New Jersey | Medicaid

Wellpoint provider webinar

[February 9, 2023]

Wellpoint

Agenda

- Wellpoint overview —– plans/members we serve
- Wellpoint/Availity* digital tools
- Utilization management/authorizations
- Claims — Wellpoint policies/disputes
- Population health/care management
- Important contacts
- Q&A
- Please submit questions in the chat. These will be reviewed at the end of the presentation.

Wellpoint overview

Through its affiliated companies, we serve approximately 118 million people, including nearly 47 million within its family of health plans.

- Wellpoint:
  - Wellpoint in New Jersey currently covers over a quarter of a million Medicaid enrollees.
  - Over 30,000 members are covered by our Medicare Advantage plans.

NJ FamilyCare

The New Jersey Division of Medical Assistance and Health Services (DMAHS) administers the NJ FamilyCare program. You can help identify potential recipients who may qualify for coverage by calling:

- The State of New Jersey Health Benefits Coordinator at **800-701-0710 (TTY 800-701-0720).**
- Wellpoint at **877-453-4080 (TTY 711).**

- Medicaid recipients include NJ FamilyCare members (including **MLTSS**, Supplemental Security Income (SSI) members, and clients of the DDD.
- Some Medicare beneficiaries are eligible for the **Fully integrated dual eligible special needs plan** (FIDE SNP) that has integrated Medicare and Medicaid coverage.
- Members can select a PCP at the time of enrollment or will be auto-assigned to a PCP. Members may change their PCP at any time. Members can change their MCO once every 12 months during annual enrollment October 1 to November 15.
- No copayment or deductible is required or may be collected for medically necessary covered services for NJ FamilyCare A, B, ABP, and MLTSS members.
- MLTSS members receiving nursing facility or assisted living services may have patient pay liability (PPL). NJ FamilyCare C and D members may be responsible for a copayment or personal contribution to care (PCC) for services.
- Refer to the benefit guide in the *Provider Manual* for benefit information.

Medicare Advantage

- Who is eligible?
  - Age 65 or older, under age 65 with permanent disabilities, and all ages with end-stage renal disease (ESRD)
  - Beneficiaries must be enrolled in Medicare Parts A and B and must live in the plan service area (New Jersey counties except for Hunterdon or Warren).

- Wellpoint **Dual Special Needs Plans** are fully integrated dual eligible SNP (FIDE SNP) plans that focus on beneficiaries who would benefit from enhanced coordination of care due to certain medical conditions. Our integrated Medicare and Medicaid care management model Medicaid coverage is consistent with state policy for MLTSS, behavioral health, and nursing facility services.

- Dental, hearing, transportation, and vision are covered under plan's integrated Medicaid benefit:
  - Wellpoint Dual Coordination (HMO D-SNP) H3240-013
  - Wellpoint Dual Secure (HMO-POS D-SNP) H3240-024
  - Wellpoint ESRD Care (HMO-POS C-SNP) H3240-014

- We also offer these Medicare Advantage plans:
  - Wellpoint Choice (PPO) H8343-007
  - Wellpoint Classic (HMO) H3240-022
  - Wellpoint Balance (HMO) H3240-021

- Beneficiaries receive a Flex Card (MasterCard debit card) that can be used at any dentist, optometrist, or audiologist.

- Healthy Groceries (grocery card) covers grocery items. Some exclusions apply.

Wellpoint in New Jersey provider website

Resources:
- *Provider Manual* and *Quick Reference Guide*
- Medical policies and *Clinical UM guidelines*
- Prior Authorization Lookup Tool (see also Availity* > Payer Spaces)
- Referrals (online provider directory)
- Training Academy

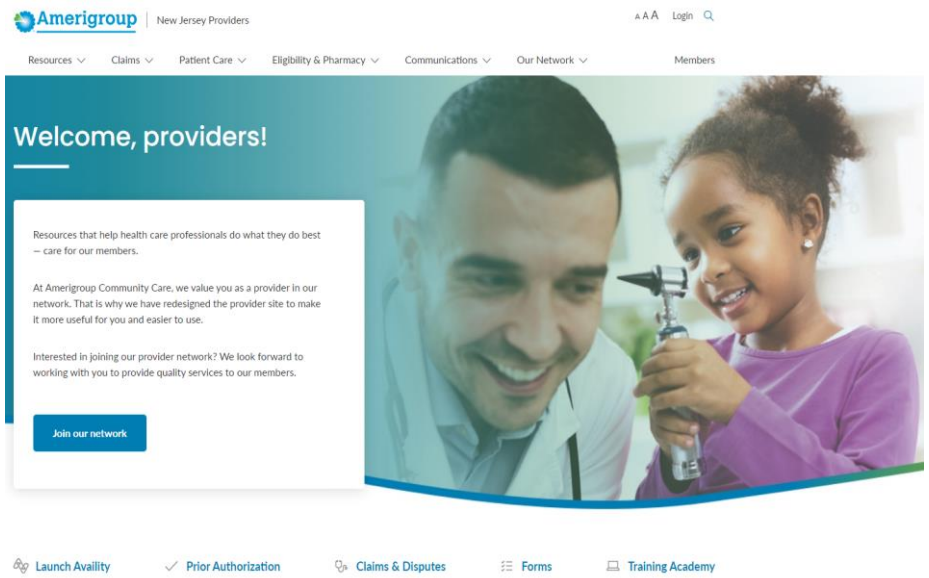
Claims:
- Reimbursement policies

Patient care:
- Behavioral health
- Care management
- Dental
- Early and periodic screening, diagnosis, and treatment (EPSDT)
- Maternal child services
- Disease management/whole health

Eligibility & pharmacy:
- Pharmacy tools

Benefits partners:
- Carelon Medical Benefits Management, Inc.*
- Superior Vision*
- Liberty Dental*

Communications:
•Newsletters



https://provider.wellpoint.com/NJ/

Training academy

- Provider Pathways eLearning - New
- My diverse patients: https://mydiversepatients.com
- Office-based Addiction Treatment (OBAT): https://camdenhealth.org/coalition-building/state-initiatives/obat-events-and-trainings
- Rutgers project ECHO telementoring clinic: https://projectecho.rutgers.edu
- Oral health prevention: https://ilikemyteeth.org/ohpp

Availity Essentials

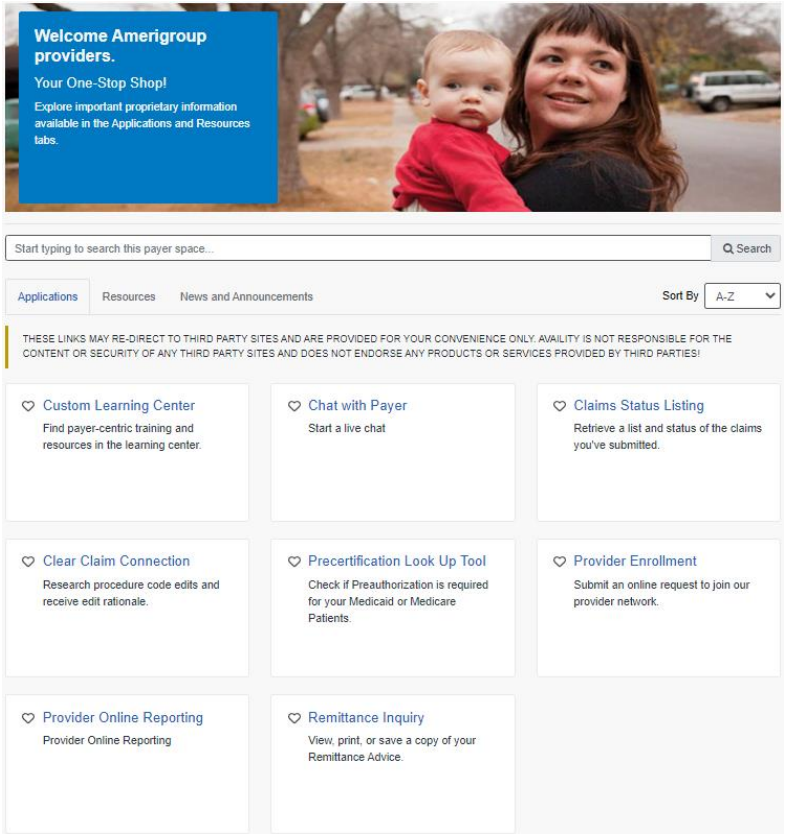
- Acceptance of **digital ID cards**
- **Eligibility and benefit inquiry** and response: Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- **Interactive care reviewer (ICR):** Prior authorization submissions including updates, attachments, and authorization status. Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- **Claim submission:** Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
- Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- **Integration with participating vendors' practice management software,** revenue cycle management software, and some electronic medical records software (B2B APIs).

- **Claim status, remittances, and payments**
- **Electronic remittance advice (ERA)**
- **Disputes**
- **Grievances and appeals**
- Demographic updates (coming soon)
- Precertification lookup tool
- Pharmacy prior authorization drug requests
- Services through Wellpoint affiliates, Carelon Medical Benefits Management,Inc., and Carelon Behavioral Health, Inc.* (coming soon)
- **Chat** with Payer
- Provider online reporting
- **Patient360**
- **Provider enrollment** (New – October 2022)

Availity (cont.)

Access Availity > **Payer Spaces > Wellpoint New Jersey**

- Applications:
  - Custom learning center
  - Chat with payer
  - Claims status listing
  - Clear claim connection
  - Precertification Look-Up Tool
  - Provider online reporting
  - Remittance inquiry
  - Digital provider enrollment
- Resources
- Enrollsafe* electronic funds transfer (EFT)
- New and announcements



Availity Essentials (cont.)

Registering for Availity:

Identify an Availity administrator for your organization:

- The Availity administrator is the person responsible for entering information such as tax IDs and NPIs and identifying which employees need system IDs and passwords.

To register, the administrator should visit **Availity.com**, and select the **Register** button located in the upper right.

Utilization management

Utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. **Inpatient services and non-emergent services by non-participating providers always require prior authorization:**

- First, use the **prior authorization look-up** tool to verify if a service requires prior authorization.
  - Please note that radiology and diagnostic procedures may be authorized through Carelon Medical Benefits Management via www.providerportal.com or **833-419-1491**.
  - To access UM criteria online, go to https://provider.wellpoint.com/new-jersey-provider/home > Resources > *Medical Policies and Clinical UM Guidelines.*
- Wellpoint will notify providers of approved prior authorization determinations for non-urgent services by telephone or in writing within **14 calendar days or sooner** as required by the needs of the enrollee.
- If the request is a **stat/urgent** request (expedited service authorizations), the decision will be made **within 24 hours,** but no later than three business days after receipt of the request for services.
- Prior authorization denials and limitations will be provided in writing in accordance with the *Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.*
- A medical necessity reviewer is available at **800-454-3730** to discuss any denial decision with the practitioner.
- Refer to the *Provider Manual* for detailed information about utilization management.

Interactive care reviewer

Interactive care reviewer (ICR) is a secure, online provider UM tool — accessed via Availity — that offers a streamlined process to request authorization of inpatient and outpatient procedures/services.

With this tool, your practice can initiate online medical and behavioral health preauthorization requests for Wellpoint members more efficiently and conveniently as well as locate information on previously submitted requests regardless of how the original prior authorization was submitted.

Prior Authorization Lookup Tool:

- This tool within Availity is the quickest way to check if an outpatient service requires prior authorization.

Digital provider enrollment (DPE)

Wellpoint has added new functionality to the provider enrollment tool hosted on Availity to further automate and improve your online enrollment experience:

- **Who can use this new tool?**
  - Digital provider enrollment is currently only available for professional practitioners:
- **Note:** Facilities and providers who submit rosters or have delegated agreements will continue to use the existing enrollment process in place.
- **What features does the tool provide?**
  - Apply to add new practitioners to an already existing group.
  - Apply and request a contract to enroll a new group of practitioners.
  - Monitor submitted applications statuses real-time with a digital dashboard.
- Please note that submission of a request for an agreement and/or credentialing application is not a guarantee of approval from Wellpoint. All requests are subject to review and approval from Wellpoint.
- **How the online enrollment application works:**
  - The system pulls in all your professional and practice details from Council for Affordable Quality Healthcare (CAQH) ProView to populate the information Wellpoint needs to complete the enrollment process — including credentialing, claims, and directory administration. Please ensure your provider information on CAQH is updated and in *complete* or *re-attested* status. The online enrollment application will guide you through the process, and a dashboard will display real-time application statuses. You'll know where each provider is in the process without having to call or email for a status.
- **Accessing the provider enrollment application:**
  - Log onto **https://availity.com** and select **Payer Spaces > Wellpoint> Applications > Provider Enrollment.**

Telemedicine

A healthcare provider may engage in telehealth as may be necessary to support and facilitate the provision of healthcare services to patients. P.L.2017, c.117 (C.45:1-61 et al.):

- Providers shall be subject to the same standard of care or practice standards as are applicable to in-person settings.
- Providers must be validly licensed to provide such services in the State of New Jersey.
- Telemedicine services may be provided using interactive, real-time, two-way communication technologies or asynchronous store-and-forward technology.

Claims

A clean claim is:

- Is accurate.
- Submitted on a *HIPAA*-compliant standard claim form (*CMS-1500, CMS-1450* or successor forms).
- Requires no further information, adjustment, or alteration to be processed and paid.
- Is not a claim under review for medical necessity.
- Includes appropriate taxonomy code.
- Is not from a provider who is under investigation for fraud or abuse.

Rejected versus denied claims:

- Rejected claims don't enter the system due to missing or incorrect information and require a correction or change on the claim (claim form or electronic data interchange (EDI) claim).
- Alterations to billing information
- Missing required information
- Mixed or altered format
- Claims that are denied go through the adjudication process, but payment is denied.
- If filing electronically, check the confirmation reports for acceptance of the claim that you receive from EDI.
- If we do not have the claim on file, resubmit your claim within the timely filing requirements.

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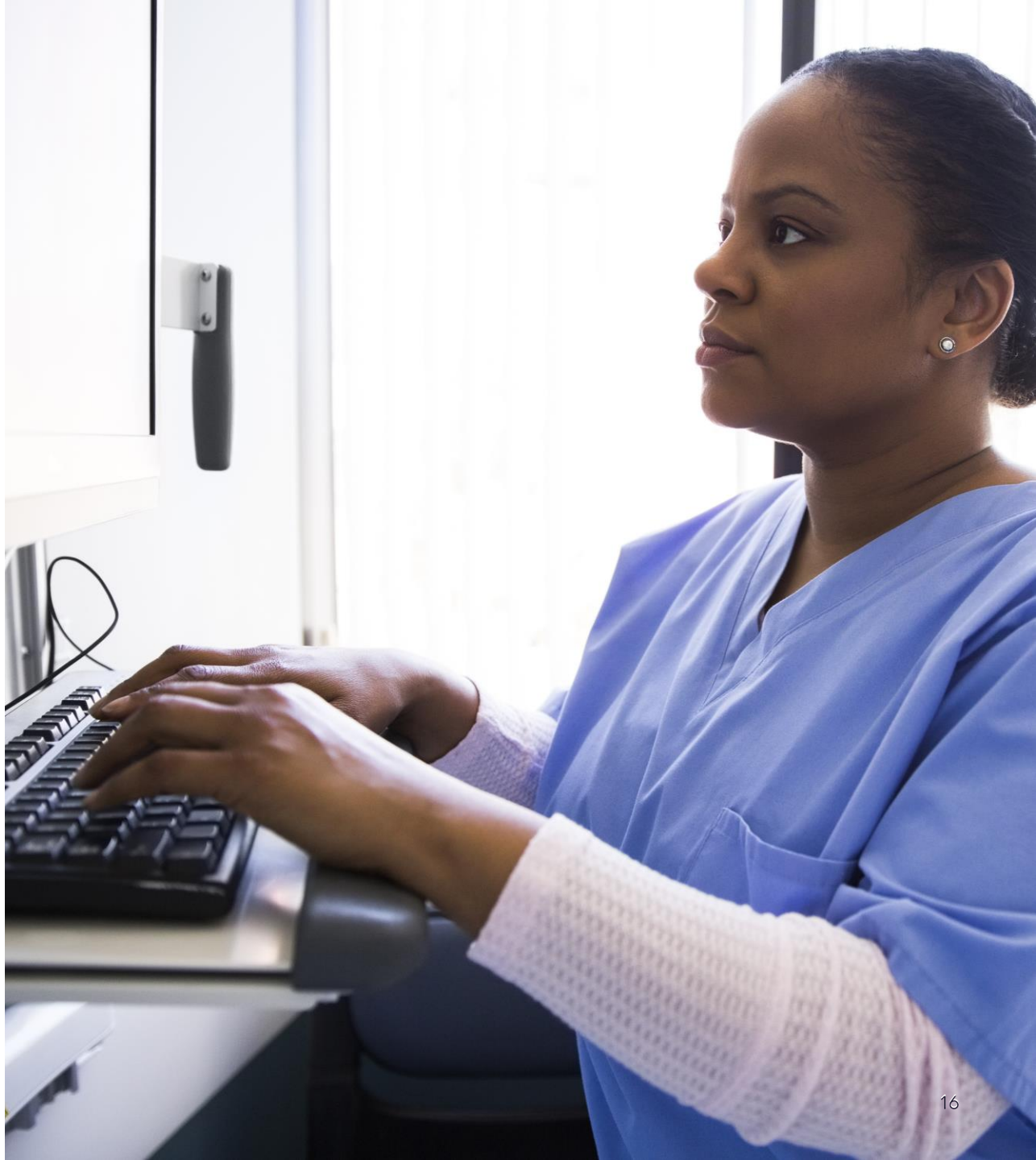

Electronic data interchange

Electronic data interchange (EDI) is the computer-to-computer exchange of business documents in a structured format. EDI provides a faster and cleaner method for delivering time-dependent data, saving you time compared to filing paper claims.

Electronic fund transfer

The EnrollSafe* electronic funds transfer (EFT) enrollment hub enables you to enroll in EFT processing for all participating plans in one simple and easy-to-use website (https://enrollsafe.payeehub.org) at no cost to providers.

Q. How would a provider know if their registration and enrollment was successful?

A. The provider's request for registration must be verified prior to enrolling their bank account. Once verified, the provider will be sent an email with instructions on how to create their login credentials for EnrollSafe. Providers should allow 5 to 7 business days for this process to be completed:

- All enrollments are subject to a two-step verification process. Provider should allow 5 to 7 business days for this process to be completed. After the provider has submitted their enrollment, the EnrollSafe homepage will display the status of any enrollments associated with the account.
- Providers can check the status of their bank account(s) via EnrollSafe. After a provider has submitted their bank account enrollment, EnrollSafe will display the status of their enrollment.

Q. What if I need further assistance?

A. The provider can contact the support team by calling **877-882-0384,** Monday through Friday 9 a.m. to 8 p.m. ET for questions related to registration and enrollment:

- **Note:** EnrollSafe does not support registration or enrollment from third-party billing agencies at this time. The provider must register and submit their enrollment requests directly through the website for greater security.

Timely filing

Claim type	Medicaid	Medicare Advantage
Claim submission	Within 180 days from date of service (DOS) (or discharge date)	90 days for participating providers (12 months for non-par providers)
Corrected claim	365 days from DOS (or discharge date) (Use applicable frequency code: 1 – Original claim, 7 – Replacement of Prior Claim, 8 – Void/Cancel Prior Claim)	
Secondary carrier	Within 60 days from date of primary carrier's *EOP*	

The practice of balance billing Medicaid-beneficiaries with NJ FamilyCare, whether eligible for fee-for-service (FFS) benefits or enrolled in managed care, is prohibited under both federal and state law. All costs related to the delivery of healthcare 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). NJAC 10:74-8.7(a).

Furthermore, federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the *Social Security Act* [the *Act]*).

Claim payment disputes

You have the right to request an appeal of a claim decision. You may request this appeal on your own behalf or on behalf of a covered person.

Claim payment disputes can be submitted through Availity.com. Benefits of submission through the secure provider website include:

- Instant receipt of acknowledgement for submissions.
- Online review for open payment dispute submissions and statuses.
- Email notification of finalized reconsiderations:
  - **Note**: Providers must log in to the secure website to receive the outcome.

Providers still have the option to submit claim payment disputes by mail. Refer to the *Provider Manual* or *Quick Reference Guide* for mailing information.

Claims requiring additional documentation:

- We may request additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, we may:
  - Deny the claim as the provider failed to provide required prepayment documentation.
  - Recover and/or recoup monies previously paid on the claim as the provider failed to provide required documentation for post-payment review.

Maternity care claims

The *Perinatal Risk Assessment (PRA) Plus Form* is a uniform assessment tool used to determine demographic, medical, and psychosocial factors considered in the risk management of the pregnant individual.

This form is required for global authorization of pregnant members and must be completed by the provider during the recipient's first prenatal visit and updated in the third trimester:

- Z3A diagnosis code indicating the gestational age is required for all professional delivery claims.
- Medical necessity diagnosis is required for early elective deliver (EED) prior to 39 weeks of gestation.

Additional coding requirements can be viewed on the state website at **https://njmmis.com** in newsletter volume 30, no. 21.

Electronic visit verification

EVV, or electronic visit verification, is a web-based system that verifies when provider visits occur and documents the precise time services begin and end. It ensures that people receive their authorized services. This new technology is now required by Section 12006(a) of the *21st Century Cures Act* for personal care and home healthcare services provided through NJ FamilyCare.

Providers may use CareBridge,* HHAeXchange, or their own third-party system (as long as it is integrated with either one):

- CareBridge: **844 924-1755** or njevv@carebridgehealth.com
- HHAeXchange: **https://hhaexchange.com/nj-home-health/**
- DMAHS: **nj.gov/humanservices/dmahs/info/evv.html**
- New Jersey's EVV mailbox: mahs.evv@dhs.state.nj.us

Care management

Our care management program is designed to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. We encourage providers to refer members that may be appropriate for comprehensive care management. The care manager will:

- Determine the level of care management services needed.
- Work with the member, the member's representatives, and provider to develop and implement an individualized plan of care.
- Coordinate medical and nonmedical services, including social, educational, and therapeutic services and other nonmedical support services, such as personal care, WIC, and transportation.

Call **800-452-7101** or **732-452-6000 ext. 106-134-2111**. Care managers are available during normal business hours from

8 a.m. to 5 p.m. ET.

For urgent issues, assistance is available after normal business hours, on weekends, and on holidays through Provider Services at **800-454-3730**.

Our disease management (DM)/Population Health Program (PHP) is designed to help physicians and other healthcare professionals manage members with chronic conditions:

- DM-PHP-ProviderReferrals@Wellpoint.com
- 888-830-4300, from 8:30 a.m. to 5:30 p.m.

Whole health and health equity

We are taking a holistic approach that can transform health. It's one that considers not just traditional physical factors but behavioral and social factors too. Health equity is about giving everyone the chance to be as healthy as possible. More equitable healthcare is attainable when we all work together. Wellpoint in New Jersey is focusing on the following whole health domains:

- Maternal child health
- Chronic health conditions:
  - Diabetes and pre-diabetes
  - Hypertension
- Behavioral health:
  - Substance use disorder
- Prevention/vaccines

We may reach out to collaborate with your practice to improve health outcomes by taking a whole health approach that incorporates physical and behavioral health, social factors, and includes equity and access barriers that impact the lives of our members.

source: https://pulse.elevancehealth.com/v3/ourinitiatives/article/PULSEPERF_124919

Substance use disorder

Under N.J. Law (P.L. 2013, c. 46, known as the Overdose Prevention Act), physicians can prescribe naloxone to anyone in a position to assist others during an overdose (e.g., bystanders) - this is called third party prescribing, as the drug is not necessarily intended to be used for the person receiving the prescription.

The NJ Board of Medical Examiners has issued a certificate of waiver allowing physicians and other prescribers to write a prescription for the opioid antidote naloxone in the name of the person receiving the prescription, rather than the end user who will be administered the agent (New Jersey State Board of Medical Examiners Certificate of Waiver Physician Prescribing Naloxone issued April 9, 2014). In addition, the BME has waived the requirements for a physical examination before or follow-up appointment after the issuance of the prescription for the antidote.

Naloxone rescue kits can reverse opioid overdoses.
Pharmacies will provide one two-dose kit per visit to any person ages 14 and older.
No prescription is needed, no name or reason is required, and there is no cost.

For Addiction Help 24/7 call 1-844-REACHNJ (732-2465)
nj.gov/humanservices/reachnj/

Resources:

- NJ Department of Health state.nj.us/humanservices/dmhas/initiatives/naloxone.html
- Substance Abuse and Mental Health Services Administration (SAMHSA) samhsa.gov/sbirt
- NJ DHS DMAHS Newsletter Vol. 29, No. 10 NJ FamilyCare Coverage of Screening Brief Intervention and Treatment (SBIRT) Services njmmis.com
- **Promoting physical and behavioral health integration in Medicaid (2020, January). Retrieved March 30, 2023, from** medicaid.gov/medicaid/downloads/promoting-pbhi.pdf

Screening, brief intervention, and referral to treatment (SBIRT)

One in five Medicaid beneficiaries have behavioral health conditions, including mental health disorders and substance use disorders (SUD). Total spending for this group constitutes nearly half of all spending for the Medicaid program (Medicaid and CHIP Payment and Access Commission 2015). Not only are these beneficiaries more costly, they frequently have unmet care needs, in part driven by insufficient behavioral health screening, treatment, and referrals.

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Coding and Reimbursement

G0396	**Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes**
G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

- Use Modifier 25 when billing with an Evaluation and Management service.
- Do not report SBIRT services with Health Risk Assessment services (96160-96161).
- Services may be billed by physicians, APNs, PAs, and behavioral health prescribers and non-prescribers.
- Unless the Provider's Agreement states otherwise, reimbursement will be at the established NJ Medicaid FFS rates.

Non-compliant members

If you have an issue with a member regarding behavior, treatment cooperation or completion, or making or appearing for appointments, please let us know:

- Our members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. Our staff will contact the member and provide more extensive education and/or case/care management as appropriate.
- We will contact the member by telephone, or an outreach associate will visit the member to provide the education and counseling necessary to address the situation and will report the outcome of any counseling efforts to you.
- In these cases, please call Provider Services at our National Customer Care Department at **800-454-3730** to address the situation.
- We must first approve any reassignments of a member from a provider's panel. We require documentation of the reasons for the request for reassignment before the provider notifies the member that they are being removed from the provider's panel.
- In extreme situations in which a member consistently refuses to cooperate with Wellpoint and/or network providers, we may request that the Division of Medical Assistance and Health Services (DMAHS) disenroll the member. In no event can a member be disenrolled due to health status, need for health services, or a change in health status.

Contact us

Did you know that most questions and issues can be resolved by using the Wellpoint provider self-service tools? Please use **Availity** for inquiries like payment disputes, claims status, member eligibility, etc. You can also live chat with a Wellpoint associate from within Availity.

Wellpoint Provider Services:

- **800-454-3730** (Medicaid) or **866-805-4589** (Medicare Advantage)
- Demographic updates: NJProviderData@Anthem.com
- Credentialing – application submissions: Availity > Payer Spaces > Enrollment

Availity support:

- **800-AVAILITY** (**800-282-4548**)

Electronic visit verification (EVV) support:

- **844-924-1755** or njevv@carebridgehealth.com

Questions and answers

Thank you for your participation.

provider.wellpoint.com/nj/

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