of providers and practitioners
- Meeting NCQA accreditation requirements
- Working to improve plan performance on HEDIS, Star

Rating, CAHPS, Health Outcome Surveys (HOS), and Performance Improvement Projects (PIP) Primary authority for the ongoing operation of the QI Program rests with the senior medical director. The day-to-day administrative management of the program is the responsibility of the Medical Director of Quality Management. The program is supported by the Quality Improvement Committee (QIC), which meets at least 6 times per year and is comprised of senior management, as well as Horizon NJ Health medical directors and network physicians. One of the functions of this committee is to present an annual program description and a program evaluation of the QI Program and plan to the board of directors for feedback and approval. Annual evaluation includes the review of all quality improvement activities conducted during the year and progress toward our goals and objectives, as outlined in the program and plan descriptions. The committee also oversees annual revisions of the QIC work plan and quarterly updates of progress toward improvements. Delegated entities present program evaluation, program description, goals and objectives annually to the QIC committee.

The specific components in place to support the QI Program goals include credentialing and recredentialing standards for providers and hospitals, office care and medical record review standards for PCPs, ongoing education for providers and members, ongoing reviews of care provided and focused studies/audits to identify initiatives for quality improvement activities. In addition, internal policies and procedures are developed to communicate program objectives and inform staff of procedures.

horizonnjhealth.com/for-providers/programs/quality-improvement-program

13.1.1 Quality Improvement Program Performance Monitoring

Horizon NJ Health's Quality Improvement (QI) Program is designed to assess and improve HEDIS (Healthcare Effectiveness Data and Information Set) measures and CMS Star Rating, member satisfaction based on the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey and practitioner satisfaction based

on a satisfaction survey and focus groups. Practitioners/providers participate in the collection and evaluation of data to improve quality of care and member experience. Practitioner/provider performance data may be used for QI activities. The QI Program also implements initiatives that improve the safety of our members in all settings and prepares for accreditations that require evaluation of all processes and opportunities for improvement.

The Quality Improvement Program is intended to:

- Expand access and enhance the quality of health care
- Enhance customer satisfaction
- Maximize the safety and quality of health care delivered to members
- Improve efficiency and effectiveness
- Fulfill quality-related reporting requirements of accrediting bodies and other local, state and federal regulatory and external review organizations

The annual Quality Improvement Program Work Plan describes specific activities that Horizon NJ Health will assume to meet the established goals. The annual Quality Improvement Program evaluation assesses how well Horizon NJ Health performed at achieving goals in the work plan.

Horizon NJ Health's Quality Improvement Program uses HEDIS (Healthcare Effectiveness Data and Information Set) measures that the National Committee for Quality Assurance (NCQA) established. HEDIS results are based on statistically valid samples of members. Certified auditors rigorously audit HEDIS results, using a process designed by NCQA. HEDIS was created as a tool to collect data about the quality of care and services provided by the health plan. This set of standardized measures compares health plans' performance on important dimensions of care and service.

Providers and practitioners should use appropriate coding when submitting claims visits or encounters. In addition, all visits, tests, or immunizations should be completed timely according to the recommended standard(s) of care. For more detailed information regarding HEDIS, please visit horizonNJhealth.com/for-providers or call **1-844-754-2451**.

Periodically, the Quality Department reaches out to providers about programs that help promote goals such as improved quality and efficiency. Providers should review horizonNJHealth.com/for-providers or also speak with the Quality Department about participation in these programs.

13.2 Occupational Safety and Health Administration

The Occupational Safety and Health Administration (OSHA) has established certain standards and guidelines to ensure that the work environment remains safe, healthy, clean and sanitary. Our physicians and providers must follow these guidelines so that all office employees are protected against potential health hazards resulting from exposure to blood and certain body fluids, including blood-borne pathogens.

13.3 Clinical Laboratory Improvement Act

All laboratory testing sites providing services to Horizon NJ Health members must have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. A physician with a certificate of waiver shall provide only the types of tests permitted under the terms of their waiver. The tests permitted under the certification of waiver are listed below.

1. Dipstick or tablet reagent urinalysis (non-automated) for the following: Bilirubin, Glucose, Hemoglobin, Ketone, Leukocyte, Nitrite, pH, Protein, Specific gravity and Urobilinogen
2. Fecal occult blood
3. Ovulation test – visual color comparison tests
4. Urine pregnancy test – visual color comparison tests

5. Erythrocyte sedimentation rate, non-automated
6. Hemoglobin
7. Blood count; Spun Microhematocrit
8. Blood glucose (FDA-cleared home use devices)

All other tests of moderate to high complexity and provider microscopies require a certificate of registration, along with a CLIA identification number. For information on CLIA rules and regulations, the Centers for Medicare and Medicaid Services (CMS) hotline number is **1-877-267-2323**.

To view the list of CPT codes that codes that were deemed reimbursable for providers in the outpatient and office setting, visit horizonNJhealth.com.

13.4 Utilization Management Program and Controls

The HMO medical delivery system is designed to allow a smooth transition from the traditional medical health care New Jersey Medicaid fee-for-service delivery system into managed health care service. An important component of Horizon NJ Health's health care delivery system is the ability to provide a thorough and detailed mechanism to effectively review, monitor and manage the availability, accessibility, appropriateness, efficiency and quality of health care within the managed care delivery system. Identified are utilization management programs and initiatives, which represent primary elements of our Quality Improvement Program and Utilization Management Program (QIC-UM) for members.

The following programs and initiatives have been carefully developed and constitute fundamental aspects of the Utilization Management program:

- Care coordination
- Concurrent review program
- Prior authorization process – DME, short procedure requests, etc.
- Discharge planning
- Drug utilization review program
- Patient hospital generic quality improvement guideline screens
- Retrospective review program
- Infectious disease program

13.4.1 Horizon NJ TotalCare (HMO D-SNP)

Members enrolled in Horizon NJ TotalCare (HMO D-SNP) receive all eligible benefits for both Medicaid/NJ FamilyCare and Medicare Advantage and do not incur any cost sharing or copayments as part of the dual special needs program. Additional benefits available to Horizon NJ TotalCare (HMO D-SNP) members may include:

- Over the Counter Quarterly allowance for purchase of certain health care items
- Medicaid Drug Wrap services to cover medications not covered by Medicare
- Additional visits for foot / podiatry care FIDE-SNP Care Management

Horizon NJ Total Care (HMO D-SNP) requests the PCP's ongoing participation to ensure that FIDE-SNP members have comprehensive access to services and meaningful coordination of care. All Horizon NJ TotalCare (HMO D-SNP) members are enrolled in Care Management and are assigned a Care Manager. Depending on their level of risk stratification (based on a health assessment), members may be visited in their home/community setting by their Care Manager. The member's individualized plan of care is developed in collaboration with the member, their care manager and the member's PCP.

The PCP is responsible for:

- Reviewing the proposed care plan faxed (or accessed via NaviNet) to them from Horizon NJ Total Care (HMO D-SNP) for their patient
- Providing any necessary additional information about the member's care to ensure the care plan is complete and accurate
- Updating each care plan as needed by faxing to FIDE-SNP Care Management or updating in NaviNet
- Discussing the care plan with the Horizon NJ Total Care (HMO D-SNP) member for whom he or she provides care
- Communicating with the Interdisciplinary Care Team as requested to ensure optimal coordination of care
- Encouraging member participation in care management

For assistance from the Horizon NJ TotalCare (HMO D-SNP) Care Management Department please call: **1-888-621-5894 (TTY 711)**, Monday through Friday, from 8:30 a.m. to 5 p.m.

13.5 Special Needs Programs

Our Pledge to Special Needs Members

Horizon NJ Health strives to ensure that services provided to special needs members are equal in quality and accessibility to services provided to all Horizon NJ Health members.

Who are Horizon NJ Health's Special Needs Members?

Adults with special needs are individuals who have complex/chronic medical conditions requiring specialized health care services. These individuals may have physical, mental, or developmental disabilities and/or substance use disorder issues. Children with special needs are individuals who have or are at increased risk of having a chronic physical, developmental, behavioral or emotional condition and who require more health and related services than the general population.

Horizon NJ Health identifies special needs members through the following:

- State file of Division of Developmental Disabilities (DDD) members
- State file of Division of Child Protection and Permanency (DCPP) members
- Identified through the State file of Program Status Codes for the Aged
- Referrals from State agencies
- Referrals from specialists, PCPs and other community agency case managers for DDD, DCPP and the Aged, i.e., County-based care managers, Special Child Health Services
- Internal department referrals from Pharmacy, Disease Management, Utilization Review, etc.

Providers should refer members with special needs to network behavioral health providers who are experienced with servicing enrollees with special needs. For assistance, please call Horizon NJ Health Provider Services at **1-800-682-9091**.

How Can the Special Needs Program Help?

Care Management will be the primary contact for coordination of any services required by the special needs member. If you have a patient who is enrolled with Horizon NJ Health and has a physical and/or developmental disability or catastrophic illness, you may contact Care Management at **1-800-682-9094 x89634** to request an evaluation. A Care Manager (nurse/social worker) will conduct a Comprehensive Needs Assessment (CNA) by phone. The screening will determine the level of care management the member requires.

Care Management will provide assistance with:

- Referrals to special care facilities for highly specialized care
- Coordinating care with specialist and other team members
- Provisions for all medically necessary dental services for members with developmental disabilities
- Referrals to behavioral health providers experienced with servicing enrollees with special needs

Transition planning is intended to transition the member into Horizon NJ Health. Transition planning includes, but is not limited to:

- Review of existing claims through the State Data Exchange Database
- A plan to ensure continuous care during the transfer of coverage
- Assurance that required durable medical equipment, (e.g., wheelchair, ventilator, etc.), is delivered

Planning shall be completed within a timeframe appropriate to the enrollee's condition, but in no case later than 10 business days from the effective date of enrollment or within 30 days after special health care conditions are identified.

After a member has been determined as having special needs, a CNA will be performed by the care manager. This review is conducted by phone and a form is completed with the information. The CNA includes, but is not limited to:

- Review of diagnoses to determine physical condition
- Review of psychosocial and developmental functioning
- Evaluation of existing medical/community relationships or linkages
- Review of pharmaceutical, dental, vision and other medical health needs
- Review of preventive health services

Horizon NJ Health will use the Health Needs Survey to assign each identified special needs member to one of the following three levels:

- Level 1 - Low complexity
- Level 2 - Moderate complexity
- Level 3 - High complexity

All care plans typically involve coordination of services for preventive care, psychosocial, life planning, barriers to care, health literacy, and self-management.

The Care Manager (CM), in collaboration with the PCP, PCD or specialist, will develop a plan of care that addresses both the physical and psychosocial needs of the special needs member. The plan will also serve as a means of identifying appropriate community resources. The PCP, PCD and/or specialist will receive a copy of the care plan to use as a reference when making appointments with various providers.

Who Conducts Follow-Up?

Once the care plan has been developed, the CM will follow up with the member/family to assess whether or not the member is achieving expected results and contact the PCP, PCD, and/or specialist to discuss the case as needed. The care plan will be updated as the needs of the member change.

Can Nonparticipating Physicians Render Service?

Horizon NJ Health encourages the use of participating physicians; however, nonparticipating physicians may be used if the following conditions exist:

- An existing relationship has been established between the special needs member and a nonparticipating physician and;
- There is not an appropriate physician to render the needed service within the network.

Who Should You Contact?

The following phone and fax numbers will enable you to directly access the CM:

Phone: 1-800-682-9094 x89634

Fax: 1-609-538-3035

Please keep in mind that the CM should be your primary point of contact and they are available to assist you in caring for your patients. For after-hours concerns, there is clinical staff available 24 hours a day, seven days a week to address any urgent or emergent needs. This staff can be reached at **1-800-682-9094**.

Dental Care for Patients with Special Needs

Dentists who treat patients with special needs (including physical, intellectual and developmental or emotional disabilities) must assist and consult with patient caregivers.

Dentists may receive a behavior management fee for treating patients with special needs, based on the needs of the member. If the patient is, by clinical presentation or medical condition, determined to have special needs, we will allow that patient to receive services as a special needs member. Forward documentation to providerservices@skygenusa.com, or call Provider Services at **1-855-878-5368**. We pay a fee per 15-minute unit, and prior authorization is not necessary. Reimbursement for two or more units is at the discretion of a Horizon NJ Health Dental Consultant and based on services provided in the patient's record. This documentation includes, but is not limited to:

- An oral evaluation of the patient
- Appropriate radiographs and other images necessary for diagnosis and documentation
- Dental prophylaxis every three months, including topical applications of fluoride
- Nonsurgical periodontal treatment, including root planning and scaling
- Thorough inquiries regarding the patient's medical history with other providers and caregivers as needed
- Consultations with patient caregivers to establish a thorough understanding of proper dental management during visits, oral hygiene techniques and anticipatory guidance

Members with special needs get an extra dental benefit of four preventive visits per year. Dental treatment in an operating room (OR) or Ambulatory Surgical Center (ASC) is also available for members with special needs when medically necessary. The Care Management team coordinates dental services and care with the help of the Dental Operations department, as needed.

Refer members and/or caregivers to the NJFC Dentists Treating Children and Adults with Intellectual and Developmental Disabilities guide for assistance finding dental providers who can accommodate members with special needs. The guide can be found at: horizonnjhealth.com/membersupport/resources/dental-guide-for-idd-members.

13.6 Medical Home

A medical home is an approach to providing health care services to ensure that differently-abled members receive care that is family-centered, accessible, continuous, comprehensive, coordinated, compassionate and culturally competent in a managed care environment. Horizon NJ Health is committed to educating and training network

physicians, facilities, administrators and office staff on how to improve the delivery of services to members who are differently-abled by applying the concepts of a medical home.

The Horizon NJ Health Medical Home objectives are:

- To provide knowledge to network physicians and facilities on how to ensure that differently-abled members have medical homes in a managed care environment
- To enhance skills for developing sustainable medical homes
- To enhance skills for identifying and developing community resources and networks
- To illustrate the importance of a collaborative effort between Horizon NJ Health, network physicians, facilities, members, their families and community resources

Note: A refinement of this concept is the Patient-Centered Medical Home (PCMH), which adds data management. Horizon NJ Health is engaging with providers to promote the PCMH concept.

The Horizon NJ Health Medical Home Components

Family-Centered: Horizon NJ Health and network physicians recognize that the family is the constant. The family is the principal caregiver and center of strength and support.

Accessible: Horizon NJ Health and network physicians ensure that care is personally, physically and geographically accessible.

Continuous: Horizon NJ Health and network physicians assist members and families with transition planning with home, school, adult services and other network physicians and facilities.

Coordinated: Horizon NJ Health and network physicians connect members and families with all needed services. These services can include specialty care and community-based services, as well as family support and advocacy groups.

Compassionate: Horizon NJ Health and network physicians demonstrate sincerity, respect and a caring attitude.

13.7 Care Management

Complex Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a member's clinical and medical needs. The primary focus is the coordination of quality health care in the most cost-effective manner for members with complex medical conditions. The intensity of care management activities varies based on a multitude of factors including, but not limited to:

- Clinical features of the individual case as reported by a member or attending/treating provider
- Evaluation/treatment setting resources available
- The member's clinical needs and situation
- The opportunity for care management intervention to have a positive impact on the member's circumstances

The purpose of this program is to direct and coordinate the delivery of cost-effective, quality-driven health care services for complex medical cases. The main objectives of care management are to:

- Ensure timely access to appropriate levels of care
- Manage health care benefits effectively
- Identify needs that follow an acute care period
- Assist with interventions for long-term health problems

- Balance cost versus quality of care issues
- Maintain continuity of care

Horizon NJ Health is able to identify complex cases by utilizing the following tools:

- Concurrent review during inpatient hospital admissions
- Phone requests from PCP or specialist
- Hospital inquiries for benefit or precertification information
- Member services phone inquiries
- Utilization Reports
- Requests for durable medical equipment information

The Care Manager gathers information relative to the case, assesses requested services, suggests alternative care plans when appropriate, advocates for the members and monitors provision of services as needed. By continually evaluating each specific case, the Care Manager will make appropriate determinations regarding when the member no longer needs specific care management. To come to this conclusion, the Care Manager will review the member's condition, the physician's recommendations and anticipated future course of action and, if possible, personally contact members to review their medical situation with them. To contact a Care Manager, please call **1-800-682-9094 x89634**.

Providers in value-based arrangements (PCMH, ACO,EOC), risk arrangements, or similar value-based programs, may be given cost of care data pertinent to their members even if such costs are associated with providers outside their particular value-based program. Any Provider objecting to the production of their data to value-based providers must notify Horizon NJ Health in writing, no later than July 30 of each year, to:

**Director, Provider Contracting and Strategy
1700 American Blvd.
Pennington, NJ 08534**

13.7.1 MLTSS Care Management

Horizon NJ Health provides every MLTSS member with a Care Manager and care management team, including a Clinical Care Coordinator. The Care Manager, usually a nurse or social worker, leads the coordination of all primary, acute, behavioral and long term services and supports for the member.

A Service Plan of Care is developed based on the member's health status and health care needs. The role of the provider (Primary Care Physician, specialist or other provider) is very important. The member, along with his/her Care Manager, will work together to develop a plan of care. The plan of care will outline the member's health care needs, what services the member may receive, frequency of service and name of provider decided upon by the member. MLTSS Services will be provided within 30 calendar days of enrollment, except for residential modification and vehicle modification. The plan of care is facilitated by the Care Manager, who ensures direct involvement of the member, member's family and/or authorized representative. The Care Manager is responsible for facilitating placement/services based on assessed needs and member's preference. The provider may receive a copy of the plan of care via fax.

The Care Manager will make a face-to-face visit every 90 days or 180 days, depending on the member's setting of residence. The Care Manager will periodically review the member's plan of care at least every 90 days or sooner and make updates as warranted if there are changes in the member's condition and service needs. Horizon NJ Health members must use in-network, contracted providers to get covered MLTSS services.

Horizon NJ Health ensures that its MLTSS Care Managers work in a conflict-free environment. Care Managers cannot work directly with members who are blood relatives or related by marriage. They also cannot be a direct-

paid caregiver or be financially responsible for or empowered to make financial or health-related decisions on behalf of a member they are assigned to.

13.8 Infectious Disease Program

The purpose of the HIV/AIDS Complex Care Management Program is to provide confidential care management specific to this disease process. All members with a diagnosis of HIV or AIDS are eligible for this program. Horizon NJ Health works in collaboration with Ryan White Care grantees to coordinate health care services and provide community linkages.

Goals

The goal of the HIV/AIDS Complex Care Management Program is to help enrollees regain and maintain functional health in a quality, cost-effective manner.

- Educate enrollees regarding appropriate preventive services
- Coordinate services for enrollees including, but not limited to:
 - PCP follow up
 - Ancillary services
 - Pharmacy
 - Community linkages/resources
 - Behavioral Health Services (including mental health and substance use disorder treatment)
 - Review and assist enrollees with compliance issues, including medication adherence and follow up with specialist visits

Program Enrollment

1. Assess pharmacy data to determine current pharmacy utilization of HIV/AIDS medication.
2. Member identification will be multifaceted, utilizing self-referral, inpatient information, emergency room information, primary care physician or specialist outreach, etc.
3. Referrals will be accepted from both internal and external sources, including:
 - Member self-referrals
 - Utilization Management
 - Care Management
 - Pharmacy
 - Horizon NJ Health physicians and other health care providers

Confidentiality

To ensure confidentiality, all persons assessed will be asked to repeat their Social Security Number or date of birth. Information for members identified with HIV/AIDS will be maintained with strict confidentiality and respect. No member's medical information will be shared with anyone who is not personally involved in their medical process. Members will identify persons who may speak on their behalf (e.g., case managers at clinics, caregivers and legally designated persons).

13.9 Disease Management

The Disease Management program has been established to coach and educate low- to moderate-risk members in the management and treatment of their disease.

Members are referred through:

- Primary care physicians/specialists

- ER/IP reports
- Encounter claims
- Care Management/Utilization Review
- Pharmacy claims
- Health Needs Survey

The Disease Management Education programs are:

- Diabetes (NCQA-identified)
- Congestive heart failure (CHF)
- Hypertension
- Asthma (NCQA-identified)
- Chronic obstructive pulmonary disease (COPD)
- HIV/Sickle cell/Hepatitis

The goals of the Disease Management programs are:

- To educate both members and providers in health management based on nationally recognized standards of care
- To promote an optimal, realistic level of an individual's wellness and functionality
- To promote behavior modification and facilitate member and provider communication
- To enable the member/family to make independent, informed health care decisions
- To provide a disease prevention and wellness education program that will improve the quality of health for our members
- To promote the cost-effective utilization of financial and human resources
- To improve overall member and provider satisfaction with Horizon NJ Health

13.9.1 Congestive Heart Failure

The Congestive Heart Failure (CHF) Disease Management has been implemented to better manage members with CHF through education and member support services.

This service is based on the ACC/AHA Guideline Update for the Diagnosis and Management of Congestive Heart Failure in the adult evidence-based standards of care. References to these guidelines are available on the Horizon NJ Health website and in Appendix A of this manual.

The service is staffed with nurses who identify CHF members by inpatient admissions, physician referrals and member self-referrals. The nurses perform global health assessments of the member's medical, psychosocial and pharmaceutical data. Individual care plans are then established for these members to track the progress of their disease management. All CHF members will receive member health education and services through the health educators via letters and phone calls. They may, if appropriate, receive a scale to empower the member to maintain weight control and detect unexplained weight gains that may lead to future complications. The program is not intended to replace any CHF instructions or education provided by primary care physician or specialists; rather, it is intended to manage the member's care in a collaborative effort with the primary care physician and/or specialist.

13.9.2 Diabetes

Our comprehensive diabetes management program offers:

- Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or Certified Nutrition Specialist (CNS) for members diagnosed with diabetes, gestational diabetes or pre-diabetes. MNT is

consistent with evidence-based nutrition practice guidelines published by the Academy of Nutrition and Dietetics.

- Diabetes Self-Management Education (DSME) provided by a Certified Diabetes Educator for members diagnosed with diabetes or gestational diabetes. The DSME Program meets current quality standards established by The American Association of Diabetes Educators (AADE) and/or the American Diabetes Association (ADA).
- National Diabetes Prevention Programs (NDPPs) for members diagnosed with pre-diabetes, which meet the standards of the NDPP established by the Centers for Disease Control and Prevention.

The service is based on ADA Clinical Practice Recommendations. A summary of revisions for Clinical Practice Recommendations and Additions to the Standards of Medical Care in Diabetes are:

- A section on driving and diabetes has been added.
- A section and table on common comorbidities of diabetes has been added.
- A table listing properties of non-insulin therapies for hyperglycemia in type 2 diabetes has been added.

Revisions to the Standards of Medical Care in Diabetes—2015

In addition to many small changes related to new evidence since the prior year, and to clarify recommendations, the following sections have undergone major changes:

- The introduction was revised to more clearly describe processes for systematic evidence review, to link to the evidence table for changes since 2011, and to link to opportunities for public comment on the Standards of Medical Care in Diabetes—2012.
- Section V.D.2. Therapy for Type 2 Diabetes was revised to include more specific recommendations for starting and advancing pharmacotherapy for hyperglycemia.
- Section X. Strategies for Improving Diabetes Care was revised to reflect growing evidence for the effectiveness of restructuring systems of chronic care delivery.

Revised Position Statement

- A revised position statement, “Diabetes Management at Camps for Children with Diabetes,” has been added.

New Position Statement

- A new position statement, “Driving and Diabetes,” has been added.

Current criteria for the diagnosis of diabetes

- A1C $\geq 6.5\%$. The test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP)-certified and standardized to the Diabetes

Control and Complications Trial (DCCT) assay; or

- Fasting plasma glucose (FPG) ≥ 126 mg/dL (7.0 mmol/l). Fasting is defined as no caloric intake for at least eight hours; or
- Plasma glucose ≥ 200 mg/dL (11.1 mmol/l) during an oral glucose tolerance test (OGTT). The test should be performed as described by the World Health Organization using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water; or
- In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dL (11.1 mmol/l);

- In the absence of unequivocal hyperglycemia, the result should be confirmed by repeat testing.

The diabetes clinical guidelines can be viewed at diabetes.org.

13.9.3 Asthma

The Asthma Program is designed to identify people with asthma through medical and pharmacy claims data, and then provide educational interventions aimed at improving compliance and reinforcing the education provided by the clinician.

Enrollment

Upon identification of a person with asthma, an assessment of medical and pharmacy utilization is done to determine risk category. Horizon NJ Health staff perform telephonic education of members with asthma. A specialist referral is strongly recommended for high-risk members with asthma (see following criteria).

Horizon NJ Health recommends that a patient be referred to a pulmonologist or allergist when he/she:

- Has an ICU admission, intubation or life-threatening asthma exacerbation; or
- Has had two or more emergency room visits in the past six months; or
- Has had a hospital admission in the past six months; or
- Has poorly controlled asthma (i.e., there is an adequate medication regimen but the patient is still having recurring symptoms using a relief inhaler >2 times per week, or has persistent nighttime awakening with symptoms); or
- Has a history of steroid dependency due to asthma of three months or more and/or > or = three trials of steroid “burst” therapy; or
- Has a high-risk pregnancy and a history of asthma; or
- Has complicating co-morbidities, such as severe rhinitis, severe sinusitis, sleep apnea, GERD, and/or a history of smoking. There are problems with differential diagnosis or atypical signs and symptoms.
- Has problems with differential diagnosis or atypical signs and symptoms.

Members with asthma who require self-monitoring are eligible for a peak flow meter through the provision of a prescription from the clinician. Peak flow meter use and peak flow zones can be taught by the clinician or the dispensing pharmacist. The optichamber spacer and masks may also be obtained from any participating pharmacy with a written prescription. Education regarding the proper use of this equipment is essential to the provision of these devices. Children who require medication during school time may have a duplicate peak flow meter and medication if the clinician provides a prescription noting “duplicate needed for school use.” An asthma treatment plan must be provided to the school nurse to allow the child to have medication during school time. Physicians are encouraged to order metered dose inhalers (MDIs) with spacers versus nebulizers for those members with asthma that are over the age of five and do not have any cognitive and/or physical disabilities that would prevent them from properly utilizing an MDI with spacer. The physician is responsible for educating the member/family of proper MDI/spacer technique.

An annual asthma intervention letter is sent to the physician and member when pharmacy data has determined that the member has been utilizing excessive beta2-agonists.

Horizon NJ Health’s pharmacy benefits cover spacers, peak flow meters, nebulizer equipment and supplies.

Medications covered by Horizon NJ Health Quick-Relief Medications

- Albuterol MDI
- Ventolin HFA

- Xopenex Neb

Long-Term Control Medications

- Advair
- Asmanex
- Cromolyn
- Flovent
- Montelukast
- Nedocromil
- Pulmicort Neb (age 8 and younger)
- Prednisolone
- Prednisone
- Qvar
- Serevent
- Sustained Release Theophylline

13.9.4 COPD

Horizon NJ Health established the Chronic Obstructive Pulmonary Disease (COPD) Management Service to improve the quality of life of members with COPD, reduce hospitalizations and emergency room visits and provide education about COPD and proper drug therapy.

The program was developed and is based on the Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (December 2007). The program focuses on the five components of effective management: assess and monitor disease, reduce risk factors, manage stable COPD, manage exacerbations and recommendations in primary care. For further information, please see goldcopd.org. References to these guidelines are available on the Horizon NJ Health website and in Appendix A in this Manual.

Members are identified based on claims/encounter data, pharmacy claims and member and PCP referral. Risk stratification determines the appropriate level of intervention for each member eligible based on their functional status and PFT findings.

13.9.5 Hypertension

Horizon NJ Health established the Hypertension Management Service to improve the quality of life of its members with hypertension, reduce hospitalizations and emergency room visits and provide education about hypertension and proper drug therapy. The service was developed and is based on the seventh report of the Joint National Committee on Prevention Detection, Evaluation, and Treatment of High Blood Pressure (2005). For further information, please see nhlbi.nih.gov/health/high-blood-pressure. References to these guidelines are available on the Horizon NJ Health website and in Appendix A in this manual.

For more information on Horizon NJ Health's Disease Management Program or to enroll your patients, please call **1-800-682-9094**. References to clinical guidelines for these disease are available on our website and in Appendix A of this manual.

13.10 Horizon *Healthy Journey*

Horizon *Healthy Journey* is the population health program sponsored by Quality Management. The goal of this program is to reach out, engage and educate members and providers on the importance of preventive visits, chronic condition management, medication adherence and timeliness of visits. Results and Recognition, Rewards and Incentives, and Health and Wellness Program for Children are just a few of the programs managed through

the Horizon *Healthy Journey* Program. For more information on the Horizon *Healthy Journey* program, please call **1-844-754-2451**.

13.11 EPSDT Program and Guidelines

Horizon NJ Health primary care physicians must furnish Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-equivalent services. EPSDT is a federally mandated, comprehensive child health program for Medicaid recipients from birth through under the age of 21. According to section 1905 of the Social Security Act (42 U.S.C. 1936(d)) and federal regulation 42 CFR 441.50 et seq., EPSDT services include the following:

Health Services

A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all diagnosis and treatment services that are medically necessary to correct or ameliorate a physical or mental condition are identified during a screening visit.

1. Comprehensive, unclothed physical examination including:
 - Vision and hearing screening
 - Dental inspection
 - Nutritional assessment
2. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. (See Appendix A Preventive & Clinical Guidelines.) Physicians must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits; necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.
3. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided. The list of screening tests is not all-inclusive; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
 - Hemoglobin/hematocrit
 - Urinalysis
 - Tuberculin test – intradermal, administered annually and when medically indicated
 - Blood lead screening using blood lead level determinations must be completed for every Horizon NJ Health member younger than six years of age. (See Appendix A Preventive & Clinical Guidelines.) Please refer to Section 3.18 Outpatient Laboratory Services.
4. Health education/anticipatory guidance.
5. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, which are treatable/correctable or require maintenance therapy uncovered or suspected. (Referral may be to the physician conducting the screening examination or to another physician, as appropriate.)
6. EPSDT screening services shall reflect the age of the child and be provided periodically, according to the following schedule:

- Within one week of birth	1 month
- 2 months	4 months
- 6 months	9 months
- 12 months	15 months
- 18 months	24 months
- 30 months	Annually through age 20

At a minimum, the primary care physician must provide the following screenings and services to children from birth to under the age of 21 in accordance with the EPSDT screening services schedule.

Vision Services

A vision screening includes diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant is defined as an eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment shall be done for each child beginning at age three.

Dental Services

A dental screening is defined, at a minimum as observation of tooth eruption, occlusion pattern, and presence of cavities or oral infection. A referral to a dentist at the eruption of the first tooth or by one year of age is mandatory.

Hearing Services

A hearing screening includes the diagnosis and treatment of defects in hearing, including hearing aids. For infants identified as at risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to 3 months of age using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant's response to auditory stimuli and audiogram for a child 3 years of age and older. Speech and hearing assessment shall be part of each preventive visit for an older child.

Mental Health/Substance Use Disorder

A mental health/substance use disorder (MH/SUD) screening includes an assessment documenting pertinent findings. When there is an indication of possible MH/SUD issues, an MH/SUD screening tool(s) shall be used to evaluate the member. Please refer to the Horizon NJ Health website for a copy of the Horizon NJ Health Behavior Health Well-Being Screening Tool.

Other Considerations

The primary care physician must provide other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental/substance use disorder illnesses and conditions discovered by the screening services.

Lead Screening

Verbal Risk Assessment: A verbal risk assessment shall be performed for lead toxicity at every periodic visit between the ages of six and 72 months, as indicated on the schedule. See Appendix A Preventive & Clinical Guidelines. The verbal risk assessment includes, at a minimum, the following types of questions:

- Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint?
- Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint?
- Does your child live in a house built before 1978 with recent, ongoing or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? Examples include construction, welding, pottery or other trades practiced in your community.
- Do you give your child home or folk remedies that may contain lead?

Providers are expected to surpass 80 percent compliance for two consecutive six-month periods for obtaining a lead screen prior to the child's second birthday.

Generally, a child's level of risk for exposure to lead depends on the answers to the above questions. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure.

If the answers to any question are affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child must be tested according to the age groups specified in the state contract. A child's risk category can change with each administration of the verbal risk assessment.

Important Lead Testing Reimbursement Facts

Horizon NJ Health reimburses \$10 for the in-office collection of blood for lead screening. The current lead screening CPT codes and modifiers include:

36405 59 Venipuncture for lead screening for children under three years of age, scalp vein
36406 59 Venipuncture for lead screening for children under three years of age, other vein
36410 59 Venipuncture for lead screening for children three years of age or older
36415 59 Collection of venous blood by Venipuncture for lead screening for children 3 years and older
36416 59 Collection of capillary blood specimen for lead screening (finger, heel, and ear stick)
83655 52 Lead test (diagnosis code required)

If your office has any difficulty submitting this claim electronically, leave out the decimal point. Use all the code numbers. Please call Horizon NJ Health with any questions or issues regarding reimbursement.

Relevant Labcorp Information

Please remember to use the correct form for Labcorp lead testing. Utilize the Heavy Metal Request form and indicate the source of the blood (venous or capillary). You can order these forms from the Labcorp Customer Service line at **1-800-631-5250**.

Labcorp can customize this form with your provider information. Labcorp can also customize this form to include any other labs you may wish to include at your request. For example, if you routinely ask for a hemoglobin and hematocrit with a lead screen, you can ask Labcorp to add this test to the Heavy Metal Request form for you. You could also add CBC and urinalysis to coordinate your EPSDT lab requirements.

Note: For NJ FamilyCare B and C members, EPSDT coverage is limited to preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening and hearing services. The EPSDT examination includes only those treatment services identified through the examination that are a covered benefit under the Horizon NJ Health benefit package or the New Jersey Medicaid fee for service program. Other services identified through an EPSDT examination that are not a covered benefit under Horizon NJ Health or Medicaid fee for service are not covered.

Note: For NJ FamilyCare D members, EPSDT coverage is limited to well-childcare visits, including immunizations, lead screenings and treatments. Private-duty nursing, an EPSDT service, is included only with prior authorization.

13.12 New Jersey Vaccines for Children Program (VFC)

The VFC Program provides vaccines for children from birth through 18 years of age who are enrolled in Medicaid and NJ FamilyCare A as well as uninsured children and children who are American Indian or Alaskan Native. The VFC program is a federally funded, state-operated vaccine supply program. The VFC program supplies most routinely recommended vaccines at no cost to all public and private health care physicians. Horizon NJ Health will reimburse physicians for the administration fee of covered vaccines.

For NJ FamilyCare A children, providers must enroll in the VFC program and use the free vaccine if it is covered by VFC. The State DHS will not pay Horizon NJ Health for the reimbursements it gives providers for any administration fees. For non-VFC vaccines, Horizon NJ Health will reimburse providers for vaccines and vaccine administrations.

Physicians participating in the VFC program must agree to comply with the following:

- Screen the parent/guardian of the child to determine VFC eligibility
- Maintain records of all children immunized with a VFC vaccine (these records must be made available to public health officials upon request)
- Comply with the recommended immunization schedule, as established by the Advisory Committee on Immunization Practices and state law
- No charge for VFC-supplied vaccines
- Provide vaccine information materials and maintain records in accordance with the National Vaccine Injury Compensation Act
- Comply with state ordering, accountability or quality assurance requirements through NJIIS
- Providers no longer enrolled in VFC must notify us in writing within seven days of disenrollment.

Horizon NJ Health
Attn: PC&S
1700 American Blvd.
Pennington, NJ 08534
Or via fax: **1-609-583-3004**

The VFC program no longer provides vaccines for children enrolled in NJ FamilyCare B, C, or D. For these members, providers must obtain all vaccines from traditional market sources and administer them, and Horizon NJ Health will reimburse providers for the vaccines and the vaccine administration. If a provider office is not able to independently obtain the necessary vaccines, it can give a prescription to a member and administer the vaccine after obtaining it – only with prior authorization – through the member’s prescription coverage. For authorization, please contact the Pharmacy Department at **1-800-682-9094**.

13.13 VFC Immunizations

Under the VFC program, the following CPT codes are to be used when billing for the administration fee for immunizations. The codes below are arranged to depict which vaccines and reimbursements are appropriate for patients under the age of 19 and which cover those over the age of 19. When billing for members over the age of 19 or if the immunization is not covered under the Vaccines for Children program, please note the appropriate codes on the table. (If the provider receives vaccines free of charge from a local health department or other finding source, none of this applies.)

CPT Code Vaccine

- 90620 Meningococcal recombinant protein and other
- 90621 Meningococcal recombinant lipoprotein vaccine
- 90630 Influenza virus vaccine, quadrivalent
- 90632 Hepatitis A, Adult
- 90633 Hepatitis A, Peds/Adolescent 2-dose schedule
- 90636 Hepatitis A and B, Adult
- 90644 Meningococcal conjugate vaccine, serogroups C & Y and haemophilus influenzae B
- 90647 Hib, PRP-OMP conjugate 3-dose schedule

- 90648 Haemophilus influenzae B (Hib) PRP-T
- 90649 Human papillomavirus (8-18 yrs. females only)
- 90650 Human papillomavirus (HPV) bivalent for intramuscular use
- 90651 Human papillomavirus 16, 11, 16, 18, 31, 33, 45, 52, 58 nonavalent 3-dose
- 90654 Influenza virus vaccine, split virus, preservative free, for intradermal use
- 90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, intramuscular use
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, intramuscular use
- 90657 Influenza, 6-35 months, IM/jet injection
- 90658 Influenza, 3 years and above, IM/jet injection
- 90660 Influenza virus (5-18 yrs.) Live, Intra-nasal
- 90662 Influenza virus vaccine, split virus, preservative free
- 90670 Pneumococcal conjugate vaccine, 13valent, for intramuscular use
- 90680 Rotavirus (2, 4, 6 mos. old ONLY)
- 90681 Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use
- 90685 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use (Code Price is per .25 ml) (Fluzone)
- 90687 Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age
- 90688 Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)
- 90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 3 years of age and older, for intramuscular use
- 90698 Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenza type B, and poliovirus vaccine, inactivated (DTaP, Hib, IPV), for intramuscular use
- 90700 DTaP
- 90707 MMR
- 90710 MMRV
- 90713 Inactivated IPV
- 90714 Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, intramuscular use
- 90715 Tdap (11-18 yrs.)
- 90716 Varicella virus vaccine
- 90717 Yellow fever vaccine
- 90723 DTaP-Hep B-IPV (Pediarix)
- 90732 Pneumococcal, Polysaccharide vaccine, 23 valent, adult or immunosuppressed patient for subcutaneous or intramuscular use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetraivalent), for intramuscular use
- 90743 Hepatitis B, Adolescent (2-dose schedule)
- 90744 Hepatitis B, Peds/Adolescent dosage (3-dose schedule) intramuscular use
- 90746 Hepatitis B, Adult
- G9142 Influenza A (H1N1) vaccine
- Q2035 Influenza virus vaccine, split virus, 3 years and above, intramuscular use

- Q2036 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2037 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2038 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2039 Influenza virus vaccine, split virus, 3 years and above, intramuscular use

For information regarding the Vaccines for Children Program call **1-609-826-4862** or fax **1-609-826-4867**.

13.14 Immunizations After the Age of 19

When billing for members over the age of 19 or if the immunization is not covered under the Vaccines for Children program, use the following CPT codes. (If the provider receives vaccines free of charge from a local health department or other finding source, this does not apply.)

Code Vaccine

- 90632 Hepatitis A, Adult
- 90633 Hepatitis A vaccine, pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
- 90634 Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
- 90636 Hepatitis A and B, Adult
- 90645 Hib vaccine Hb0C conjugate (4 dose) for intramuscular use
- 90646 Hib vaccine Hb0C conjugate (4 dose) for intramuscular use
- 90647 Hib, PRP-OMP conjugate 3-dose schedule
- 90648 Haemophilus influenzae B (Hib) PRP-t
- 90649 Human papillomavirus (19-26 yrs., females only)
- 90650 Human papillomavirus (HPV) bivalent for intramuscular use
- 90654 Influenza virus vaccine, split virus, preservative free, for intradermal use
- 90656 Influenza
- 90658 Influenza, 3 years and above, IM/jet injection
- 90660 Influenza virus vaccine live, intranasal
- 90662 Influenza virus vaccine, split virus, preservative free
- 90670 Pneumococcal conjugate vaccine, 13valent, for intramuscular use
- 90672 Influenza virus vaccine, quadrivalent, live, for intranasal use (Code price is per dose) (Flumist)
- 90680 Rotavirus vaccine, tetravalent, live, for oral use
- 90681 Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use
- 90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use (Code Price is per 0.5mL)
- 90688 Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)
- 90698 Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenzae type B, and poliovirus vaccine, inactivated (DTaP, Hib, IPV), for intramuscular use
- 90701 DTP
- 90704 Mumps
- 90705 Measles virus vaccine, live, for subcutaneous use
- 90706 Rubella virus vaccine, live, for subcutaneous use
- 90707 MMR
- 90712 Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
- 90713 Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use

- 90714 Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
- 90715 Tdap
- 90716 Varicella
- 90718 Td, adsorbed for use in individuals 7 years or older for intramuscular or jet injection
- 90720 DTP-Hib
- 90732 Pneumococcal, Polysaccharide vaccine, 23 valent, adult or immunosuppressed patient for subcutaneous or intramuscular use
- 90733 Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
- 90736 Zoster (shingles) vaccine, live, for subcutaneous injection
- 90746 Hepatitis B, Adult
- 90747 Hepatitis B (Dialysis or HIV), immuno-suppressed patient dosage (4-dose schedule) for intramuscular use
- 90748 Hepatitis B and Hemophilus influenza b vaccine (Hep B-hib), for intramuscular use
- Q2035 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2036 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2037 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2038 Influenza virus vaccine, split virus, 3 years and above, intramuscular use
- Q2039 Influenza virus vaccine, split virus, 3 years and above, intramuscular use

13.15 New Jersey Immunization Information System

The New Jersey Immunization Information System (NJiIS) is a mandated statewide, web-based immunization registry designed to capture immunization histories of all New Jersey children, regardless of where they receive their vaccinations. There are no software costs or user fees for physicians to use the NJiIS. Children are entered into the registry at birth through a linkage with the electronic birth record process. Health care providers can initiate a registry record in their practice when a vaccine is administered to a child. The benefits to health care providers are:

- Access real-time clinical immunization information and current vaccine recommendations
- Reduce paperwork and staff time in obtaining records and responding to record requests
- Instantly print a child's official immunization record for school enrollment
- Consolidate immunizations from all providers to complete the child's immunization history
- Enable accurate immunization assessment
- Help interpret the complex immunization schedule
- Electronic interfaces with health plans, WIC and the Child Lead Program
- Access child's preventive health history, such as TB and lead test results
- Quick access to newborn hearing screening results
- Electronically submit newborn hearing "lost to follow-up" form
- Automated vaccine inventory adjusts each time a shot is administered
- Ability to electronically generate VFC eligibility form
- Online vaccine ordering and inventory management

For more information, visit NJiIS online at njiis.nj.gov.

13.16 Prenatal Program – Mom’s GEMS

Mom’s Getting Early Maternity Services (GEMS) prenatal program is available to all pregnant Horizon NJ Health members. This program is designed to improve birth outcomes for Horizon NJ Health members through the provision of appropriate maternity care services.

The key components to this program are:

- Medical care coordination
- Care management
- Health education
- Outreach
- Social/psychological counseling referrals

Primary Care Providers

Visit horizonNJhealth.com/findadoctor, to help members who are pregnant obtain appropriate prenatal care.

Ob/Gyn Physicians

All members must receive prenatal care within their first trimester. All newly enrolled members must receive prenatal care within their first trimester or within 42 days of enrolling in Horizon NJ Health.

The postpartum visit must be completed on or between 21 and 56 days after delivery.

All Ob/Gyn physicians must notify Horizon NJ Health of members who present for prenatal care after the first contact and must receive precertification for the remainder of the services. Upon the initial prenatal visit with a Horizon NJ Health member, the physician is required to complete a pregnancy risk assessment (PRA). At Horizon NJ Health, the Pregnancy Risk Assessment (PRA) serves to:

- Coordinate care
- Obtain baseline information about the member
- Initiate care management with the goal of improving birth outcomes
- Provide Ob/Gyn physicians with a method to guarantee payment for eligible services
- Promote early and accurate identification of prenatal risk factors
- Reduce administrative burden on obstetric practices

In addition, the use of a common risk assessment tool will allow the Division of Medical Assistance and Health Services/Medicaid to gather information and learn more about Medicaid-eligible pregnant women in New Jersey.

The (PRA) and the WIC referral form must be completed within seven days of the initial prenatal visit. The completed PRA must be sent to Family Health Initiatives (FHI) at **1-856-675-5286**. The preferred method is electronic submission. An updated PRA form must also be completed if there are changes or updates to the members’ pregnancy.

The PRA is a state-derived assessment form that is sent to Family Health Initiatives (FHI), a subsidiary of the Southern NJ Perinatal Cooperative, to collect state required information for provider reimbursement. FHI is responsible for form processing, data management and training. For questions about the PRA form or process, please contact the FHI at **1-856-675-5286** or pra@snjpc.org. You can view the PRA training manual at praspect.org/documentation/PRA_Training_Manual_Jan2012.pdf or request on site or virtual training by contacting FHI.

If the PRA is not received, Horizon NJ Health will not pay for any professional charges related to prenatal and/or postpartum visits. If the PRA is received after seven days of the initial Horizon NJ Health visit, Horizon NJ Health will only pay for the subsequent care provided after the date that the PRA is received by Horizon NJ Health.

The GEMS Global Authorization now covers up to three OB Ultrasounds for non high-risk pregnancies, and up to 13 total for confirmed or suspected high-risk pregnancies. To secure a GEMS Global Authorization, you must submit a PRA to FHI in a timely manner. The PRA will be utilized to initially determine risk.

For OB Ultrasounds beyond what is covered in the GEMS Global Authorization, use Utilization Management Request Tool. OB Ultrasounds will not be authorized without a PRA on file. Please remember that Horizon NJ Health has 14 calendar days to respond to each authorization request.

Horizon NJ Health reserves the right to audit medical records for documentation supporting medical necessity. If such documentation is not available or the service is deemed not medically necessary, we will recover payment(s). Additionally, we will continue to monitor trends from claims data to ensure that utilization continues to be medically appropriate. In the event that utilization trends change, we may further modify authorization requirements and processes.

Doula services

A doula is a trained professional who provides continuous physical, emotional and informational support throughout the perinatal period. The services include the following:

- Prenatal visits
- Labor and delivery support
- Postpartum visits

There will be two levels of doula services, standard care and enhanced care for members age 19 or younger:

Standard care (8 perinatal visits — 1 labor support visit)

- Up to eight visits in the prenatal or postpartum period, including the option of one initial prenatal visit
- Attendance at the labor/delivery

Enhanced care (12 perinatal visits — 1 labor support visit)

- Enhanced care delivery is available to members who are 19 years old or younger at the time of the first doula service visit
- Up to 12 visits in the prenatal or postpartum period, including the option of one initial prenatal visit
- Attendance at the labor/delivery

Please use the following codes for doula services.

99600 HD U7 Initial prenatal service visit
99600 HD Standard care, prenatal visit
99600 HD 22 Enhanced care, prenatal visit
59409 HD Labor support, Vaginal birth
59514 HD Labor support, C-section
99199 HD Standard care, postpartum visit¹
99199 HD 22 Enhanced care, postpartum visit¹

Claims for doula services may be submitted to Horizon NJ Health up to 365 days after the date of service. For more information, please review the [doula services reimbursement policy](#).

¹A value-based incentive payment will be considered when a doula provides a postpartum service visit (99199-HD or 99199-HD-22) within six weeks of delivery. This should be submitted with CPT code 99199-HD-U8.

[Doulas can find information about joining our network on our website.](#)

Breast pump for pregnant or new moms

Pregnant women and new moms are eligible to obtain a free breast pump if they are going to breastfeed their infant.

Benefit guidelines:

- Pregnant women and new moms who intend to breastfeed their infant are eligible for a breast pump and supplies.
- Pregnant women and new moms can use any participating network durable medical equipment supplier that stocks manual or electric breast pumps
- There is no authorization, prescription or referral required for Manual or Standard, electric breast pumps.

Types of pumps covered with a prescription:

- Manual breast pump (CPT code E0602): A non-electric pump that works by vacuum suction.
- Standard, electric breast pump (CPT code E0603): An electric pump that works by creating a pulsating suction, usually by pneumatic action against a diaphragm.
- Hospital grade pump (CPT code E0604) is available for rental only. A letter of medical necessity and/or the physician order may be requested on a post-service basis.

Lactation Counseling and Consultation:

Pregnant women and new moms are eligible for lactation counseling and consultation services individually, in a group or by phone.

Refer to [reimbursement policies and guidelines](#) for detailed billing guidelines for breast pumps and lactation counseling.

Postpartum

Well Mom/Well Baby Home Visit Referral Coordination

Please contact your assigned GEMS Care Manager for assistance in requesting postpartum home and newborn visits. Postpartum visits need to occur within 21 and 56 days post-delivery for payment. If visits have not been scheduled, we ask that you assist the member in scheduling them.

If you need supplies or more information regarding the Mom's GEMS prenatal program, contact Provider Services at **1-800-682-9091**.

If a member does not have a Mom's GEMS authorization, please confirm that a PRA has been sent to FHI and if urgent authorization for OB/US services is needed, please contact the Prior Authorization Unit at **1-800-682-9094** and assistance will be provided.

If a member does not have a Mom's GEMS authorization, please confirm that a PRA has been sent to FHI and if urgent authorization for OB/US services is needed, please contact the Prior Authorization Unit at **1-800-682-9094** and assistance will be provided.

- Fetal biophysical profile
- Professional delivery fees
- Non-stress test
- Perinatal consult
- Prenatal and Postpartum visit
- RhoGam
- Breast pumps
- Vaccines (clinically required)

All other procedures require a referral and authorization when performed by a participating physician and billed using a valid CPT or HCPC code.

- For non-obstetrical Radiology Tests please refer to NIA.

Frequently Used Obstetrical Codes

59425 Antepartum Care Only: 4-6 visits

59426 Antepartum Care Only: 7 or more visits

59409 Regular Vaginal Delivery

59430 Postpartum Care Visit Only

59514 Cesarean Section Delivery Only

59409, 59612 Vaginal After Cesarean Delivery (First Newborn)

59510, 59514, 59515, 59618, 59620, 59622 Vaginal After Cesarean Delivery (Subsequent Newborn)

14.0 FIDE-SNP Programs and Services

14.1 Introduction to Horizon NJ TotalCare (HMO D-SNP) Appendices

Horizon NJ TotalCare (HMO D-SNP), a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), is a Medicare Advantage plan that integrates all covered Medicare and Medicaid managed care benefits into one health plan.

Among the most important features of the plan are:

- A team of doctors, specialists and Care Managers working together for the FIDE-SNP member
- A Model of Care (MOC) that calls for individual care plans for members
- All the same member rights available to Medicare and Medicaid recipients
- Zero dollar cost share: no copayments, premiums or deductibles for virtually all services including prescriptions services
- Same comprehensive dental benefits as offered to NJ FamilyCare members
- No referrals needed

FIDE-SNP members can see any provider in any county as long as the providers are part of Horizon's FIDE-SNP provider network.

Those who wish to enroll in Horizon NJ TotalCare (HMO D-SNP) can call **1-877-234-1240**.

14.2 Individuals Eligible To Enroll

To be eligible for Horizon NJ TotalCare (HMO D-SNP), an enrollee must:

- Be a full-time New Jersey resident residing in one of the counties in which the program is available
- Have Medicare Parts A and B
- Have NJ FamilyCare (Medicaid) eligibility
- Not be enrolled in a breast cancer or cervical cancer waiver program
- Not be enrolled in a PACE (Program for All Inclusive Care for the Elderly) program

FIDE-SNP members may also be eligible for Managed Long Term Services & Supports (MLTSS); those who are enrolled as MLTSS members must meet nursing facility level of care. For more information about MLTSS eligibility, please consult Section 2.1.1 (Eligibility Requirements for MLTSS Membership) of this Manual.

14.2.1 ID Card

Horizon NJ TotalCare (HMO D-SNP) members receive an identification card with the prefix "YKU" in front of their ID numbers.

14.2.2 Deeming Periods and Deemed Members

A Horizon NJ TotalCare (HMO D-SNP) member who loses Medicaid eligibility is known as a deemed member. A deemed member will remain in the Horizon NJ TotalCare (HMO D-SNP) plan for a period of time not to exceed two calendar months.

Benefits during this deeming period will be Medicare only. During the Deeming Period (60 days) Horizon will continue to provide all appropriate Medicare Advantage plan covered benefits. However, during this period the deemed member will not continue to receive Medicaid benefits (including MLTSS).

If during the 60 days the member regains Medicaid eligibility their benefit eligibility will be retroactive to the date they lost Medicaid eligibility. If they do not regain Medicaid eligibility after 60 days they will be involuntarily disenrolled from the FIDE-SNP program.

Participating providers should not request payment for any services during this deeming period. If the member is reinstated back into full FIDE-SNP status Horizon will reprocess claims for any services provided during this deeming period.

14.3 Benefits

Horizon NJ TotalCare (HMO D-SNP) members receive all benefits provided under original Medicare including:

- Medicare Part A: Hospital Services
- Medicare Part B: Outpatient and Physician Services

In addition, members will receive Medicare Part D prescription drug coverage and all benefits provided under NJ FamilyCare (including dental benefits) as well as these enhanced benefits:

- \$0 for all prescription drugs on formulary
- Medicaid Wrap Drug Coverage – select prescriptions and over-the-counter (OTC) drugs at zero cost when a provider writes a prescription (see Medicaid Wrap Drug Coverage List)
- An EXTRA Benefits card with quarterly preloaded funds that can be used as a credit card to:
 - Purchase health-related items and over-the-counter medications and, if they qualify,
 - Special Supplemental Benefits for the Chronically Ill (SSBCI), which allows members to use the card to purchase healthy food/groceries and pay their utility bills (gas, water or electric) and,
 - Additional funds can be loaded if members complete certain screenings and tests
- Fitness and exercise programs
- Telemedicine
- A 24/ Nurse Line
- Routine podiatry (8 visits per year)
- Worldwide coverage for emergency/urgent care
- \$0 home delivery of up to 14 days of ready-to-eat meals following a qualifying inpatient stay (two episodes per year)

14.4 Care Management/Model of Care Information

14.4.1 Goals of FIDE-SNP Care Management

The goal of Horizon NJ TotalCare (HMO D-SNP) Care Management is to:

- Improve members' health outcomes
- Efficiently coordinate the care members receive
- Keep members in the community
- Improve members' experience with care
- Improve quality
- Reduce unnecessary costs

Dual-eligible beneficiaries may be more likely to require multiple large-dollar health care services when their care is not managed efficiently. Some activities that may contribute to increased costs include:

- Frequent emergency room visits
- Readmissions to the hospital
- Stays in a long-term care facility
- Nonadherence to prescribed medications
- Multiple comorbidities (including behavioral health)
- Lack of caregiver support

14.4.2 Model of Care

The Centers for Medicare and Medicaid Services (CMS) require that all FIDE-SNP plans have a Model of Care that contains the guiding principles and standards of care for Horizon's FIDE-SNP Program components.

The following components are covered under Horizon NJ TotalCare (HMO D-SNP) Model of Care (MOC):

- Care Management
- Finance
- Network
- Operations
- Pharmacy
- Quality

The MOC is comprised of clinical and non-clinical elements:

- Care Coordination
- Description of the FIDE-SNP Population
- FIDE-SNP Provider Network
- Quality Measurement & Performance Improvement

14.4.3 The Role of the PCP in the MOC

The PCP has an important role in assuring the effectiveness of the MOC. Some of the PCP's most important responsibilities are to:

- Receive calls from the member's Care Manager
- Review the completed Health Needs Survey
- Review and comment on the Plan of Care
- Serve as an important participant on the member's Interdisciplinary Care Team (ICT), comprised of internal and external attendees that impact the member's Plan of Care
- Attend and participate in weekly ICT Meetings
- Assure ongoing participation from members and providers, which is essential to the success of the MOC

Horizon NJ Total Care (HMO D-SNP) requests the PCP's ongoing participation to ensure that FIDE-SNP members have comprehensive access to services and meaningful coordination of care. The PCP is responsible for:

- Reviewing the proposed care plan mailed (or accessed via NaviNet) to them from Horizon NJ TotalCare (HMO D-SNP) for their member
- Providing any necessary additional information about the member's care to ensure the care plan is complete and accurate
- Updating each care plan as needed
- Discussing the care plan with the Horizon NJ TotalCare (HMO D-SNP) member for whom he or she provides care
- Communicating with the ICT as requested to ensure optimal coordination of care
- Encouraging member participation in care management

For assistance from the Horizon NJ TotalCare (HMO D-SNP) Care Management Department, please call **1-888-621-5894 (TTY 711)**, Monday through Friday between the hours of 8:30 a.m. and 5 p.m.

14.5 FIDE-SNP Provider Network Information

Horizon BCBSNJ has contracted with providers across New Jersey to create a new network to serve FIDE-SNP members. Horizon NJ TotalCare (HMO D-SNP) members will be able to access all participating providers in the FIDE-SNP network.

Members will be required to select a PCP. No referrals are required.

To get the most up-to-date information about Horizon NJ TotalCare (HMO D-SNP)'s network providers, go to horizonNJhealth.com/findadoctor, and on the Physicians tab, select Choose a Plan to Start. Under that tab, select Horizon NJ TotalCare (HMO D-SNP) to find a list of network providers.

For more information on the FIDE-SNP Provider Network, please call FIDE-SNP Provider Services at **1-855-955-5590**.

14.5.1 Network Participation and Medicare Participation

Horizon BCBSNJ's Credentialing Department reviews the CMS Opt Out List on a quarterly basis. Our Credentialing Committee reviews the files of those physicians or health care professionals who have opted out of (or have been excluded from) Medicare.

As stated in our Credentialing and Recredentialing Policy for *Participating Physicians and Health Care Professionals*, "Physicians and health care professionals who have opted out of Medicare may not participate in the Horizon Managed Care Network." Physicians or health care professionals who have opted out of (or have been excluded from) Medicare will be terminated from the Horizon Managed Care Network.

14.6 FIDE-SNP Remittance Advice Information

An example of the Horizon NJ TotalCare (HMO D-SNP) Remittance Advice is below. It shows the fields and explanations of benefits and payments that are specific to FIDE-SNP claims. Please remember that no copayments or deductibles may be billed or collected for any members of this plan.

Horizon NJ Total Care (HMO SNP)
PO Box 24081
Newark, NJ 07101-0406

Forwarding Service Requested

WHITE STOCK

TEST

For Questions, Call Provider Services at 1-855-955-5590

1 1-8570 CP 0-1870

Single Piece

1

Payee Provider ID: 00000000
Payment Date: 12/22/15
Check Number: 0000000000
Check Amount: 0.00
Reference Number: 0000000000000000
Prior Overpayment: 0.00
Overpayment Incurred this Period: 0.00
Recovered this Check: 0.00
Outstanding Overpayment: 0.00
Total Amount Charged: 0.00
Total Denied: 0.00
Total Allowed: 0.00
Non Paid Amount: 0.00
Prior Paid Amount: 0.00
Tax ID: 000000000

Subscriber Name: Patient and Service Information
Chain Number: Account Number: Provider Name:

Line Number	Date of Service From To	Proc-Rev Code	Unit	Charged Amount	Allowed Amount	COB Amount	Copay	Co-Ins	Deductible	PFL	Plan Payment	Remark Codes	LOB
001	10/25/16-10/26/16	00000	1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PFC	MC
001				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PFC	MC
Chain Total				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
				Interest Payment		0.00							
				Prior Payment		0.00							
				Total Paid to Payee		0.00							

Subscriber Name: Patient and Service Information
Chain Number: Account Number: Provider Name:

Line Number	Date of Service From To	Proc-Rev Code	Unit	Charged Amount	Allowed Amount	COB Amount	Copay	Co-Ins	Deductible	PFL	Plan Payment	Remark Codes	LOB
001	11/01/16-11/02/16	00000	1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		MC
001				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		MC
Chain Total				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
				Interest Payment		0.00							
				Prior Payment		0.00							
				Total Paid to Payee		0.00							

Statement Total:

Charged Amount	Allowed Amount	COB Amount	Co Pay	Co-Ins	Deductible	PFL	Interest Payment	Prior Payment	Plan Payment
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net General Claims Total									0.00
Less: Prior Payments									0.00
Total Paid to Payee									0.00

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Horizon NJ Total Care (HMO SNP)
PO Box 24081
Newark, NJ 07101-0406

WHITE STOCK

TEST

For Questions, Call Provider Services at 1-855-955-5590

Provider Remittance Advice

Please note:
* A special reminder: Horizon NJ TotalCare - HMO SNP members are not liable for Medicare Part A and B cost sharing, including deductibles, coinsurance and copayments.
Visit Navinet.com to check eligibility and status of claims, review payments, obtain benefit information, and more!

Payment Reduction and Recovery Summary
Adjustment Detail - Retractions could be applied to the net payment
*Type: M = Overpayments for which manual refund is requested but has not yet been applied taken;
A = Overpayments that can be auto-recovered on a check

Claim Number Ref Number	Patent Name	Patent Account Number	Revise Code	Date of Service	Original Amount Billed	Original Amount Paid	Original Balance	Previously Recovered	Recovered This Check	Current Balance	Original Check Date	Type
					0.00	0.00	0.00	0.00	0.00	0.00		M

LOB Key:
MC = Medicare
ME = Medicaid

Remark Explanation Codes:
D05
CDD
PDC

When a Medicare Advantage Health Plan denies a payment request from a nonparticipating provider, the provider has the right to request a reconsideration of the plan's denial of payment within sixty (60) calendar days from the notification date. A signed waiver of liability statement, which holds the provider harmless regardless of the outcome of the appeal, must be included with any request for reconsideration. This form can be found at horizonline.com/provider/forms-by-type/appeal-claims. Your written request should include a copy of the original claim, remittance notification (showing the denial and any clinical records and other documentation that supports the claim for reimbursement). Requests for reconsideration must be mailed to:
Horizon NJ TotalCare Appeals and Grievances
PO Box 24079
Newark, NJ 07101-0406

Health Care Fraud Notice
Health care fraud affects us all and causes an increase in health care costs. If you suspect any person or company of defrauding or attempting to defraud Horizon NJ TotalCare (HMO SNP), please call us. All calls are confidential and you may report your suspicions anonymously via our toll-free hotline at 1-800-424-2048 (TTY: TDD 711).

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14.7 Claims/Grievances/Appeals

For information about billing and filing claims, please consult Section 9 of this Manual. Below are some addresses that providers can use for correspondence regarding different aspects of Horizon NJ TotalCare (HMO D-SNP).

**Horizon NJ TotalCare (HMO D-SNP)
Appeals and Grievances
PO Box 24079
Newark, NJ 07101-0406**

**Horizon NJ TotalCare (HMO D-SNP)
Claims Processing Department
PO Box 24080
Newark, NJ 07101-0406**

**Horizon NJ TotalCare (HMO D-SNP)
Misc Member/ Provider Correspondence
PO Box 24081
Newark, NJ 07101-0406**

14.7.1 Grievance Resolution

Horizon NJ TotalCare (HMO D-SNP) has a system and procedure for the resolution of grievances by members and physicians. The grievance procedure is available to all members and physicians; timely resolution will be executed as soon as possible and will not exceed 48 hours from initiation of the grievance for urgent cases and 30 days for all other issues. For grievances related to Medicaid benefits, please refer to Section 10 of this manual. For Medicare benefit grievances, please see below:

When a member is dissatisfied with care or service received, a grievance can be initiated through any of the following means:

- Call a Horizon NJ Health representative at **1-855-355-5599** for MLTSS members. Non-MLTSS members can call **1-800-543-5656 (TTY 711)**.
- Send a written letter to:

Horizon NJ TotalCare (HMO D-SNP)
PO Box 24081
Newark, NJ 0710-0406

For provider grievances related to administrative issues, quality of care, actions, sanctions or terminations, refer to Section 12.29 and Section 12.30. Horizon NJ Health is required by the State contract to investigate all grievances and alleged incidents reported by or related to our members, which may include:

- A phone call to the health care practitioner or facility by Provider Contracting & Strategy to clarify the circumstances of the complaint
- A Request for medical records and/or written response from the health care practitioner or facility, which is due within 10 calendar days
- A site visit

Within the grievance process, a vital part of the resolution is the assistance of a health care practitioner or facility. Using the information from the member and provider, all grievances are thoroughly investigated. After all the information is gathered, a medical director will determine if there is a quality issue.

14.7.2 Utilization Management Member Appeals Process for FIDE-SNP

Horizon NJ TotalCare (HMO D-SNP) has appeals policies to receive and adjudicate utilization management appeals made by members or, with the member's documented consent, providers who are acting on behalf of members. This procedure ensures timely resolution, provides easy access and offers prompt, fair and full investigation of member appeals. The procedures are the same as those outlined in Section 10.2 with the following additions:

All written appeals must be submitted to:

Horizon NJ TotalCare (HMO D-SNP)
UM Appeals
PO Box 10196
Newark, NJ 07101

If the appeal is not resolved to the member's satisfaction, Horizon NJ TotalCare (HMO D-SNP) will provide a written explanation of how to proceed to the next steps. There are two processes, one Medicare-based and one Medicaid-based, that are available to members depending on the benefit/service that was denied. If an appeal is upheld, members will be notified of their right to proceed to subsequent levels of appeal for both Medicare and Medicaid.

Internal appeals which are upheld, partially or in whole, are automatically sent to the CMS Independent Review Entity (IRE) through MAXIMUS, Inc. for review and determination in compliance with the Medicare portion of the member's FIDE-SNP benefit. This review is binding if the determination is overturned by the IRE.

14.7.3 Horizon Medicare Advantage Member Appeals

Members have the right to appeal any decision regarding our reimbursement or our denial of coverage based on medical necessity. Appeals may be requested verbally or in writing.

Medical records and your professional opinion should be included to support the appeal. Based on the medical circumstances of the case, a Horizon BCBSNJ physician reviewer will determine if the request qualifies as an expedited appeal. However, the member, physician or other authorized representative acting on behalf of the member may request an expedited appeal based on the medical circumstances of the case. If coverage of services is denied, you must inform your Medicare Advantage patient of their appeal rights. Members will also receive a notice of denial from Horizon NJ TotalCare (HMO D-SNP). At each patient encounter with a Medicare Advantage enrollee, you must notify the enrollee of that, upon request, a detailed written notice from the Medicare Advantage organization regarding the enrollee's benefits levels will be communicated in writing as part of each coverage determination and/or appeal determination notification.

14.7.4 Medical Appeals for Medicare Services

Generally, we have 30 days to process an appeal pertaining to the denial of a requested service (pre-service appeal for service), and 60 days to process an appeal pertaining to post-service denial of claim payment (appeal for payment).

Expedited appeals are processed within 72 hours. To file an expedited appeal, the member may call Member Services at **1-800-365-2223**. Appeals for payment may not utilize the expedited process.

Pre- and Post-Service medical appeals may be faxed to **1-609-583-3028** or mailed to:

**Horizon NJ TotalCare (HMO D-SNP)
Utilization Management Member Appeals
PO Box 10196
Newark, NJ 07101**

A completed Appointment of Representative (AOR) form or other court-appointed document indicating the member's consent may be required for a physician to request post-service appeals on behalf of the member.

Integrated Appeals for Horizon NJ TotalCare (HMO D-SNP)

Because Horizon NJ TotalCare (HMO D-SNP) members have Medicare and receive assistance from Medicaid, appeals for these members may follow both processes concurrently. Standard appeals requests should be sent within 60 days of denial notice or from date of discharge from a facility. Standard determinations are rendered within 30 calendar days. Decisions on expedited reconsiderations are reached within 72 hours or sooner depending upon the medical exigencies.

14.7.5 Additional Appeal Rights for Medicaid Services

Members enrolled in the Horizon NJ TotalCare (HMO D-SNP) plan also have the right to file for a State Fair Hearing (Medicaid). State Fair Hearings (Medicaid) must be requested within 120 days of a Horizon BCBSNJ appeal determination letter about a Medicaid service. Members have the right to represent themselves at the State Fair Hearing (Medicaid) or to be represented by an attorney, family, friend or other spokesperson.

Requests for State Fair Hearings (Medicaid) must be made to:

**New Jersey Department of Human Services
Division of Medical Assistance and Health Services
Fair Hearing Services
PO Box 712
Trenton, NJ 08625-0712**

For continuation of benefits, the appeal request must be made on or before the final day of the previously approved authorization, or within 10 calendar days of the notification of adverse benefit determination, whichever is later.

Requests for continuation of benefits must be received within 10 days of the notice of action or before the end of the authorization in question whichever is later.

14.8 Quality Management and Performance Improvement

14.8.1 Quality Improvement Program

The Horizon NJ TotalCare (HMO D-SNP) Quality Improvement Program (QIP) is a coordinated and comprehensive program designed to oversee and evaluate execution of the Model of Care (MOC). The QIP assists the responsible business segments in reaching their applicable goals by collaborating to develop a process for continuous collection, analysis and evaluation of performance based on the MOC. Applicable business units will utilize their respective work plans to identify, monitor, assess and improve the quality and appropriateness of care and services provided to dual eligible members with special needs. QIP will oversee these work plans. The program's success is accomplished by setting standards and monitoring outcomes. The QIP program utilizes the program description, the MOC, the QIP work plan, the CMS Five-Star work plan, and the annual program evaluation in order to detect whether the overall MOC structure effectively meets the beneficiaries' unique health care needs.

14.8.2 Clinical Quality Program

Horizon NJ TotalCare (HMO D-SNP) has a Clinical Quality Program that assists providers in improving their Quality Performance through various clinical transformation initiatives. For more info, contact the Quality Management Department toll free at **1-844-754-2451 (TTY 711)**, Monday through Friday from 8 a.m. to 5 p.m.

14.8.3 Evaluating the Effectiveness of the Model of Care

Measures of Program Effectiveness may include:

- HEDIS/Star Rating
- Member Satisfaction / Health Outcomes Survey (HOS)
- Member Participation rate in Case Management
- Emergency Room Utilization rate
- Readmission rate
- Medication Adherence
- Provider Satisfaction
- Medical Cost Ratio / Medical Loss Ratio (MCR / MLR)
- Appeals & Grievances
- Complaints To Medicare (CTM)
- Medication Therapy Management

14.8.4 Model of Care (MOC) Measures

The Horizon NJ TotalCare (HMO D-SNP) Quality Improvement Program (QIP) will review all relevant quality performance measures when evaluating effectiveness. The metric goal for all measures 75th National Committee

for Quality Assurance (NCQA) percentile and the benchmark is 90th NCQA percentile. Sample measures and metrics:

- All Cause Readmission Rate
- Health Needs Survey within 90 days of enrollment and annually
- Medication Therapy Management (MTM) program
- Diabetes Treatment, A1c, LDL-C, Eye Exam, Nephropathy screening
- Care for Older Adults – Medication Review, Functional Status Assessment, and Pain Screening
- Consumer Assessment of Healthcare Providers and Systems Survey Results

14.8.5 Additional FIDE-SNP HEDIS and STARS Measures

The business segments analyze additional metrics to assist in reaching goals. The HEDIS (Healthcare Effectiveness Data and Information Set) measures identified help assess the population and possible barriers to care. These are assessed and reassessed annually using the 50th to 75th national percentile ratings depending on the plan's performance history with that metric.

Measure

- Adults' Access to Preventive/Ambulatory Health Services
- Follow-Up After Hospitalization for Mental Illness
- Medication Reconciliation Post-Discharge
- Care of Older Adults:
 - Pain Assessment
 - Functional Assessment
 - Medication Review (or Comprehensive Medication Review)

Appendix A. Clinical Practice Guidelines

Disease	Guidelines
Asthma	National Heart, Lung and Blood Institute's (NHLBI) 2020 Focused Updates to the Asthma Management Guidelines (2020)
ADHD	American Academy of Pediatrics, Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
Cardiac Care	2017 ACC/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America
Cholesterol Management	2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statins Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk
Cognitive Impairment	American Academy of Neurology Guideline Summary for Clinicians DETECTION, DIAGNOSIS AND MANAGEMENT OF DEMENTIA
	Practice Parameter update: Evaluation and Management of Driving Risk in Dementia
Congestive Heart Failure	2013 ACCF/AHA Guideline for the Management of Heart Failure A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines
	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America
Chronic Kidney Disease	KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification
COPD	Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2021
Depression	American Psychiatric Association (APA) Psychiatric Evaluation of Adults (June 2006)
Diabetes	American Diabetes Association Standards of Care Guidelines
HIV/AIDS	Department of Health and Human Services Centers for Disease Control and Prevention
Hypertension	The seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
	Hypertension 2017 Clinical Practice Guidelines
	2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)
Lead Case Management	CDC Clinical Lead Poisoning Program
	NJ Department of Health Childhood Lead
Management of Controlled Substance Medication for Chronic Non-Cancer and Cancer Pain	CDC Opioid Prescribing Guideline
	VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain

Disease	Guidelines
Obesity	American Academy of Pediatrics Assessment of Child and Adolescent Overweight and Obesity
	NIH Managing Overweight and Obesity in Adults Systemic Evidence Review From the Obesity Expert Panel, 2013
	Agency for Healthcare Research and Quality: Obesity
Perinatal Care	State of NJ Department of Health Maternal and Child Health
Preventive Care	American Cancer Society: Breast Cancer Prevention and Early Detection
	American Cancer Society: Cervical Cancer
	American Cancer Society: Colorectal Cancer Prevention and Early Detection
	American Cancer Society: Prostate Cancer
	American Cancer Society: Skin Cancer Prevention and Early Detection
	CDC Guidelines: Pneumococcal
	CDC Guidelines: Influenza
	CDC Guidelines: Childhood Vaccinations
	Adult Preventive Health (Ages 18-65)
	Pediatric Preventive Health Guidelines
Prevention and Treatment of Osteoporosis in Patients aged 50 or older	National Osteoporosis Foundation Bone Source
Sickle Cell Disease	National Heart, Lung and Blood Institute's (NHLBI) Evidenced-based Management of Sickle Cell Disease 2014
Smoking Cessation	Treating Tobacco Use and Dependence from the U.S. Department of Health and Human Services, June 2008 and United States Preventive Services Task Force
	CDC tools from Former Smokers Healthcare Providers: Tools and Resources

Appendix B. Glossary of Terms

1.0 Provider

Term	Definition
Affiliate	means any entity, as previously identified or as identified in the future by HMO as an affiliate, which owns or is owned by HMO, directly or indirectly, and any entity, as previously identified or as identified in the future by HMO as an affiliate, which is under common ownership, directly or indirectly, with HMO.
Capitation	means the prospective payment for primary care services (as defined herein) made at a predetermined, monthly rate reflecting the number of persons in a primary care provider (PCP)'s panel (as defined herein).
Claim	means a request for payment of charges for services rendered or supplied, provided by a provider to a member.
Clean claim	means a claim that has no defect or impropriety, including any lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment being made on the claim. A "clean claim" is a claim, or part of a claim, which can be paid exactly as submitted without the need for further documentation or explanation.
CMS	means the Centers for Medicare & Medicaid Services of the United States government.
Coinsurance	means a percent of the payment (as defined herein) that a member is responsible to pay for covered services.
Consultation (dental)	means, in the case of dentistry, a referral to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or when needed to medically necessary services provided by that specialty provider.
Contested claim	means a claim, or part of a claim, that has not been adjudicated because it has a material defect or impropriety. A "contested claim" is a claim, or part of a claim, which cannot be paid because further documentation or explanation is necessary before the claim can be considered a clean claim.
Copayment	means a specified dollar amount that a member is responsible to pay for covered services.
Covered service	means those medically necessary health care services, as set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which members are entitled under the New Jersey Medicaid program unless expressly provided in the Medicaid/NJ FamilyCare contract or set forth in the Provider Manual.
Declined claim	means a claim that is not covered because the member is not a covered member, the member has not used a Horizon NJ Health network provider, the particular service is not a covered service under the member's contract or requested information or documentation has not been submitted in a timely manner.
Dental records	means the complete, comprehensive records of dental services, to include chief complaint, treatment needed and treatment planned to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on site of enrollees participating dentist and in the records of a facility for enrollees in a facility.
Digital ID Card	is an electronic ID card available through the Horizon NJ Health app . Digital ID cards include the same detail and information that would be included on a traditional physical Horizon NJ Health ID card.
Emergency services	shall mean health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorder, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or party. With respect

Term	Definition
	to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.
Health benefit plan	means the contract describing the benefits partially or wholly insured, underwritten by the State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services and administered by Horizon NJ Health of which you have received or will receive written notice that this agreement applies.
Medical emergency	means health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorder, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.
Member	means an enrolled participant in the HMO relating to the managed Medicaid and NJ FamilyCare programs.
Network hospital	means a hospital that has a contractual arrangement with Horizon NJ Health to provide covered services for certain inpatient and outpatient hospital services.
Panel	means the group of members who have notified Horizon NJ Health that they have selected you to be their PCP or who may be assigned to you.
Participating Physician	means a physician who has a contractual arrangement with HMO relating to the managed Medicaid and NJ FamilyCare programs.
Participating Provider	means a participating physician, network hospital or other health care professional or entity who has a contractual arrangement with HMO relating to the managed Medicaid and NJ FamilyCare programs.
Payment	means the amount payable to you for covered services, which shall be either of the following types: (i) provider's billed charges or Horizon NJ Health's applicable fee, whichever is less; or (ii) capitation. You acknowledge that the type of payment generally and the type of payment for any particular covered service is determined by Horizon NJ Health and is subject to revision from time to time.
Primary Care Provider	means any duly licensed medical doctor (MD) or doctor of osteopathy (DO) who has entered into a physician agreement with the HMO relating to the managed Medicaid and NJ FamilyCare programs, and who is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnoses and treatment of illness or injury, coordination of overall medical care, record maintenance, initiation of referrals to specialty providers and for maintaining continuity of patient care.
Primary Care Dentist	means a dentist who assumes responsibility for the primary and continuing dental care of the member.
Primary care services	means the following medically necessary basic health care services: <ul style="list-style-type: none"> • All primary ambulatory care visits and routine office procedures; periodic physical examinations; • Appropriate referrals to specialty physicians and other health care providers, who have an agreement with HMO relating to the managed Medicaid and NJ FamilyCare programs to provide services to members. In the case of a medical emergency, no prior authorization or approval is required for referral to a non-affiliated provider. Horizon NJ Health shall

Term	Definition
	periodically supply to the physician a list of primary care and specialty physicians affiliated with the managed Medicaid and NJ FamilyCare programs; <ul style="list-style-type: none"> • Provision or arrangement for primary care services 24 hours a day, seven days per week; • Obtain lab specimens for lab studies, including pap smears and phlebotomy services; and • Supervise, coordinate and manage the member's care.
Specialty physician	means a duly licensed medical doctor (MD) or doctor of osteopathy (DO), other than a PCP, who has entered into a physician agreement with the HMO relating to the managed Medicaid and NJ FamilyCare programs, and who is responsible for providing health care services that are ordered and approved by the PCP or Horizon NJ Health.
Specialty physician Services	means those medically necessary covered services provided by participating physicians, which are not primary care services.
You, provider, provider/subcontractor	means the physician bound by this agreement.

2.0 Ancillary

Term	Definition
Capitation	shall mean the method of payment for covered services that are set forth in Section 2 (B) of this agreement (“Capitated Health Care Services”), paid to provider at a predetermined monthly rate, as set forth in Appendix A, which is attached hereto and made a part hereof for those members who have selected or been assigned to provider. Capitation shall be the method of payment only for those providers who directly and actually provide health care.
Covered services	shall mean those medical and hospital services set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which Medicaid recipients/ NJ FamilyCare beneficiaries are entitled under the New Jersey Medical Assistance Program unless expressly provided in the Medicaid/NJ FamilyCare contract or set forth in Appendix A and shall include capitated health care Services and non-capitated health care services.
Fee-for-service Payment	shall mean the fee-for-service payments set forth in Appendix B for covered services that are ancillary services as set forth in Appendix A.
Medical facility(ies)	means the health care facilities where a provider provides or arranges covered services for members.
Medically necessary	means services or supplies received by a member whose HMO, through Horizon NJ Health, determines to be: (1) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice within the community; (3) not primarily for the convenience of the member, his/her physician, hospital or other health care provider; and (4) the most appropriate supply or level of service that can be safely provided to the member in the least costly setting, or as otherwise provided in the Medicaid/NJ FamilyCare contract.
PCP	means a physician who has entered into a primary care provider agreement with HMO.
Utilization management/quality	means the programs established by Horizon NJ Health to monitor and enhance the quality of health care services provided to members and those methodologies used to

Term	Definition
improvement (UM/QI) protocols	improve the effective, efficient use of the health care delivery system and covered services including, but not limited to, pre-review, concurrent review and retrospective review as well as discharge planning, as applicable, consistent with the Medicaid/NJ FamilyCare contract.

3.0 Hospital

Term	Definition
Covered services	shall mean those medically necessary medical and hospital services and supplies as set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which Medicaid recipients are entitled under the New Jersey Medical Assistance Program, unless expressly provided in the Medicaid/NJ FamilyCare contract.
Department	shall mean the Department of Human Services of the State of New Jersey.
DOH	shall mean the Department of Health of the State of New Jersey.
DOBI	shall mean the Department of Banking and Insurance of the State of New Jersey.
Emergency services	shall mean health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorder, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or party. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.
Fee-for-service Payment	shall mean the provider's billed charge or the fee-for-service rates set forth in Appendix B, which may be amended by HMO from time to time, whichever is less.
Hospital, provider, provider/ subcontractor	shall mean the contracting health care facility.
Hospital services	shall mean those services set forth in Appendix A.
Member	means an enrolled participant in the HMO relating to the Medicaid/NJ FamilyCare contract.
Participating Provider	means a physician, network hospital or other health care professional or entity who has a contractual arrangement with HMO relating to the managed Medicaid and NJ FamilyCare programs to provide covered services.
Utilization management/quality improvement (UM/QI) protocols	means the programs established by Horizon NJ Health to monitor and enhance the quality of health care services provided to members and those methodologies used to improve the effective, efficient use of the health care delivery system and covered services including, but not limited to: pre-review, concurrent review and retrospective review, as well as discharge planning, as applicable, consistent with the Medicaid/NJ FamilyCare contract.

Appendix C. Contract Compliance

The State of New Jersey requires that any provider/ subcontractor who agrees to serve Medicaid/NJ FamilyCare members comply with all the following provisions. Any changes made to the required verbatim language by the State of New Jersey shall be deemed to be incorporated herein by reference without amendment, and provider/subcontractor shall remain apprised of, and comply with, any such changes.

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

1.0 Subjection of Provider Contract/Subcontract

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2022, dependent upon available appropriation. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2022. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.
2. The Any Willing Plan status also expires June 30, 2022.
3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.
4. Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:
 - a. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;
 - b. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.
5. Nursing Facility Quality Incentive Payment Program (NF QIPP) replaces Any Willing Qualified Provider (AWQP): MLTSS.

The AWQP initiative quality measures were utilized to provide rate enhancements and the program was replaced by the Nursing Facility Quality Incentive Payment Program (NF QIPP).

The NF QIPP leverages quality outcome performance rate add-ons to state set Medicaid NF rate payments and is dependent on budget appropriations. The NF QIPP focuses on long-stay Medicaid residents, includes SCNFs, and excludes low volume Medicaid facilities with low Medicaid member census.

The NF QIPP currently uses six quality measures that includes five Minimum Data Set (MDS) measures that are collected by CMS under its Medicare Nursing Home Compare program and one resident and family satisfaction survey measure collected by NJ. The CoreQ Long Stay Satisfaction Survey is the tool utilized to determine a resident and family overall satisfaction score. These five core MDS measures are a part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes collected by CMS. DHS utilizes four standard quarters that are both finalized (no further revisions by CMS) and publicly available.

2.0 Compliance with Federal and State Laws and Regulations

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.
2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.
3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

3.0 Approval of Provider Contracts/Subcontracts and Amendments

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

4.0 Effective Date

This provider contract/subcontract shall become effective only when the Contractor's agreement with the State takes effect.

5.0 Non-Renewal/Termination of Provider/Subcontract

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor's network. If the termination was "for cause," as related to fraud, waste, and abuse, the Contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

6.0 Enrollee-Provider Communications

1. The Contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/ subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's

patient. Providers/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:
 - a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or
 - b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontract or to otherwise require the Contractor to reimburse providers/subcontractors for benefits not covered.

7.0 Restriction on Termination of Provider Contract/Subcontract by Contractor

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of the Contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.
2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

8.0 Termination of Provider Contract/Subcontract by State

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;
2. Takes any action that threatens the fiscal integrity of the Medicaid program;
3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;
6. Materially breaches the provider contract/subcontract; or
7. Violates state or federal law, including laws involving fraud, waste, and abuse.

9.0 Non-Discrimination

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.
2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are “qualified individuals with a disability” covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A “qualified individual with a disability” as defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to Horizon a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.
4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment,

sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.
6. Grievances. The provider/subcontractor agrees to forward to Horizon copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

10.0 Obligation to Provide Services After the Period of the Contractor's Insolvency and to Hold Enrollees and Former Enrollees Harmless

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.
2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.
3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.
4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.
5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.
6. The provider/subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

11.0 Inspection

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and

audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;
2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;
3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and
4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b)(1).

12.0 Record Maintenance

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

12.1 Record Retention and Provider/Subcontractor Documentation Requirements

Provider/Subcontractor Documentation Requirements - The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8. The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A. 30:4D-12(e) and N.J.A.C. 10:49-5.5(a)(13)(i) through (iv) may apply to these documentation requirements.

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10(a) and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Contractor, the Provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

Compliance with Specific Requirements - Providers/subcontractors must comply with the following requirements:

1. Medical supplies and DME:

- a. Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:
 - i. The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;
 - ii. A detailed description of the specific supplies and/or equipment prescribed;
 1. For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;
 - iii. The length of time the medical equipment items or supplies are required;
 - iv. A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and
 - v. The prescriber's printed name, address and signature.
2. Orders for laboratory tests:
 - a. All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.
 - b. If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:
 - i. In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;
 - ii. A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or
 - iii. Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.
 - c. Standing orders shall be:
 - i. Patient specific, and not blanket requests from the physician or licensed practitioner;
 - ii. Medically necessary and related to the diagnosis of the recipient; and
 - iii. Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.
 - d. The laboratory must ensure that all orders described in (a) through (c) above contain the following information:
 - i. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;
 - ii. The patient's name or unique patient identifier;

- iii. The sex (if known) and date of birth of the patient;
 - iv. The specific test(s) to be performed;
 - v. The source of the specimen, when appropriate;
 - vi. The date and, if appropriate, time of specimen collection;
 - vii. For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;
 - viii. For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;
 - ix. Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.
- e. All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.
 - f. The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.
 - g. All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.
 - h. If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.
3. Services Provided by a Psychologist
- a. Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).
 - b. For the initial examination, the record shall include, as a minimum, the following:
 - i. Date(s) of service rendered;
 - ii. Signature of the psychologist;
 - iii. Chief complaint(s);
 - iv. Pertinent historical, social, emotional, and additional data;
 - v. Reports of evaluation procedures undertaken or ordered;
 - vi. Diagnosis; and
 - vii. The intended course of treatment and tentative prognosis.
 - c. For subsequent progress notes made for each Medicaid/ NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:
 - i. Date(s) and duration of service (for example, hour, half-hour);
 - ii. Signature of the psychologist;
 - iii. Name(s) of modality used, such as individual, group, or family therapy;
 - iv. Notations of progress, impediments, or treatment complications; and
 - v. Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.
 - vi. One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):
 - 1. Symptoms and complaints;

2. Affect;
 3. Behavior;
 4. Focus topics; and
 5. Significant incidents or historical events.
4. Mental Health Services Provided by an Independent Clinic
- a. An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:
 - i. Evaluates the beneficiary's mental condition;
 - ii. Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;
 - iii. Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment needs; and
 - iv. Is made part of the beneficiary's records.
 - v. The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.
 - b. A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:
 - i. A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.
 1. Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;
 - ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
 - iii. The type of personnel that will be furnishing the services; and
 - iv. A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.
 - c. The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.
 - i. This documentation, at a minimum, shall consist of:
 1. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;
 2. The date and time that services were rendered;
 3. The duration of services provided;
 4. The signature of the practitioner or provider who rendered the services;
 5. The setting in which services were rendered; and

6. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.
 - d. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.
 - e. The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.
 - f. Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.
 - i. The periodic review shall determine:
 1. The beneficiary's progress toward the treatment objectives;
 2. The appropriateness of the services being furnished; and
 3. The need for the beneficiary's continued participation in the program
 - ii. Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.
5. APN Services:
- a. The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.
 - b. Documentation of services performed by the APN shall include, as a minimum:
 - i. The date of service;
 - ii. The name of the beneficiary;
 - iii. The beneficiary's chief complaint(s), reason for visit;
 - iv. Review of systems;
 - v. Physical examination;
 - vi. Diagnosis;
 - vii. A plan of care, including diagnostic testing and treatment(s);
 - viii. The signature of the APN rendering the service; and
 - ix. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)
 - c. In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:
 - i. Chief complaint(s);
 - ii. A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;
 - iii. Pertinent medical history;
 - iv. Pertinent family and social history;
 - v. A complete physical examination;
 - vi. Diagnosis; and
 - vii. Plan of care, including diagnostic testing and treatment.
 - d. In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:
 - i. In an office or residential health care facility:
 1. The beneficiary's chief complaint(s), reason for visit;

2. Pertinent medical, family and social history obtained;
 3. Pertinent physical findings;
 4. All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and
 5. A diagnosis.
- ii. In a hospital or nursing facility setting:
 1. An update of symptoms;
 2. An update of physical symptoms;
 3. A resume of findings of procedures, if any done;
 4. Pertinent positive and negative findings of lab, X-ray or any other test;
 5. Additional planned studies, if any, and the reason for the studies; and
 6. Treatment changes, if any.
- e. To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:
 - i. Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;
 - ii. Performed a physical examination, as appropriate;
 - iii. Confirmed or revised the diagnosis; and
 - iv. Visited and examined the beneficiary on the days for which a claim for reimbursement is made.
 - f. The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.
 - g. For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:
 - i. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.
 - ii. A developmental and nutritional assessment.
 - iii. A complete, unclothed, physical examination to also include the following:
 1. Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and
 2. Vision, dental and hearing screening;
 - iv. The assessment and administration of immunizations appropriate for age and need;
 - v. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;
 - vi. Mandatory referral to a dentist for children age twelve months or older;
 - vii. The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines;
 - viii. Health education and anticipatory guidance; and
 - ix. An offer of social service assistance; and, if requested, referral to a county welfare agency.
 - h. The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:
 - i. The beneficiary's chief complaint(s), reason for visit;
 - ii. Pertinent medical, family and social history obtained;
 - iii. Pertinent physical findings;
 - iv. The procedures, if any performed, with results;
 - v. Lab, X-ray, ECG, etc., ordered with results; and

- vi. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.
6. Physician Services
- a. Physician Recordkeeping; general
 - i. All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.
 - ii. The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.
 - iii. The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.
 - iv. Records of Residential Health Care Facility patients shall be maintained in the physician's office.
 - v. The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.
 - b. Minimum documentation; initial visit; new patient
 - i. The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit--New patient:
 - 1. Chief complaint(s);
 - 2. Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;
 - 3. Pertinent past medical history;
 - 4. Pertinent family and social history;
 - 5. A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;
 - 6. Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;
 - 7. Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and
 - 8. The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).
 - c. Minimum documentation; established patient
 - i. The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:
 - 1. In an office or Residential Health Care Facility:
 - a. The purpose of the visit;
 - b. The pertinent physical, family and social history obtained;
 - c. A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;
 - d. Procedures performed, if any, with results;
 - e. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

- f. Prognosis and diagnosis.
- d. Minimum documentation; home visits and house calls
 - i. For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.
- e. Minimum documentation; hospital or nursing facility
 - i. In a hospital or nursing facility, documentation shall include:
 1. An update of symptoms;
 2. An update of physical findings;
 3. A resume of findings of procedures, if any are applicable;
 4. The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;
 5. Any additional planned studies, if any, including the reasons for any studies; and
 6. Treatment changes, if any.
- f. Minimum documentation; hospital discharge medical summary
 - i. When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.
 - ii. The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.
- g. Minimum documentation; mental health services
 - i. For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:
 1. The specific services rendered and modality used, for example, individual, group, and/or family therapy;
 2. The date and the time services were rendered;
 3. The duration of services provided, for example, one hour, or one- half hour;
 4. The signature of the physician who rendered the service;
 5. The setting in which services were rendered;
 6. A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;
 7. Notations of progress, impediments, treatment, or complications; and
 8. Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.
 - ii. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care.

Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

7. Pharmaceutical services

- a. Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.
- b. Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABP- VAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.
- c. Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.
- d. Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.
- e. Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non- legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address and registration number.

13.0 Data Reporting

The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

14.0 Disclosure

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.
3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

15.0 Limitations on Collection of Cost Sharing

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

16.0 Indemnification by Provider/Subcontractor

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.
2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.
3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.
4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.
5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

17.0 Confidentiality

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and

Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.
3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.
4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.
5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.
6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U.S.C. 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

18.0 Clinical Laboratory Improvement

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

19.0 Fraud, Waste and Abuse

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.
2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.
3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the

Contractor's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.
5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.
6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors that for purposes of audits of inpatient hospital admissions by DMAHS or MFD or its subcontractors, MCG criteria will be applied.

20.0 Third Party Liability

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.
2. Except as provided in subsection 3 below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the Contractor.
3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.
 - a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
 - b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
 - c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.
 - d. The claim is for a child who is in a DCP&P supported out of home placement.
 - e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.
4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.
5. Sharing of TPL Information by the Provider/Subcontractor.
 - a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.
 - b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of

enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

- c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.
- d. The provider/subcontractor agrees to cooperate with the Contractor's and the State's efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.

21.0 Enrollee protections against liability for payment

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family Member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:
 - a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and
 - b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and
 - c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and
 - d. The service is not a trauma service covered by the provisions of NJAC 11:24- 6.3(a)3.i; and
 - e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and
 - f. The provider has received no program payments from either DMAHS or the Contractor for the service; or
 - g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.
2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:
 - a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or
 - b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

22.0 Off-Shore

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

23.0 Further delegation of any delegated activity is not permissible

Appendix D - Dental Services and Benefits

A Dental Services

Horizon NJ Health offers comprehensive dental services to NJ FamilyCare A, B, C, D, and ABP members as well as MLTSS members and Horizon NJ TotalCare (HMO D-SNP) members. These groups have an identical dental benefit. These services include preventive, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgical, and adjunctive dental services. Some procedures require prior authorization. When necessary, orthodontic services are age-restricted (covered for members under 21 years of age or as allowed by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and only approved with adequate documentation of medical necessity. Referral to a dentist is mandatory when a member reaches 1 year of age and annually thereafter.

Dental services include an initial examination and any required dental services determined to be medically necessary. A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a Primary Care Dentist (PCD) requires a consultation for services by that provider. Any PCP or PCD may refer a member to a participating dental specialist. All dental specialists are required to have a current NJ specialty permit and to be either board eligible or board certified. All general dentists and dental specialists are listed in the Doctor & Hospital Finder at horizonNJhealth.com/findadoctor. NJ FamilyCare C and D members are responsible for a \$5 copayment for dental services with the exception of diagnostic and preventive dentistry services.

Additional diagnostic, preventive and periodontal services shall be available beyond the frequency limitations of every six months and be allowed four times a rolling year to enrollees with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service. As part of the State contract with Horizon NJ Health, members have the option to obtain a second opinion for diagnosis and treatment of dental conditions that are treated within a dental specialty. Providers may refer and members may go to any participating Horizon NJ Health dental specialist.

The Plan may arrange for the member to obtain a second opinion outside the network at no cost to the member when the plan's network of providers does not have a provider located in the member's geo-access area to provide the services the member needs. Every effort will be made to locate an in-network provider. Members who seek self-initiated care from a nonparticipating dentist or a non-covered service will be responsible for the cost of the care.

Horizon NJ Health publishes a searchable Provider Directory at horizonNJhealth.com. All dental providers including dental specialists are listed and the information is updated daily. Printed copies of the Provider Directory are available by calling Provider Services at **1-800-682-9091**.

Caries Risk Assessment is provided by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided on the same date of service as the oral evaluations (D0120, D0145, and D0150) at least once per year by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.

The state-approved Clinical Criteria Grid and Policy is available by visiting horizonNJhealth.com/DentalCCG. The NJ FamilyCare Dental Services Clinical Criteria Grid (CCG) includes all services included in the NJ FamilyCare dental benefit, their CDT codes, descriptors, age and frequency limits, prior authorization requirements and clinical criteria; the NJ FamilyCare Dental Services Clinical Criteria Policy supplies helpful information regarding the use of the CCG.

The American Dental Association (ADA) Caries Risk Assessment Tool Form (Age >6) for dentist, ADA Caries Risk Assessment Tool Form (Age 0-6) for dentist, American Academy of Pediatrics Oral Health Risk Assessment Tool for PCPs and the New Jersey Orthodontic Evaluation HLD (NJ-Mod2) Index Form are available at the end of this Appendix, at horizonNJhealth.com in the *For Providers* tab; select *Resources* and then *Forms*.

SKYGEN USA administers dental services for Horizon NJ Health members and coordinates all precertifications for the provision of inpatient dental care. The SKYGEN USA Provider Portal is at pwp.sciondental.com.

Email: providerportal@skygenusa.com

Providers who have registered for the portal can:

- Automate their office scheduling and billing
- Check patient eligibility and treatment history
- Download and print office documents
- Get paid electronically with Electronic Funds Transfer (EFT)
- Submit authorization requests
- Submit claims electronically
- View the status of claims and authorizations

Providers can also contact SKYGEN USA by telephone to obtain more information about covered benefits, claims, and authorizations.

SKYGEN USA: **1-855-878-5368**

[SKYGEN USA Provider Manual](#)

Paper dental claims can be mailed to:

**SKYGEN USA
PO Box 299
Milwaukee, WI 53201**

NJ FamilyCare C and D members are responsible for a \$5 copayment for dental services with the exception of diagnostic and preventive dentistry services.

B Dental Director

Horizon NJ Health shall retain on staff at all times a Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD). The Dental Director must have practiced in New Jersey and is responsible for:

- The development, implementation and interpretation of dental policies and procedures to guide and support the provision of dental care
- Oversight or shared oversight of dental provider recruitment activities
- Reviewing all dental provider applications and making recommendations to those with provider contracting authority regarding credentialing and recredentialing of all dental providers
- Surveillance of provider performance in their provision of dental care to members
- Administration of all Horizon NJ Health dental activities
- Continuous assessment and improvement of the quality of dental care provided to members
- Serving on the Quality Management Committee
- Oversight of dental providers' orientation, education and in-service training
- Ensuring that adequate staff and resources are available for the provision of dental care
- The review and approval of studies and responses to DMAHS concerning quality matters

- Representing Horizon NJ Health at meetings of the DMAHS Dental Advisory Council and at local dental societies and associations
- Monitoring performance of SKYGEN USA or that of any other dental contractor or vendor; providing direction to dental contractor or vendor; ensuring that any decisions are made in a timely and clinically important manner; addressing dental issues at the level of the contractor or vendor
- Verifying on a monthly basis that dental providers and subcontractors have not been suspended, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs
- Coordinating and conducting public appearances on Horizon NJ Health's Care-A-Vans, the mobile health units that travel throughout New Jersey to provide on-site dental screenings to NJ FamilyCare members and community members at select events

Any dentist with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission of, valid DEA and CDS certificates.

Mobile Dental Practice and Mobile Dental Van Definitions:

Mobile Dental Practice (utilizing portable equipment) is a provider traveling to various locations and utilizing portable dental equipment to provide dental services outside of a dental office/clinic in settings to include but not limited to facilities, schools and residences.

- **Facilities:** These providers are expected to provide on-site comprehensive dental care (to include intra-oral radiographs), necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care.
- **Schools:** These locations are not considered a dental home and are limited to providing the following services: oral assessment/screening, prophylaxis, fluoride treatment, emergency care and referral to the member's dental home when known or their MCO for assistance in locating a dentist.
- **Private Residences and other residential settings:** These providers are expected to provide on-site dental care for the homebound based on patient safety and ability to tolerate procedures outside of a clinical setting.
- The MCO is responsible for assisting the member, family, facility or school in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long term care facility, skilled nursing facility or school and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The provider must submit documentation to the MCO of all locations they visit and serve and include the days and times for each location, except when a visit is to a residence.

Mobile Dental Practice (utilizing van) is a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van.

- Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). They must demonstrate their ability to render dental treatment services and assist with dental referrals as needed.
- An exception to the brick and mortar requirements can be considered for providers using mobile dental vans that demonstrate they are only providing dental services to NJ FamilyCare enrollees residing in a long term care facility or that are in a private residence/group home and unable to travel.

- The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements.
- When a mobile dental van is used for school visits, health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish/topical fluoride treatment, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed and patient records are to be maintained in accordance with State Board of Dentistry regulations.
- Providers utilizing Mobile Dental Vans must submit to the MCO documentation of all locations they will visit including the days and times (except when visit is to homebound members).

Provisions will be granted for visits to a Member's place of residence, long term care facility, skilled nursing facility or medical day care facility when medically necessary and where available. The contractor must monitor on an annual basis the standard of dental care rendered and ensure that needed referrals for dental treatment that cannot be provided by a mobile dental practice occur.

Noncompliant members

Contact Member Services when a member does not abide by the member responsibilities, continues with disruptive behavior at the provider's practice or refuses to comply with the recommended treatment program. Member Services will contact the member to discuss his or her responsibilities as a Horizon NJ Health member and seek to find a resolution to the situation.

Member Services: **1-800-682-9090 (TTY 711)**, 24 hours, seven days a week

A healthy relationship between a provider and a member is important. If the provider believes that he or she cannot have a healthy relationship with a member, the provider may ask that the member receive treatment from another provider. Other circumstances in which a provider may request that a member be changed to another provider include:

- Inability to solve conflicts between the member and his or her dentist
- If a member fails to comply with oral health care instructions, where such non-compliance prevents the dentist from safely or ethically proceeding with the member's oral health care services
- If a member has taken legal action against the provider

C The NJFC Directory of Dentists Treating Children under the Age of 6

The NJFC Directory of Dentists Treating Children under the Age of 6 is a directory listing every pediatric and general dentist seeing children through 6 years of age who participates with Horizon NJ Health. The directory is available on horizonNJhealth.com/membersupport.

Dental services may not be limited to emergency services. Dental screening by the PCP in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection and include completion of the AAP caries risk assessment.

- a) A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory and at a minimum a dental visit twice a year with follow up during well child visits to ensure that all needed dental preventive and treatment services are provided thereafter through the age of 20.
- b) A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider.

NJ Smiles Program

The NJ Smiles Program is based on recommendations of the American Academy of Pediatrics Bright Futures guidelines. The preventive program allows non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of 5 years old.

Fluoride varnish may be applied by any trained medical staff. The physician must be trained and submit attestation that all staff providing this service have been trained and will be supervised.

Fluoride varnish application will be combined with anticipatory guidance, risk assessment and referral to a dentist that treats children under the age of six and will be linked to well child visits for children through the age of six.

1. These three services will be reimbursed as an all-inclusive service billed using CPT code 99188 and can be provided up to four times a year. This frequency does not affect the frequency of this service by the dentist. Training for Caries Risk Assessment, Fluoride Varnish & Counseling is available online by visiting smilesforlifeorallhealth.org, click *Online Courses* then select *Course Six: Caries Risk Assessment, Fluoride Varnish & Counseling*.
2. PCPs are required to refer members by 12 months of age to a dentist for a dental visit. Every quarter PCPs receive a list of members that have not had a dental appointment in the past 12 months. PCPs are required to assist the member with getting a dental appointment.
3. Bidirectional communication between PCPs and PCDs is required between these provider groups.
4. Prescribing fluoride supplements is based on access and use to fluoridated public water. PCPs and PCDs should be aware of the towns that fluoridate their water. According to the NJ Dental Association, the following locations have fluoridated water:
 - Atlantic County: Atlantic City, Egg Harbor City
 - Burlington County: McGuire Air force base, Willingboro, Mt. Laurel, Fort Dix and Aqua
 - Gloucester County: Washington
 - Hunterdon County: Flemington, Readington, Three Bridges, Whitehouse, Whitehouse Station
 - Mercer County: Ewing, Hamilton, Hightstown, Hopewell Township, Lawrence, Pennington, Princeton, West Windsor
 - Monmouth County: Allentown, Colts Neck, Freehold, NJ American Coastal North
 - Somerset County: NJ American
 - Sussex County: Newton
 - Union County: Rahway
5. PCDs and PCPs are responsible to counsel parents and guardians of young children on oral health, age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.
6. The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.

D Fluoride Varnish Provider Incentive Program

In an effort to help quell the alarming rate of early childhood caries for Horizon NJ Health members under the age of 6, Horizon NJ Health has developed a pediatric fluoride varnish program. This program encourages trained non-dental providers in pediatric practices to apply fluoride varnish to children's teeth, perform caries risk assessments and anticipatory guidance, and refer our young members to a dental home.

Horizon NJ Health is offering reimbursement to trained pediatrician offices when their pediatricians, nurse practitioners or physician assistants or other trained medical staff apply fluoride varnish to the teeth of Horizon NJ

Health members at well-child visits under the age of 6. Pediatricians will receive \$15 for each fluoride varnish application up to four times a rolling year. Pediatricians are also encouraged to discuss with patients the importance of nutrition and oral hygiene and provide anticipatory guidance.

Providers will receive compensation for members under the age of 6 who visit a dentist within 60 days of the application of fluoride varnish. Providers receive \$10 per child for dental visits within 30 days of their physician visit and \$5 for dental visits within 31 to 60 days.

In order to receive CME training credit (in some cases) and collect the reimbursement, practitioners must complete the following online training and assessment:

- Go to smilesforlifeoralhealth.org and click Course Six in the right column – *Caries Risk Assessment, Fluoride Varnish & Counseling*.
- One provider per facility may complete the curriculum and agree to train their colleagues.
- After completing the curriculum, that provider must sign the Fluoride Varnish Attestation Form attesting that they completed the training and agree to train the other providers in their office.

Once the training is complete, the PCP should fax the attestation to **1-609-583-3024**. All providers under the PCP's TIN should be listed on the attestation form. Please use CPT code 99188. A copy of the form is on the Horizon NJ Health website in the *For Providers* tab, select Resources and then *Forms*.

Note that providers who have not completed the training are not eligible for reimbursement.

[E Dental Prior Authorization Procedures for SHCN Members to Access Care in an OR/ASC](#)

For members with special health care needs, intellectual and developmental disabilities, and children under the age of 5 years old who require dental services to be provided in an operating room (OR) or ambulatory surgical center(ASC), all dental services requiring prior authorization should be submitted to:

**Horizon NJ Health
PO Box 362
Milwaukee, WI 53201**

When submitted prior-authorizations, remember to:

- Report CDT procedure code D9999 to request prior authorization on ADA 2012 Claim/prior-authorization form.
- Report the beneficiary's medical condition and related diagnosis codes on office letterhead.
- Report on office letterhead how the clinical presentation of the beneficiary prevents the beneficiary from receiving dental treatment in an office or clinic setting, including reason(s) why other levels of sedation are not an option.
- Report the planned or expected treatment (e.g., oral examination, cleaning, restorative dental treatment, extractions) to be provided during the hospital visit and a summary of the beneficiary's most recent dental history, including dental treatment provided in the last 12 calendar months.

To ensure services rendered in a hospital operating room or outpatient facility meet the criteria for medical necessity, submit an authorization for procedure code D9999 and include the required documentation supporting the treatment plan. Required documentation includes X-rays, letter of medical necessity, general anesthesia attestation form, treatment plan, diagnosis and facility ID.

A signed informed consent along with the dental diagnosis codes are also required.

Dental Diagnosis Codes:

520.0, 520.1, 520.2, 520.3, 520.4, 520.5, 520.8, 520.9, 521.00, 521.01, 521.02, 521.03, 521.04, 521.05, 521.06, 521.07, 521.08, 521.09, 521.10, 521.11, 521.12, 521.13, 521.14, 521.15, 521.20, 521.21, 521.22, 521.23, 521.24, 521.25, 521.30, 521.31, 521.32, 521.33, 521.34, 521.35, 521.40, 521.41, 521.42, 521.49, 521.5, 521.6, 521.7, 521.81, 521.89, 521.9, 522.0, 522.1, 522.2, 522.3, 522.4, 522.5, 522.6, 522.8, 522.9, 523.00, 522.01, 523.10, 522.11, 523.20, 523.21, 523.22, 523.23, 523.24, 523.25, 523.30, 523.31, 523.32, 523.33, 523.40, 523.41,

SHCN Clinical Criteria and Medical Exception ICD 10 Codes

The codes which relate to clinical criteria for medical exceptions/disabilities/special needs are listed below:

E75-E756, F03-F0391, F06-F068, F07-F079, F09, F48-F489, F53, F60-F609, F70, F71, F72, F73, F78, F79, F84-F849, F88, F89, F90-F909, F91-F919, G10, G25-G259, G31-G319, G40-G409, G71-G719, G72-G729, G73-G737, G80-G809, G93-G939, P04-P049, Q86, Q90-Q99, R56-R569, S06-S069X9, F819, I6783, P154, P158, P159

You may submit authorizations along with any required documentation directly to Horizon NJ Health through our Provider Web Portal: pwp.sciondental.com. In an emergency, fax the authorization request for D9999 (submitted on an ADA Dental Claim form), along with all required documentation to **1-866-899-6186**.

To ensure services rendered in a hospital operating room or outpatient facility meet the criteria for medical necessity, submit an authorization for procedure code D9999 and include the required documentation supporting the treatment plan. Required documentation includes X-rays, letter of medical necessity, general anesthesia attestation form, treatment plan, diagnosis and facility ID.

Providers shall be reimbursed for costs of pre-op and post-op costs related to Operating Room (OR) services. Prior authorization will not be required for restorative care. Informed consent will be obtained and OR procedures to be subject to post-payment review.

Providers may receive reimbursement for the cost of providing oral hygiene instructions to caregivers to maintain a patient's overall oral health between dental visits. In situations where the treating dentist recommends a non-standard, specialized toothbrush to improve a member's oral hygiene, Horizon NJ Health will include these devices as a benefit. Such provisions shall include designing and implementing a "dental management" plan, coordinated by the Horizon NJ Health Care Manager, for overseeing a patient's oral health. A Care Manager will be assigned to members requiring these additional services and reimbursed by report to the Horizon NJ Health Dental Director.

You may submit authorizations along with any required documentation directly to Horizon NJ Health through our Provider Web Portal: pwp.sciondental.com. In an emergency, fax the authorization request for D9999 (submitted on an ADA Dental Claim form), along with all required documentation to: **1-866-899-6186**.

Prorated Basis for Dental Services

Horizon NJ Health will pay on a prorated basis for dental services that have a dental lab component, including cast crowns, fixed and removable prosthetics, retainers, and habit appliances based on stage of completion, if an enrollee dies or does not return to complete these services within three months from the last office visit for that service. For cast restorative and fixed prosthodontics, the prorate shall be 10 percent of the total payment for preparation of tooth with or without temporary, 85 percent of the total payment for impression and 95 percent of the total payment for completed not inserted. For removable prosthodontics, the prorate shall be 10 percent of the total payment for impression, 55 percent of the total payment for bite registration, 75 percent of the total payment

for “try-in” stage and 85 percent of the total payment for completed not inserted. For appliances and retainers, the prorated shall be 10 percent of the total pay.

This information will be available in the Member Handbook and by visiting horizonNJhealth.com/for-providers.

Prior Authorizations

A list of dental services that require prior authorization can be obtained from SKYGEN USA at the above address or by calling **1-855-878-5368**. Consideration for prior authorization shall be based on medical necessity. Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome.

The dental treatment plan provided shall be in accordance with the ethical and professional standards of the dental profession and meet the same high standards of quality normally provided to the community at large.

In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment. Those services that require prior authorization are defined as “non-routine services.” Prior authorization requests cannot be transferred from one dentist to another. Horizon NJ Health will not impose an arbitrary number of attempted dental treatment visits by a Primary Care Dentist (PCD) as a condition prior to the PCD initiating any specialty referral requests. The referring dentist is not obligated to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. The dentist receiving the referral is not obligated to prepare and submit diagnostic materials in order to approve or reimburse for a referral.

All final decisions regarding denials of referrals, prior authorizations, treatment and treatment plans for non-emergency services shall be made by a licensed New Jersey dentist/dental specialist. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the member.

All dental services requiring prior authorization should be submitted to:

**Horizon NJ Health
PO Box 362
Milwaukee, WI 53201**

How to Submit Dental Claims Requiring Prior Authorization

Prior authorization request forms with applicable X-rays should be submitted to Horizon NJ Health. Do not staple X-rays to the forms. A copy of all dental prior authorization forms should be maintained by the dentist. Prior authorization request forms received by Horizon NJ Health will be reviewed by the dental consultant. Upon completion of the review, the dentist will be notified of a decision in writing.

All questions concerning prior authorizations may be directed to:

**Horizon NJ Health
PO Box 362
Milwaukee, WI 53201**

Or call: **1-855-878-5368**

Horizon NJ Health has policies and procedures for prior authorization and mechanisms to ensure consistent application of service criteria for authorization decisions. Prior authorization shall be conducted by a currently licensed NJ Dentist, who is appropriately trained in the principles, procedures and standards of utilization review.

Long Term Care Facilities

Members should receive oral evaluation and preventive services by a dentist twice a year. However, Horizon NJ Health recognizes that members in long term care (LTC) facilities may be on medications that cause an increase in oral health issues. LTC members have an additional benefit of four cleanings per year to maintain their oral health.

Please note, LTC facility staff must assist our members with locating an in-network dentist. Members or staff can locate an in-network dentist by:

- Visiting horizonNJhealth.com/findadoctor
- Calling Member Services

Medicaid/NJ FamilyCare: **1-800-682-9090**

MLTSS: **1-844-444-4410**

Horizon NJ TotalCare (HMO D-SNP): **1-800-543-5656**

Dentists will provide any necessary treatment the member needs and/or refer members to specialists (i.e. oral surgeons) as needed. Some services (i.e., dentures) require prior-authorization before members can receive treatment.

F Dental Treatment Plan

In accordance with good dental practice, a treatment plan shall be developed and described for each patient on the ADA 2012 Claim Form following a comprehensive examination. Any dental treatment plan, including those not requiring prior authorization, may be reviewed by Horizon NJ Health dental consultants. A further review by the Dental Director may be requested.

In any dental treatment plan, the dentist must discuss the proposed treatment plan and receive approval from the member and/or family member/guardian before submission for authorization, after authorization is received and prior to initiation of treatment. It is suggested that the dentist have the member sign the office records or a separate statement that the treatment plan meets with his/her approval, since no alteration of the treatment plan will be reimbursed based on the subsequent rejection of all or part of that treatment plan by the member or family member/guardian.

Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation. On the basis of post utilization review, any dental treatment plan, including those not requiring prior authorization, may be reviewed by Horizon NJ Health dental consultants to determine appropriateness of treatment. If the treatment is not appropriate, the payment shall be recovered.

Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

Authorization for a dental treatment plan does not guarantee eligibility for payment under Horizon NJ Health. It is recommended that, on the first visit of each month, eligibility should be checked by calling Provider Services at **1-855-878-5368** or through the Provider Portal at pwp.sciondental.com.

G Continuity of Care

If a member transfers from another plan to Horizon NJ Health with an approved authorization for services, providers are required to submit this approval to obtain authorization from Horizon NJ Health to enable accurate processing of the future claim.

- Submit the new prior authorization request before expiration of the prior plan approval, or if no expiration, no more than 180 calendar days from the date of the previous approval by the previous MCO.
- Submit the new prior authorization request through normal Horizon NJ Health authorization process including evidence of the prior approval, the requested CDT codes, and CDT code D2999.
- Code D2999 is for purposes of authorization only and will not be payable on a claim.
- Please note that this does not apply to or change the existing process for comprehensive orthodontic transfer of care.

H Orthodontic Services

In order to qualify for orthodontic services, medical necessity must be met by demonstrating one or more of the following pathologies:

- Severe functional difficulties;
- Developmental anomalies of facial bones and/or oral structures;
- Facial trauma resulting in severe functional difficulties and/or,
- Demonstration that long term psychological health requires orthodontic correction.

As of January 2022, the following policies apply to orthodontic services in the Medicaid/NJ FamilyCare program. The provider and Horizon NJ Health will work together to ensure the anticipated treatment completion date will occur prior to the loss of benefit eligibility due to age. The dental office must provide an “Informed Consent Form” which must be signed after the patient and parent or guardian are advised of the following:

- The age limit for orthodontic coverage;
- Expected length of treatment;
- Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner; and,
- Their responsibilities should coverage be lost.

Orthodontic Consultation (D9310) – must include a visual examination and may also include a completed HLD (NJ-Mod3) Assessment Tool by the attending provider or a provider in the same group. This consultation does not require prior authorization, can be provided once a year and will be linked to the provider and not to the patient (which allows for a second opinion with a different provider).

Pre-orthodontic Treatment Visit (D8660) – includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool.

The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ-Mod3) is completed by the dentist that will be rendering the orthodontic treatment.

The HLD (NJ-Mod3) Assessment Tool and instructions begin on Page 228.

If the HLD (NJ-Mod3) Assessment Tool has an “X” and correctly documented clinical criteria found in sections 1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool

requires documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor Treatment to Control Harmful Habits

Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity.

For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records.

Upon completion of the case pre-treatment and post treatment photographs must be submitted.

Orthodontic Treatment Services

Limited and comprehensive orthodontic **services must be prior authorized** and will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition for treatment of the permanent teeth.

Prior authorization determinations shall be made and notice sent to the provider within ten (10) days of receipt of necessary information sufficient for a dental consultant to make an informed decision.

In cases where prior authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) or denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six months of receiving the approval.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition. Any therapeutic modality (to include palatal expansion) with a limited objective or scale of treatment may be utilized. The objective may be limited by: not involving the entire dentition; not attempting to address the full scope of the existing or developing orthodontic problem; mitigating an aspect of a greater malocclusion or a decision to defer or forego comprehensive treatment. Additionally, this may also include treatment for localized tooth movement, for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary, transitional or adult dentition for children.

For prior authorization, the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films;

- Diagnostic study models or diagnostic digital study cast images; and,
- The referring primary care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy must be submitted with the orthodontic treatment request.

In the Medicaid Fee for Service program, the billing date for the service is the date of insertion of the appliance. When the Medicaid/NJ FamilyCare beneficiary is enrolled in a MCO, the provider shall consult the MCO in which the beneficiary is enrolled for additional information regarding billing procedures.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered with documentation of medical necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post treatment photographs must be submitted.

Comprehensive Orthodontic Treatment

For prior authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction and dental diagnosis;
- The comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring primary care dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models;
- Diagnostic photographs (which may suffice in place of models);
- Diagnostic x-rays, digital x-rays or cephalometric film with tracing (when applicable); and,
- When applicable:
 - Medical diagnosis and surgical treatment plan
 - Detailed documentation of extenuating circumstances
 - Detailed documentation from a mental health professional as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

Eligibility should be checked prior to each visit.

The Medicaid/NJ FamilyCare Fee-for-Service (FFS) program reimburses for periodic treatment visits (D8670) which are billed for the date of service. A maximum of 24 units of D8670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is requested using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) is billed separately on the date of service. Services reimbursed

through these codes will include all appliances, their insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the service; however replacement of retainers or removable appliances due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires prior authorization and can be considered with documentation of the incident and medical necessity.

Reimbursement for orthodontic services includes the placement **and removal** of all appliances and brackets; therefore should it become necessary to remove the bands following or due to loss of eligibility, noncompliance or elective discontinuation of treatment by the parent, guardian or patient the **appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service**. In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting Prior Authorization

Prior authorization for comprehensive orthodontic treatment will only be considered for the **late mixed and permanent dentitions**. Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning Treatment

- In addition to submission requirements already noted, the prior authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with a maximum number of units for treatment visits to be considered on any one prior authorization being 12;
- The case start date is considered to be the banding date which must occur within six months of approval;
- If the prior authorization expires before all approved units are used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.

Continuing treatment

- Prior authorization for the continuation of treatment visits for the continuation of the case shall be submitted after completing the first twelve (12) units of treatment visits or at the mid-point of treatment.
- The maximum number of additional treatment visits allowed to continue the case is twelve (12).
- If the prior authorization expires before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.
- The following shall be included with the prior authorization to continue treatment:
 - A copy of the treatment notes;
 - Documentation of any problems with compliance;
 - Attestation from the current primary care dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;

- Pre-treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
- A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the Medicaid/NJ FamilyCare Program

For continuation of care for transfer cases whether they were or were not started by another Medicaid/NJ FamilyCare provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval (if applicable);
- Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes from provider that started the case (if available);
- Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment images;
- The date when active treatment was started;
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed; and,
- If applicable a new treatment plan and documentation to support the treatment change if re-banding is planned.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the Medicaid/NJ FamilyCare program.

Conclusion of Active Treatment

- Attestation of case completion must be submitted to document that active treatment had a favorable outcome and that the case is ready for retention.
- Procedure code D8680, orthodontic retention, shall be submitted for prior authorization along with recent panorex and photographs when the active phase of orthodontic treatment is completed.
- Once approved, the bands can be removed and the case placed in retention.
- If denied, a detailed explanation including what is required to end active treatment must be included with the name of the reviewing consultant.

Documentation for Completion of Comprehensive Cases – Final Records

After the appliances have been removed, the following must be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph;

- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen; and,
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that treatment is not progressing because the patient is exhibiting non-compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered. A letter must be sent to the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the discontinuation of treatment with de-banding. A copy of this letter and the patient treatment records must be sent to The Bureau of Dental Services, PO Box 712, Trenton, NJ 08625.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. For members not enrolled in a NJ FamilyCare MCO, a copy of the signed form and the patient treatment records must be sent to the Bureau of Dental Services along with the request to remove the appliance for reasons other than case completion. For members enrolled in an MCO, a copy of the signed form and the patient treatment records must be sent to the NJ FamilyCare MCO of enrollment. **The reimbursement for appliance placement includes their removal,** however, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

For questions regarding patients not enrolled in a NJ FamilyCare MCO, please contact the Bureau of Dental Services at **1-609-588-7136**. If the patient is enrolled in a NJ FamilyCare MCO, please refer to the MCO's Provider Manual for guidance, or contact the MCO's Provider Service Unit for assistance.

I Medical Versus Dental Services

Horizon NJ Health recognizes that medical conditions may exist that can exhibit one or more dental components. These dental components/conditions may be 1) causative to the medical situation of the patient, 2) completely unrelated, or 3) the sequelae of the medical condition or its treatment.

A physician or oral surgeon may perform procedures that may be considered medical or dental (e.g., surgical procedures for fractured jaw, removal of cyst, or provision of maxillofacial prosthetics). Please see Section 8.2 Precertification Process to obtain the authorization process or you may call the Horizon NJ Health Utilization Management Department at **1-800-682-9094**.

A broad definition of dental services would be those procedures used to treat the dental structures, including primary and permanent dentition and supporting structures including the periodontium and alveolar bone.

Specific procedures that would fall under the category of dental treatment are:

- Restoration of tooth structure lost by decay, fracture, attrition or erosion using synthetic materials. This can include intra-coronal restorations, such as amalgam, gold or composite, full or partial coverage crowns and tooth strengthening and retention enhancement for endodontically treated teeth.
- Endodontic treatment of teeth, including re-treatment, if necessary, and any necessary periapical or sectioning surgical intervention
- Surgical services and post-op treatment performed on the dental supporting structures that include treatment of periodontal disease, osseous surgery and any other surgery to the periodontium
- Replacement of missing teeth using full dentures, removable partial dentures or fixed prostheses and related services
- Removal of teeth and re-implantation of teeth and associated services
- Orthodontic treatment, even if a component of an eligible medical condition or treatment

Obtain authorization by calling Horizon NJ Health’s Utilization Management Department at least five business days prior to the inpatient or outpatient procedure if the procedure requires anesthesia or is performed in an inpatient setting or non-participating ambulatory surgical center. Utilization Management Department: **1-800-682-9094**.

J Member Appeals Process

Horizon NJ Health has developed and implemented appeal policies to receive and adjudicate utilization management appeals made by members or health care professionals acting on behalf of members with the member’s documented consent. This procedure will ensure timely resolution, be easily accessible and provide prompt, fair and full investigation of member appeals.

The procedure to process an appeal is as follows:

1. A member or health care professional acting on behalf of a member with the member’s documented consent may submit an appeal within 60 days of receiving a denial letter for a dental or orthodontic procedure or out-of-network provider. Hospitals may obtain consent from the covered person prior to receiving hospital services. The consent is valid for all stages of internal and external appeals. Patients may revoke consent at any time. Members can verbally appeal adverse utilization management determinations. All appeals from a physician must be submitted with a written signed consent from the member except when the request is for an expedited resolution.

PCDs and/or all other health care professionals must provide the covered person notice of an appeal whenever an appeal is initiated and again each time the appeal is continued to the next stage, including any appeal to an IURO. All written appeals must be submitted to the following address:

**Horizon NJ Health
Appeals Unit
PO Box 295
Milwaukee, WI 53201**

2. A member may also make an appeal or grievance by contacting Member Services at **1-800-682-9090** for assistance with writing the appeal.
3. All appeals (regardless of level or type) must include the following information:
 - Name, address and phone number (if applicable) of the member(s) and/or dentist(s)/physician(s) making the appeal
 - Member identification number
 - Date(s) of service

- Name(s) of dentist/physician, vendor or facility
- Specific details regarding the actions in question
- The nature and reasoning behind the appeal
- The desired outcome
- Supporting documentation, i.e., dental record
- Consent form

The procedure for handling non-Utilization Management (administrative) appeals for dental services is the same as that used for medical services. More information about the appeals process can be found in Section 10.0, Complaint and Appeals Process of this Manual.

FOR DENTIST		ADA American Dental Association® America's leading advocate for oral health		
Caries Risk Assessment Form (Age >6)				
Patient Name:				
Birth Date:			Date:	
Age:			Initials:	
		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes <input type="checkbox"/>		Frequent or prolonged between meal exposures/day <input type="checkbox"/>
III.	Caries Experience of Mother, Caregiver and/or other Siblings (for patients ages 6-14)	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>	Carious lesions in last 6 months <input type="checkbox"/>
IV.	Dental Home: established patient of record, receiving regular dental care in a dental office	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
General Health Conditions		Check or Circle the conditions that apply		
I.	Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	<input type="checkbox"/> No	Yes (over age 14) <input type="checkbox"/>	Yes (ages 6-14) <input type="checkbox"/>
II.	Chemo/Radiation Therapy	<input type="checkbox"/> No		<input type="checkbox"/> Yes
III.	Eating Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IV.	Medications that Reduce Salivary Flow	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Drug/Alcohol Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	Cavitated or Non-Cavitated (incipient) Carious Lesions or Restorations (visually or radiographically evident)	No new carious lesions or restorations in last 36 months <input type="checkbox"/>	1 or 2 new carious lesions or restorations in last 36 months <input type="checkbox"/>	3 or more carious lesions or restorations in last 36 months <input type="checkbox"/>
II.	Teeth Missing Due to Caries in past 36 months	<input type="checkbox"/> No		<input type="checkbox"/> Yes
III.	Visible Plaque	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IV.	Unusual Tooth Morphology that compromises oral hygiene	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Interproximal Restorations - 1 or more	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VI.	Exposed Root Surfaces Present	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VII.	Restorations with Overhangs and/or Open Margins; Open Contacts with Food Impaction	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VIII.	Dental/Orthodontic Appliances (fixed or removable)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IX.	Severe Dry Mouth (Xerostomia)	<input type="checkbox"/> No		<input type="checkbox"/> Yes
Overall assessment of dental caries risk:		<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High
Patient Instructions:				

Caries Risk Assessment Form (Age >6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Caries Risk Assessment Form (Age 0-6)

Patient Name:

Birth Date:

Date:

Age:

Initials:

		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes <input type="checkbox"/>	Frequent or prolonged between meal exposures/day <input type="checkbox"/>	Bottle or sippy cup with anything other than water at bed time <input type="checkbox"/>
III.	Eligible for Government Programs (WIC, Head Start, Medicaid or SCHIP)	<input type="checkbox"/> No		<input type="checkbox"/> Yes
IV.	Caries Experience of Mother, Caregiver and/or other Siblings	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>	Carious lesions in last 6 months <input type="checkbox"/>
V.	Dental Home established patient of record in a dental office	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
General Health Conditions		Check or Circle the conditions that apply		
I.	Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	<input type="checkbox"/> No		<input type="checkbox"/> Yes
Clinical Conditions		Check or Circle the conditions that apply		
I.	Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions	No new carious lesions or restorations in last 24 months <input type="checkbox"/>		Carious lesions or restorations in last 24 months <input type="checkbox"/>
II.	Non-cavitated (incipient) Carious Lesions	No new lesions in last 24 months <input type="checkbox"/>		New lesions in last 24 months <input type="checkbox"/>
III.	Teeth Missing Due to Caries	<input type="checkbox"/> No		<input type="checkbox"/> Yes
IV.	Visible Plaque	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Dental/Orthodontic Appliances Present (fixed or removable)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VI.	Salivary Flow	Visually adequate <input type="checkbox"/>		Visually inadequate <input type="checkbox"/>

Overall assessment of dental caries risk:

 Low Moderate High

Instructions for Caregiver:

FOR DENTIST

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a **▲** sign, are documented yes. In the absence of **▲** risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name: _____ Date of Birth: _____ Date: _____		
Visit: <input type="checkbox"/> 6 month <input type="checkbox"/> 9 month <input type="checkbox"/> 12 month <input type="checkbox"/> 15 month <input type="checkbox"/> 18 month <input type="checkbox"/> 24 month <input type="checkbox"/> 30 month <input type="checkbox"/> 3 year <input type="checkbox"/> 4 year <input type="checkbox"/> 5 year <input type="checkbox"/> 6 year <input type="checkbox"/> Other _____		
RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
<p>▲ Mother or primary caregiver had active decay in the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Mother or primary caregiver does not have a dentist <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Continual bottle/sippy cup use with fluid other than water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Frequent snacking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Special health care needs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Medicaid eligible <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>● Existing dental home <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Drinks fluoridated water or takes fluoride supplements <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Fluoride varnish in the last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Has teeth brushed twice daily <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>▲ White spots or visible decalcifications in the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>▲ Obvious decay <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>▲ Restorations (fillings) present <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Visible plaque accumulation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Gingivitis (swollen/bleeding gums) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Teeth present <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● Healthy teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
ASSESSMENT/PLAN		
<p>Caries Risk: <input type="checkbox"/> Low <input type="checkbox"/> High</p> <p>Completed: <input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Dental Referral</p>	<p>Self Management Goals: <input type="checkbox"/> Regular dental visits <input type="checkbox"/> Dental treatment for parents <input type="checkbox"/> Brush twice daily <input type="checkbox"/> Use fluoride toothpaste</p>	<p><input type="checkbox"/> Wean off bottle <input type="checkbox"/> Less/No juice <input type="checkbox"/> Only water in sippy cup <input type="checkbox"/> Drink tap water</p> <p><input type="checkbox"/> Healthy snacks <input type="checkbox"/> Less/No junk food or candy <input type="checkbox"/> No soda <input type="checkbox"/> Xylitol</p>

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MK, Orall JJ, Featherstone JD. Pediatric dental care, prevention and management protocols based on caries risk assessment. J Calif Dent Assoc. 2010;38(10):746-761. American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. Pediatrics. 2003; 122(5):1367-1394; and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. Pediatrics. 2003; 111(5):1113-1116.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2011 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.



Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment

The Bright Futures/AAP "Recommendations for Preventive Pediatric Health Care," (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

⚠ Maternal Oral Health

Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. **This child is high risk.**

Maternal Access to Dental Care

Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use

Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking

Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs

Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home

According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements

Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page <http://aap.org/oralhealth/PracticeTools.html>.

Fluoride Varnish in the Last 6 Months

Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening>. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, www.smilesforlifeforalhealth.org.

Tooth Brushing and Oral Hygiene

Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information <http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699>.



Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod3) Index Form

The intent of the HLD (NJ-Mod3) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose Malocclusion. Presence of any of the conditions sections 1 through 6A and 15, or a score total equal to or greater than 26 (when scored correctly) qualifies for medical necessity exception. Total scores less than 26 with extenuating circumstances must include appropriate documentation.

GENERAL INFORMATION:

- **Only cases with late mixed and permanent dentition will be considered (see Pre-orthodontic Treatment Visit (D8660) for exception).**
- A Boley Gauge or disposable ruler scaled in millimeters should be used;
- The patient's teeth are positioned in centric occlusion;
- All measurements are recorded and rounded off to the nearest millimeter (mm);
- For sections 1 to 6A and 15 an X is placed if the condition exists and **scoring is completed**, as needed;
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 score is entered;
- **Diagnostic models are required** with the submission of prior authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion; or,
- **Diagnostic Digital models may be submitted** to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views;
- **Diagnostic quality photographs** to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views). Photographs shall include views with a millimeter ruler in place to demonstrate measurement for the following condition(s) when present as found in sections 6A, 6B, 7, 8, 9 and 13.

INSTRUCTIONS FOR FORM COMPLETION:

1. **Cleft Palate Deformity** – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report by a qualified specialist or craniofacial panel. Score an X if present.
2. **Cranio-facial Anomaly** – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.
3. **Impacted Permanent Anterior Teeth** – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction. Score an X if present.
4. **Crossbite of Individual Anterior teeth** – Score an X if present. – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive wear, significant mobility or soft tissue damage. A narrative to include the class of mobility for the involved teeth and photographs of all areas with soft tissue damage. Score X as noted. **If these conditions do not exist, it is to be considered an ectopic eruption and scored in section 10.**
5. **Severe Traumatic Deviation** – damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.

6. **A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5** – Overjet is recorded with the patient’s teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.
- B. Overjet equal to or less than 9mm** – Overjet is recorded as in condition in section 6A. The measurement is rounded to the nearest millimeter and entered on the score form.
- Overbite** – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form.
7. **Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm** – Mandibular protrusion (reverse overjet) is recorded as a condition and rounded to the nearest millimeter. Enter the score on the form and multiply the measurement by five (5).
- Open Bite in millimeters** – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply the measurement by four (4). If measurement is not possible, measurement can usually be estimated.
8. **Ectopic Eruption** – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition 12) also exists in the same arch, score the condition that produces the most points. **DO NOT COUNT BOTH CONDITIONS.** The exception to this rule is: (a) posterior ectopic eruptions in the same arch (b) if ectopic eruption score is transferred due to anterior crossbite without trauma, excessive wear of mobility. In these two exceptions, count ectopic eruption PLUS the crowding.
9. **Deep Impinging Overbite** – This occurs when either destruction of soft tissue on palate, gingival recession and mobility and/or abrasion of teeth are present. Submit intraoral photographs of tissue damage/impingement. The presence of deep impinging overbite is indicated by a total score of three (3) on the score form.
10. **Anterior Crowding** – Arch length insufficiency must exceed 3.5 mm. Mild rotations are not to be scored as crowded. Score one (1) crowding per arch. Enter the total on score form and multiply the measurement by five (5). If ectopic eruption is scored in section 10 (not from crossbite in section 4) this crowding cannot be scored in addition. However if ectopic eruption is due to a transfer of score from section 4 to section 10, because crossbite did not result in damage, both ectopic and crowding can be counted.
11. **Labio-Lingual Spread** – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labio-lingual spread, but only the most severe individual measurement should be entered on the score form.
12. **Posterior Unilateral Crossbite** – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior

unilateral crossbite is indicated by a total score of four (4) on the score form. THERE IS NO ADDITIONAL SCORE FOR BI-LATERAL CROSSBITE.

13. **Psychological factors affecting child's development** – This condition requires detailed documentation by a **mental health provider** as described in the NJFC Medicaid managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE
NJ Orthodontic Assessment Tool for Comprehensive Treatment
HLD (NJ-Mod3)

****Attach attestation that all needed preventive and dental treatment was completed ****

Date _____

Name: _____ NJFC ID # _____

DOB: _____ Sex: M / F Class/Type of Case _____

Name of Orthodontist: _____

The instructions for completing this form begin on page 7. Sections 1-6A and 15 automatically qualify. Score with an X when these conditions are present. Sections 6B-14 scores must total 26 or more, or when less than 26 must include documentation of medically necessity.

	Condition	Score
1.	Cleft palate deformity (attach description from credentialed specialist)	
2.	Cranio-facial Anomaly (attach description from credentialed specialist)	
3.	Impacted permanent anteriors where extraction is not indicated Note the number of teeth _____	
4.	Crossbite of individual anterior teeth with trauma, mobility and/or soft tissue damage must be present and documented	
5.	Severe traumatic deviations	
6A.	Overjet greater than 9 mm with incompetent lips or reverse overjet greater than 3.5 mm	
6B.	Overjet (mm)	
7.	Overbite (mm)	
8.	Mandibular protrusion (mm) x 5	
9.	Open bite (mm) x 4	
10.	Ectopic eruption or crossbite of individual anterior teeth without damage (# of teeth x 3)	
11.	Deep impinging overbite (intra-oral photos showing palatal soft tissue impingement/destruction, gingival recession or attrition of teeth are required) Score 3 points if present	
12.	Anterior crowding MX _____ MD _____ Total _____ x 5 (score 1 per arch)	
13.	Labiolingual spread (mm)	
14.	Posterior unilateral crossbite (involving molar): Score 4 if present	
15.	Psychological factors affecting development ("X" requires detailed documentation by mental health provider as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

Documentation of extenuating circumstances attached for score total less than 26 (independent of conditions described in #s1-6A and 15).

Appendix E – MLTSS Services

A MLTSS Service Descriptions

These MLTSS service descriptions provide a comprehensive overview of the services available to Horizon NJ Health MLTSS members that are furnished by MLTSS non-medical ancillary providers. Benefits are established by the State of New Jersey and are subject to change.

Adult Family Care (AFC)

AFC enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. AFC providers may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision and medication administration.

Service Limitations:

Individuals that opt for AFC are not eligible for Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or the Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of AFC services. A person may not receive long-term nursing home care at the same time as AFC. The individual service recipient or authorized representative is responsible to pay the cost of room and board.

AFC members may attend Social Adult Day Care two days per week.

Provider Specifications:

- Licensed AFC Sponsor Agency (Agency)
- Licensed by Health Facilities Evaluation and Licensing (HFEL)

Assisted Living Services (ALS)

ALS are a coordinated array of supportive personal and health services and medication administration. These services are available 24 hours a day to residents who have been assessed to need these services – including persons who require a nursing home level of care. Assisted living services include personal care and medication oversight and administration throughout the day. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, onsite or offsite, to meet the individual needs of residents.

Assisted living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted living promotes a member's self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings.

An Assisted Living Residence (ALR) is a facility that is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the ALR offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit's kitchen 24 hours a day, seven days a week, and to facility food and beverages 24 hours a day, seven days a week.

A Comprehensive Personal Care Home (CPCH) is a facility that is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed to four or more adults unrelated to the proprietor. Residential units in CPCHs house no more than two residents and have a

lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24 hours a day, seven days a week and, if equipped, access to their own unit's food preparation area.

Service Limitations:

Individuals that opt for ALS in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), AFC, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care,

Home-Based Supportive Care, or Respite, as the above would duplicate services integral to and inherent in the provision of ALS. Individuals in an ALR/CPCH are responsible for paying their room and board costs.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process.

Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

Assisted Living Program (ALP)

ALP provides assisted living services to the tenants/ residents of certain publicly subsidized housing buildings. ALPs are available in some subsidized senior housing buildings. Each ALP provider shall be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

ALP includes personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an ALP is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident

meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP providers shall develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans.

ALP participants, not ALR or CPCH participants, may attend Social Adult Day Care two days a week; three days with prior authorization.

Service Limitations:

Individuals that opt for ALP do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of ALP services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

Traumatic Brain Injury (TBI) Behavioral Management (Group and Individual)

TBI Behavioral Management is a daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior, which is potentially destructive to self or others. The program, provided in the home or outside the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan; implementation of the plan; ongoing training and supervision of caregivers and behavioral aides; and periodic reassessment of the plan.

The goal of the program is to return the individual to the prior level of functioning, which is safe for him/her and others.

Service Limitations:

Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative TBI or be a former TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation from a board-certified and eligible psychiatrist, a licensed neuropsychologist or neuropsychiatrist with subsequent consultation by same on an as-needed basis.

Provider Specifications:

- Board-certified and board-eligible psychiatrist
- Clinical psychologist
- Mental health agency
- Rehabilitation hospital
- Community Residential Services (CRS) provider
- Post-acute non-residential rehabilitative services provider agency

TBI Community Residential Services (CRS)

A package of services provided to a participant living in the community, residence-owned, rented or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision and recreational activities. A CRS is a participant's home. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and Care Manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The Care Manager, in conjunction with CRS staff, evaluates participant, using the "Level of Care Guidelines for CRS" form as a guide.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI or be a former TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants' care. Only one level of service can be billed per 24-hour period (12 a.m. to 11:59 p.m.)

- The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
- The participant or responsible party must pay room and board costs
- The participant must agree to receive the therapy services of the CRS provider

Provider Specifications:

- Current license per N.J.A.C 10:44C to operate as a group home for individuals with a diagnosis of TBI

Community Transition Services

Those services provided to a participant to aid in transition from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy

- Necessary accessibility adaptations to promote safety and independence
- Activities to assess need, arrange for and procure needed resources

Service Limitations:

- Limit of up to \$5,000 Community Transition Services **do not include:**
- Residential or vehicle modifications
- Recreational items such as televisions, cable television access or video players
- Monthly rental or mortgage expenses; payment for security deposit is not considered rent
- Recurring expenses such as food and regular utility charges
- Payment for room and board
- Are one time per the life of the individual
- Are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources
- Service is based on identified need as indicated in the Plan of Care

Nursing Facility Services (Custodial)

A nursing facility (NF) is a facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3. NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Service Limitations:

The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee.

Provider Specifications:

- Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85

TBI Occupational Therapy (Group and Individual)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable. MLTSS will include rehabilitation therapies for an individual with a TBI diagnosis. CPT codes are to be used for these services.

Provider Specifications:

- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute, non-residential rehabilitative services provider agency

TBI Cognitive Therapy (Group and Individual)

Therapeutic interventions for maintenance and prevention of deterioration, which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs.

This service may be provided by professionals with the credentials, training, experience and supervision noted in Provider Specifications.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI or formerly a TBI waiver participant who transitions to MLTSS.

Provider Specifications:

- Minimum of a master's degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification
- Minimum of a bachelor's degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (e.g., special education)
- Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work and special education
- Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists
- Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met)

Supervision:

- This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below
- Supervision for providers who are not licensed or certified is based on the number of years of experience
- For staff with less than one year of experience: four hours of individual supervision per month
- For staff with one to five years of experience: two hours individual supervision per month
- For staff with more than five years of experience: one hour per month

All individuals who provide or supervise the service must complete six hours of relevant ongoing training in cognitive therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences and in-services.

Caregiver Participant Training

Training/instruction to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long-term care needs; and skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia and seminars to support someone with mobility difficulties. Training needs must be identified through comprehensive evaluation/re-evaluation or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Chore Services

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the member's level of safety. Chore services include cleaning appliances; cleaning and securing rugs and carpets; washing walls; windows, scrubbing floors; cleaning attics and basements to remove fire and health hazards; clearing walkways of ice, snow, leaves; trimming overhanging tree branches; replacing fuses, light bulbs, electric plugs, frayed cords; replacing door locks, window catches; replacing faucet washers; installing safety equipment; seasonal changes of screens and storm windows; weather stripping around doors; and caulking windows.

Home-Delivered Meals

Deliver nutritionally balanced meals to a member's home when this meal provision is more cost-effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least one third of the current Recommended Dietary Allowance (RDA) established by the Food & Nutrition Board of the National Academy of Sciences and National Research Council.

Residential Modifications

Those physical modifications/adaptations to a participant's private primary residence required by his/her Plan of Care, which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual. Residential modifications are limited to \$5,000 per calendar year, \$10,000 lifetime.

Non-Medical Transportation

Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them.

Transportation services shall be offered in accordance with the individual's Plan of Care. Transportation is a service that enhances the individual's quality of life.

An approved provider may transport the participant to locations including but not limited to: shopping, beauty salon, financial institution, or religious services of his or her choice.

Service Limitations:

Services are limited to those that are required for implementation of the Plan of Care.

Whenever possible, family, neighbors, friends, public transit, tickets or community agencies, which can provide this service without charge, will be utilized.

Provider Specifications:

- Vehicle must be maintained in proper operating condition and must meet the requirements of

New Jersey regulations, as evidenced by a valid inspection sticker.

- Owner must have proof of liability insurance coverage for the vehicle.
- Owners and drivers are required to undergo civil and criminal background checks.
- Evidence of Insurance, i.e. Declaration Page from insurance company, must be produced.
- Provide description of vehicles used in service and copies of any required licenses.
- Vehicle appropriately registered, inspected and insured; Driver licensed to operate the vehicle.
- Provides proof of New Jersey Business Authority, e.g., tax certificate or trade name registration.
- Provides Fee Schedule.
- Participant-Directed Provider.

Vehicle Modifications

The services include needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved Plan of Care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes. The vehicle must be registered in New Jersey and must be owned by the member or the member's authorized representative.

Medication Dispensing Device (MDD) Set Up and Monthly Monitoring

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner, the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person and case management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the MCO contract, MDD is for an individual who lives alone or who is alone for significant amounts of time per the Plan of Care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Personal Emergency Response System (PERS) Set Up and Monitoring

PERS is an electronic device that enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment, and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously, the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per Medical Necessity as defined in the MCO contract, PERS is for an individual who lives alone for significant amounts of time per the Plan of Care. Individual might not have a regular caregiver for extended periods of time or would require extensive routine supervision.

Respite (Daily and Hourly)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid caregiver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Service Limitations:

Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a CRS setting, an ALR or CPCH or for individuals that are admitted to a nursing facility.

Respite care shall not be reimbursed as a separate service during the hours the participant is in either Adult Day Health Services or Social Adult Day Care.

Services excluded from additional billing while simultaneously receiving Respite care include: Chore,

Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in or companion services are not considered Respite services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (e.g., Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant.

Eight or more hours of respite in one 24-hour period provided by the same provider is the DAILY respite service.

Provider Specifications:

Respite care may be provided in the following location(s):

- Individual's home or place of residence
- Medicaid-certified nursing facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an ALR, a CPCH or an Adult Family Care (AFC) Home

The 21st Century Cures Act requires the use of Electronic Visit Verification (EVV) for all Medicaid-funded, personal-care services. EVV is a web-based system that verifies when a provider documents the precise time a service visit begins and ends, and the location where the service is being provided. [Learn more about EVV requirements.](#)

Home-Based Supportive Care (HBSC) Services

HBSC services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC services are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wraparound service to non-Medicaid programs such as those administered by the Department of Veterans Affairs that are assisting participants with their ADL health-related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond “health-related” services.

HBSC is distinct from the State Plan service of Personal Care Assistant in that it does not include “hands-on personal care.” According to N.J.A.C. 10:60-1.2, Personal Care Assistant (PCA) services means “health-related tasks” performed by a qualified individual in a beneficiary's home, under the supervision of a registered nurse, as certified by a physician in accordance with a beneficiary's written Plan of Care.

HBSC services include, but are not limited to, the following: meal preparation, grocery shopping, money management, light housework or laundry.

Service Limitations:

HBSC services are not available for those who have chosen ALR, CPCH, ALP. Since the PCA State Plan

Service can assist with IADL, HBSC is offered only when ADL-related tasks are provided by a caregiver or another non-Medicaid program.

Provider Specifications:

- Licensed home health agency
- Licensed health care service firm
- Licensed employment agency or temporary help agency
- Congregate Housing Services Program
- Licensed hospice provider
- Participant-directed provider

Electronic Visit Verification (EVV) is required for all Medicaid-funded, personal-care services. [Learn more about EVV requirements.](#)

Private Duty Nursing (Adult)

Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

Service Limitations:

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid

EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program.

Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after

enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care.

Approval is provided by the MCO for MLTSS beneficiaries. Approval is provided by the state for fee-for-service beneficiaries.

Provider Specifications:

- RN or an LPN under the direction of the enrollee's physician.

PDN services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by at least one of the following accrediting entities:

- Commission on Accreditation for Home Care, Inc.
- Community Health Accreditation Program
- The Joint Commission
- National Association for Home Care and Hospice

Social Adult Day Care (SADC)

SADC is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized Plan of Care. SADC is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day, but less than 24-hour care. Individuals who participate in SADC attend on a planned basis during specified hours. SADC assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. SADC services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Service Limitations:

Per the identified need as included in the individual's Plan of Care:

- SADC services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week
- SADC is not available to those residing in an ALF as it would duplicate services required by the Assisted Living Licensing Regulations
- SADC cannot be combined with Adult Day Health Services
- The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the SADC
- ALP participants, not ALR or CPCH participants, may attend SADC two (2) days a week
- AFC participants may attend SADC two (2) days per week

Provider Specifications:

The provider must be a Medicaid-approved entity that meets the following qualifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures
- Personnel: (a) program director designated, (b) has adequate staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant
- Client population: established criteria for target population based on resources and program capabilities of facility

- Program activities: planned and ongoing age appropriate activities based on social, physical and cognitive needs of the target population
- Individualized Plans of Care: based on identified individual client needs, jointly developed with client and family
- Social Services: coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families
- Nutrition: provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary
- Health Management: (a) an initial health profile is completed. (b) monthly weights are taken and other health-related observations are recorded as necessary
- Personal Care: personal assistance as needed with mobility and ADL
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes and regulations, including physical plant requirements, fire safety and ADA compliance

Speech, Language and Hearing Therapy (Group and Individual)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MLTSS will include rehabilitation therapies for an individual with a TBI diagnosis. CPT codes are to be used for these services.

Service Limitations:

Per Medical Necessity as defined in the contract. MLTSS rehabilitation therapies for individuals with TBI diagnoses are limited to one session per day.

Provider Specifications:

- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute non-residential rehabilitative services provider agency

TBI Structured Day Program

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management and safety. This service will include nutritional supervision, health monitoring and recreation as appropriate to the individualized Plan of Care.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI, or formerly a TBI waiver participant who is transitioning to MLTSS. The program will not cover services paid for by other agencies. The program excludes medical day care.

TBI Supported Day Services

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight at least monthly.

The Supported Day Service is intended to be a home- and community-based service, not provided in an outpatient setting or within a Community Residential Service, although it may be provided by staff that work in either of these settings. The service supports a person's Plan of Care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to therapeutic recreation; volunteer activities; household management; shopping for food, household goods, clothing; negotiating various components of activities in the community; and building social supports in the community.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI, or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to a Structured Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the master's level rehabilitation professional. The amount, frequency and duration of this service are determined by the recommendation made by the qualified professional. The Care Manager develops the Plan of Care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

Provider Specifications:

A professional holding at least a master's degree in a rehabilitation-related discipline (including but not limited to; psychology, social work, PT, OT, SLP, nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned master's level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

The following services are state plan services that would be beneficial to the support of a MLTSS member. In developing a Plan of Care for a member, the services below should be considered.

- Medical Day Services – Pediatric and Adult
- As specified at N.J.A.C. 8:86 (five hours per day/five days per week)
- MLTSS PCA

B Grievance/Appeals Process for MLTSS Providers

Horizon NJ Health has a system and procedure for the resolution of grievances by providers. The grievance procedure is available to all providers; timely resolution will be executed as soon as possible and will not exceed 48 hours from initiation of the grievance for urgent cases and 30 days for all other issues.

The procedure for initiating a grievance is outlined below:

1. When a provider is dissatisfied, a grievance can be initiated through any of the following:
 - Call a Provider Services representative at **1-800-682-9091**
 - Send a written letter to:

Horizon NJ Health
Member/Provider Correspondence
PO Box 24077
Newark, NJ 07101-0406

- Inform any Horizon NJ Health staff member within any department that you wish to file a formal grievance
 - Submit a verbal or written request directly to the Department of Banking and Insurance, via phone call, fax or [complaint form](#)
2. Once received by the appropriate representative, efforts will be made to resolve the grievance.
 3. If you are not satisfied with the resolution offered by the representative, you should request that a formal grievance be filed.
 4. A grievance resolution analyst will investigate the grievance, and you will be notified within the following timeframes:
 - Urgent cases, including verbal notification, will be addressed within 48 hours
 - Those grievances resolved within five business days will receive verbal notification of the outcome from the resolution analyst. If Horizon NJ Health is unable to reach the initiator of the grievance through a phone call, a written notification that includes the outcome will be sent within 30 days
 5. Unless an appeal is requested, the grievance is considered to be satisfactorily resolved.
 6. Horizon NJ Health investigates all grievances and alleged incidents reported by or related to our members, which may include, but not limited to:
 - Phone call to the health care practitioner or facility by Provider Contracting & Servicing to clarify the circumstances of the grievance
 - Request for medical records and/or a written response from the health care practitioner or facility, which is due within 10 calendar days
 - Site visit
 7. Within the grievance process, a vital part of the resolution is the assistance of a health care practitioner or facility. Using the information from the member and provider, all grievances are thoroughly investigated. After all the information is gathered, a medical director makes a determination if there is a quality issue.
 8. For provider grievances related to administrative issues, quality of care, actions, sanctions or terminations, refer to Section 8.29 and Section 8.30.

MLTSS Member Grievance and Appeals Process

Horizon NJ Health has a grievance procedure for resolving disagreements between members, providers and/or Horizon NJ Health. Disputes may involve our benefits, the delivery of services or our operation. This procedure includes both medical and non-medical (dissatisfaction with the Plan of Care, quality of member services, appointment availability, or other concerns not directly related to a denial based on medical necessity) issues. A grievance, by phone or in writing, can usually be resolved by contacting Member Services.

A member may file a grievance and/or appeal in his or her primary language. All steps of the process shall be in his or her primary language, including the notification of the grievance and appeal rights and the decision of the appeal.

Issues regarding emergency care will be addressed immediately. Issues regarding urgent care will be addressed within 48 hours in the member's primary language. Horizon NJ Health will not discriminate against a member or attempt to disenroll a member for filing a grievance or appeal.

A member who is not satisfied with the supports and services he or she is receiving should call his or her Care Manager right away. The Care Manager will work with the member and his or her service agencies to try and fix the problem. At times it may be appropriate to contact Member Services at **1-844-444-4410 (TTY 711)** for help in resolving the grievance or problem.

Filing a Formal Grievance

If a member feels that neither his or her MLTSS Care Manager nor the Member Advocate has resolved his or her issue, the member can file a formal grievance in two ways: either verbally or in writing. The member can call Member Services toll free at **1-844-444-4410 (TTY 711)**, and speak to a representative.

A written grievance can be mailed to:

**Horizon NJ Health
Member/Provider Correspondence
PO Box 24077
Newark, NJ 07101-0406**

A member can also contact the Department of Banking and Insurance at **1-609-292-5316** or submit a grievance form.

Medical Appeals

A member or his or her provider, with the member's written approval, has the right to ask Horizon NJ Health to review and change our decision if we have denied or reduced the member's benefits. This is called an appeal. An appeal can be oral or written. All appeals must be submitted within 60 days of the date of the denial notification.

The appeal process is described below. A member also has the right to ask Medicaid to review Horizon NJ Health's decision about services. This is called a Fair Hearing.

Utilization Management Appeals Process

Horizon NJ Health has appeals policies to receive and adjudicate utilization management appeals made by members and providers. This procedure ensures timely resolution, provides easy access and offers prompt, fair and full investigation of UM appeals.

The appeal procedure is as follows:

In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.

**Horizon Medical Appeals
PO Box 10194
Newark, NJ 07101**

You can also request an appeal by calling our UM Appeals Department at **1-800-682-9094 x89606** or by fax at **1-609-583-3028**.

Actions that can be appealed include but are not limited to:

1. Any member or provider may appeal any UM decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services. Horizon NJ Health must inform the member and provider of its decision using the Notice of Action template letters developed and provided by the state. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. Members and providers will be given a written explanation of the appeal process upon the conclusion of each stage in the appeal process.
2. A member or provider, acting on behalf of a member and with the member's documented consent, may request an appeal by contacting the UM Appeals Department. All written appeal requests must be submitted to the following address:
3. All appeals (regardless of level or type) must include the following information:
 - Name, address and number (if applicable) of the member(s) and/or physician(s) making the appeal
 - Member ID number
 - Date(s) of service
 - Name(s) of physician, vendor or facility
 - Specific details regarding the actions in question
 - The nature and reasoning behind the appeal
 - The desired outcome
 - Supporting documentation, e.g., medical record

Actions that can be appealed include but are not limited to:

- An adverse determination under a utilization review program
- Denial of access to specialty and other care
- Denial of continuation of care
- Denial of a choice of provider if based on medical necessity
- Denial of access to needed drugs
- The imposition of arbitrary limitation on medically necessary services
- Denial, in whole or in part, of payment for a benefit if based on medical necessity
- Denial or limited authorization of a requested service, including the type or level of services
- The reduction, suspension or termination of a previously authorized service
- Failure to provide services in a timely manner
- Denial of a service, based on lack of medical necessity

Continuation of Benefits During UM Appeals and IURO Appeals

Horizon NJ Health will continue services automatically during Internal and External Independent Utilization Review Organization (IURO) appeals if all of the following conditions are met:

- Appeal is filed timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- Services were ordered by an authorized provider
- Appeal request is made on or before the final day of previously approved authorization, or within 10 calendar days of the notification of adverse benefit determination, whichever is later. (A later request – one taking place after an interruption – will not constitute a continuation of benefits. An appeal request

can still be made after this point – up to 60 days from the notice of adverse determination – but it will not include continued benefits.)

- If the above criteria are not satisfied, the member will not be eligible for continuation of benefits.

NOTE: Horizon NJ Health will notify the member and provider at least 10 days in advance of the termination, suspension or reduction of a previously authorized course of treatment. If we fail to meet this deadline, we will extend the original authorization (and the member’s timeframe to request continued benefits) to a date 10 days after the date of notification.

Internal Appeal

Internal appeals are reviewed by health professionals who are clinical peers; hold an active, unrestricted license to practice medicine or a health profession; are board certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); are in the same profession and in a similar specialty that typically manages the medical condition, procedure or treatment, as mutually deemed appropriate; and are neither the individual who made the original non-certification, nor the subordinate of such an individual.

Urgent or emergent appeals determinations, including verbal and written notification, shall be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request. Non-urgent and non-emergent internal utilization management appeal determinations, including written notification, shall be completed within 30 calendar days.

If the appeal is not resolved to the member’s satisfaction, Horizon NJ Health will provide a written explanation of how to proceed to an External appeal. All Adverse Determination letters will document the clinical rationale for the decision, including a statement that the clinical rationale used in making the appeal decision will be provided in writing upon request. A member or physician acting on behalf of a member with the member’s documented consent can obtain, upon request, reasonable access to and copies of all documents relevant to the appeal.

External Appeal – IURO

Following an adverse determination for an Internal Appeal, the External appeal process includes filing an appeal with the Independent Utilization Review Organization (IURO) assigned by the New Jersey Department of Banking and Insurance (DOBI). Send External appeal requests to:

**New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329**

**Fax: 1-609-633-0807
Email: ihcap@dob.nj.gov
Phone: 1-888-393-1062 (option 3)**

External appeals must be filed with the IURO within 60 days of the adverse Internal appeal determination.

The request must be filed on the application for the Independent Health Care Appeals Program form. The request should be accompanied by the specified fee and general release, executed by the member, for all medical records pertinent to the appeal, as indicated on the form.

Upon receipt of the request to review an appeal from DOBI, the IURO will conduct a preliminary review of the appeal and accept for processing if it determines that:

1. The individual was a covered person of Horizon NJ Health at the time of the action on which the appeal is based.
2. The service, which is subject to the appeal, reasonably appears to be a covered service under the terms of the contract between the covered person and Horizon NJ Health.
3. The member, or provider acting on behalf of the member with the member's consent, has provided all information required by the IURO and DOBI to make the preliminary determination. This information includes the IURO appeal form and a copy of any information provided by Horizon NJ Health regarding the decision to deny, reduce or terminate the covered service and a fully executed release to obtain any necessary medical records from Horizon NJ Health and any other relevant health care provider.

Upon completion of the preliminary review, the IURO notifies the covered person and/or provider in writing if the appeal has been accepted for processing and if not, the reason(s) why, within five business days of receipt of the request. The External appeal process is administered by DOBI and is utilized for the review of the appropriate utilization and medical necessity of covered health care services. The services below may not be eligible for the DOBI External appeal process.

1. Adult Family Care
2. Assisted Living Program
3. Assisted Living Services – when the denial is not based on medical necessity
4. Caregiver/Participant Training
5. Chore Services
6. Community Transition Services
7. Home-Based Supportive Care
8. Home-Delivered Meals
9. Personal Care Assistance
10. Respite (Daily and Hourly)
11. Social Day Care
12. Structured Day Program – when the denial is not based on medical necessity
13. Supported Day Services – when the denial is not based on the diagnosis of TBI

Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of our UM determination, the covered person was deprived of medically necessary covered services. In reaching this determination, the IURO will take into consideration all information submitted by the parties and information deemed appropriate in the opinion of the IURO, including pertinent medical records; consulting physician reports and other documents submitted by the parties; any applicable, generally accepted practice guidelines developed by the federal government; national or professional medical societies, boards and associations; and any applicable clinical protocols and/or practice guidelines developed by Horizon NJ Health.

The IURO shall refer all appeals to an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of appeal. All final decisions of the IURO shall be approved by a medical director of the IURO, who is a physician licensed to practice medicine in the state of New Jersey. The IURO does not have any direct financial interest in the organization or outcome of the independent review.

The IURO shall complete its review and issue a decision as soon as possible in accordance with medical exigencies of the case. Standard appeals must be completed within 45 calendar days and expedited appeals must be completed within 48 hours.

Once the IURO renders a determination, the decision is binding on Horizon NJ Health and the member, except to the extent that other remedies are available to either party under state or federal law. The IURO will send a written notification of the decision. The decision will be acknowledged in writing by Horizon NJ Health. If the IURO overturns an adverse determination resulting from an Internal appeal, we will reprocess the payment (if previously processed) within 10 business days.

External Appeal - Fair Hearing

Only NJ FamilyCare A and NJ FamilyCare ABP members have access to the Fair Hearing Process. Members or providers, acting on behalf of members with the members' written consent, can request a Fair Hearing within 120 days from the date of the notice of action letter following an adverse determination resulting from an Internal appeal. The internal appeal must be completed prior to a request for a Fair Hearing.

A member has the right to pursue a Fair Hearing after the completion of, in lieu of, or concurrently with an External IURO Appeal. Members enrolled in NJ FamilyCare B, C or D do not have the right to request a Fair Hearing. Those members only have access to Internal and External IURO appeals. Members of these plans have up to 60 days after the adverse determination to file an Internal appeal and, if that is denied, up to 60 days to file an External appeal.

Continuation of Benefits during a Fair Hearing

Although a member has up to 120 days to request a Fair Hearing, he or she must request continuation of benefits during a Fair Hearing within the following timeframes:

- Within 10 calendar days of the notice of action letter following an adverse determination resulting from an Internal Appeal (if he or she wishes to pursue a Fair Hearing concurrently with or instead of an External/ IURO appeal)
- Within 10 calendar days of the notice of action letter following an adverse determination resulting from an External/IURO appeal, or on or before the final day of the previously approved authorization, whichever is later

If the member did not qualify for a continuation of benefits during a UM Appeal or an IURO Appeal, then the member will not qualify for a continuation of benefits during a Fair Hearing. If the Fair Hearing results in an outcome that is not in favor of the member, he or she may be required to pay for the cost of the services that were provided during the continuation of benefits. If Horizon NJ Health does not cover the services while the Fair Hearing is pending, and the Fair Hearing results in a decision to reverse the adverse determination, we will cover the services that were not furnished. If the Fair Hearing results in a decision to uphold the adverse determination, we will still pay for the services that were provided during the continuation of benefits.

Claim Appeals Process

Please refer to Section 10.5 of the Manual for the MLTSS Claim Appeal Process.

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