Wellpoint

Provider Manual

833-731-2149 | provider.wellpoint.com/nj/

Wellpoint

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including, but not limited to, bulletins and newsletters.

How to apply for participation
If you are interested in applying for participation with the Wellpoint, please visit **provider.wellpoint.com/nj** and select *Join our network*. For assistance, please call Provider Services at **833-731-2149**.

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1 INTRODUCTION

1.1 Who We Are

Wellpoint is a licensed health maintenance organization (HMO) focused on meeting the health care needs of financially vulnerable Americans. As one of the nation's leading health plans, Wellpoint serves millions of members in state-sponsored programs across the nation. Each Wellpoint plan is unique to the state it serves. Our approach centers on a strong local presence, community-based expertise, and relationships coupled with national resources as well as best and promising practices. We draw from the experience of all our affiliate plans and leverage a centralized infrastructure that offers broad knowledge, cost-efficiency, and scale. This creates a perfectly balanced local health plan positioned to meet the needs and preferences of the many specialized member populations we serve.

We serve approximately 43 million medical members of state sponsored health plans in 23 states, making us the nation’s leading provider of health care solutions for public programs. We strive to educate members to be involved in all aspects of their healthcare and encourage stable, long-term relationships with their providers. Our strategy is to improve access to preventative primary care services; facilitate the coordination of physical, behavioral, and dental care; improve health status and outcomes; educate members about their benefits and the responsible use of health care services; and foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery.

We’d like to welcome you to the Wellpoint network participating provider family. We are pleased you have chosen to join us. We believe physicians, hospitals and other providers play a pivotal role in integrated managed care. Earning your respect and loyalty are essential to a successful collaboration in the delivery of quality health care. Our manual contains information you need to know about us and our programs and how we work with you.

We want to hear from you! Participate in one of our quality improvement committees or call Provider Services at **833-731-2149** with any suggestions, comments or questions. Together, we can make a difference in the lives of our members — your patients.

1.2 Nondiscrimination Statement

Section 1557 of the *Affordable Care Act (ACA)* prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs and activities that a) receive financial assistance from the federal government and b) are administered by any entity established under *Title I* of the *ACA*. Wellpoint complies with all applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, sex, age or disability in its health programs and activities.

Wellpoint provides free aids and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary languages are not English (e.g., qualified interpreters and information written in other languages).

Wellpoint does not discriminate on the basis of gender identity or expression, or on the basis a member is transgender. Wellpoint will also not deny, cancel, refuse to renew or limit coverage, or deny a claim, for Covered Services due to gender identity or expression, or for the reason that the covered person is transgender. Covered Services include:

- Health care services related to gender transition if coverage is available under the NJ FamilyCare contract when the services are not related to gender transition. This includes but is not limited to hormone therapy, hysterectomy, mastectomy, and vocal training.
- Health care services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition.

1.3 Confidentiality of Information

Information used by utilization management, case/care management, condition care, discharge planning, quality management and claims payment activities are designed to ensure that patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with the *Health Insurance Portability and Accountability Act (HIPAA)*. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Wellpoint is committed to safeguarding patient/member information. As a contracted provider, you must have procedures in place to demonstrate compliance with *HIPAA* privacy regulations. You must also have safeguards in place to protect patient/member information, such as locked cabinets clearly marked and containing only protected health information, unique employee passwords for accessing computers and active screen savers.

Requests for such information fit the *HIPAA* definition of treatment, payment or health care operations. We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care.
- Make an authorization determination.
- Resolve a payment appeal.

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us, please verify the receiving fax number, notify us you are faxing information, and verify that we received your fax.

Do not use internet email (unless encrypted) to transfer files containing member information to us. You should mail or fax this information. Mail medical records in a sealed envelope marked **confidential** and addressed to a specific individual or department in our company.

Our voice mail system is secure and password protected. You should only leave messages with the minimum amount of member information necessary.

The following language must be included at the bottom of all communications containing member PHI:

Important Note: *You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.*

1.4 Fraud, Waste and Abuse

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- *Fraud* - Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it—or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- *Waste* - includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* - when health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

As the recipient of funds from federal and state-sponsored health care programs, we have a duty to help prevent, detect and deter fraud, waste and abuse. Wellpoint has outlined its commitment to this in the Wellpoint Corporate Compliance Program.

Providers are the first line of defense against fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness. To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at **www.fighthealthcarefraud.com**

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on our website and by telephone. Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOBs) for any errors and then contact member services if something is incorrect.

Reporting Fraud, Waste and Abuse

You, your staff and our members can report any fraud, waste or abuse concerns:

- Visiting our **www.fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- by calling Member Services: **833-731-2147 (TTY 711)**
- by calling Provider Services: **833-731-2149**
- by calling the State of New Jersey Medicaid Fraud Division: **888-937-2835**.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

1.5 Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

1.6 Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a MEMBER include:

- The member's name
- The member's date of birth, Member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

1.7 Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are sent to a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

Acting on Investigative Findings
If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our health care plan, with state approval.

Relevant Laws

We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties. Federal law adjusts the penalties for inflation periodically. For information about additional requirements, please see the NJ DMAHS (New Jersey Division of Medical Assistance and Health Services) website at: **www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC54.pdf**.

> Wellpoint will not retaliate against any individual who reports violations or suspected fraud, waste and abuse, and we will make every effort to maintain anonymity and confidentiality. An individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government is protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages plus civil penalties. Federal law adjusts the penalties for inflation periodically. In June 2020 the penalties ranged from $11,665 to $23,331 per violation. Penalty amounts are subject to adjustment for inflation. The False Claims Act prohibits, among other things:
    - Knowingly presenting a false or fraudulent claim for payment or approval
    - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
    - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid
    - Retaliatory Actions- Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action.

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

All providers contracted with Wellpoint must agree to be bound by and comply with all applicable State and federal laws and regulations, including:

- Anti-Kickback Statute
    - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in-kind.

- Self-Referral Prohibition Statute (Stark Law)
    - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies

- Red Flag Rule (Identity Theft Protection)
    - Requires "creditors" to implement programs to identify, detect and respond to patterns, practices or specific activities that could indicate identity theft

- Health Insurance Portability and Accountability Act (HIPAA) requires:
    - Transaction standards
    - Minimum security requirements
    - Minimum privacy protections for protected health information
    - National Provider Identification (NPI) numbers

- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties can be $11,665 to $23,331 (in 2021) for each false claim or statement and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Wellpoint services through NJ Medicaid/NJ FamilyCare.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Wellpoint contracted providers must follow federal and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs, including programs for children and families accessing Wellpoint services through NJ Medicaid/NJ FamilyCare.

- The New Jersey False Claims Act (NJFCA), P.L. 2007, Chapter 265, codified at N.J.S.A. 2A:32C-1 through 2A:32C-17, and amending N.J.S.A. 30:4D-17(e), which was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts: (a) the main part authorizes the New Jersey Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act and has similar whistleblower protections; (b) another part amends the New Jersey Medicaid statute to make violations of the New Jersey False Claims Act give rise to liability under N.J.S.A. 30:4D-17(e); and (c) a third part amends the New Jersey Medicaid statute to increase the $2000 per false claim civil penalties under N.J.S.A. 30:4D-17(e)(3) to the same level provided for under the Federal False Claims Act, which is currently between $11,665 to $23,331 per false claim. Penalty amounts are subject to adjustment for inflation.

- The New Jersey Insurance Fraud Prevention Act, N.J.S.A 17:33A-1 et seq, The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims. Any person who violates any provision of P.L.1983, c.320 (C.17:33A-1 et seq.) can be liable, in a civil action brought by the commissioner in a court of competent jurisdiction, for a penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $ 15,000 for each subsequent violation and ordered to pay restitution. After the hearing and upon a finding that a violation has occurred, the commissioner may issue a final order assessing up to the amount of the penalty in the notice, restitution, and costs of prosecution, including attorneys' fees. If no hearing is requested, the notice shall become a final order after the expiration of the 20-day period. Payment of the assessment is due when a final order is issued or the notice becomes a final order.
- Under the criminal provisions of the New Jersey Medical Assistance and Health Services Act (MAHSA), codified at N.J.S.A. § 30:4D-17(a) – (d), providers contracted with Wellpoint must refrain from engaging in fraud or other criminal violations relating to Title XIX (Medicaid)-funded programs. Prohibited conduct includes, but is not limited to: (a) fraudulent receipt of payments or benefits; (b) false claims, statements or omissions or conversion of benefits or payments; (c) kickbacks, rebates and bribes; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments. Providers engaging in criminal violations may be excluded from participation in Medicaid and other health care programs under N.J.S.A. § 30:4D-17.1(a).
- Under the civil provisions of the MAHSA, codified at N.J.S.A. §§ 30:4D-7(h) and 30:4D-17(e) – (i), providers contracted with Wellpoint: (1) shall repay with interest any amounts received as a result of unintentional violations; and (2) are liable to pay up to triple damages and (as a result of the New Jersey False Claims Act) can be $11,665 to $23,331 (in 2021) for each false claim or statement and an assessment in lieu of damages sustained by the. Penalty amounts are subject to adjustment for inflation. Per false claim when violations of the Medicaid statute are intentional or when there is a violation of the New Jersey False Claims Act. Providers engaging in civil violations may be excluded from participation in Medicaid and other health care programs under N.J.S.A. § 30:4D-17.1(a)
- Under the Health Care Claims Fraud Act (HCCFA), codified at N.J.S.A. §§ 2C:21-4.2, 2C:21-4.3 and 2C:51-5, providers contracted with Wellpoint services who (1) knowingly commit health care claims fraud in the course of providing professional services; (2) recklessly commit health care claims fraud in the course of providing services; or (3) commit acts of health care claims fraud as

described in (1) and (2), if the commission of such acts would be performed by an individual other than the professional who provided services (e.g., claims processing staff), are guilty of a crime. Providers may lose his/her license as part of the penalties of this act.

- Under the Uniform Enforcement Act (UEA), codified at N.J.S.A. § 45:1-21(b) and (o), licensed providers are prohibited from engaging in conduct that amounts to, "dishonesty, fraud, deception, misrepresentation, false promise or false pretense" or involves false or fraudulent advertising.
- Under the New Jersey Consumer Fraud Act (CFA), codified at N.J.S.A. §§ 56:8-2, 56:8-3.1, 56:8-13, 56:8-14, and 56:8-15, provider agencies and the individuals working for them shall be prohibited from the unlawful use of "any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact", with the intent that others rely upon it, in connection with the sale, rental or distribution of any product or service by the provider agency or its employees, or with the subsequent performance of that provider agency or its employees.
- Under the Conscientious Employee Protection Act (CEPA), codified at N.J.S.A. §34:19-1, et seq., provider agencies are prohibited from taking retaliatory action against employees who: (a) disclose or threaten to disclose to a supervisor or any public agency an activity, policy or practice of the provider agency or another business with which the provider agency shares a business relationship, that the employee reasonably believes to be illegal, fraudulent and/or criminal; (b) provides information or testimony to any public agency conducting an investigation, hearing or inquiry into any violation of law, rule or regulation by the provider agency or another business with which the provider agency shares a business relationship; or (c) objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes is illegal, fraudulent, criminal or incompatible with a clear mandate of public policy concerning the public health, safety or welfare, or protection of the environment.

Provider Compliance with Relevant Laws

Under Section 6032 of the *Deficit Reduction Act of 2005*, Wellpoint contracted providers who receive either 1) Medicaid payments of at least 5 million dollars from NJ FamilyCare or 2) any payment amount from Wellpoint, in a Federal fiscal year, must:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the *False Claims Act*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in *Section 1902(a)(68)(A)*:
    - Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste, and abuse.
    - Include in any employee handbook a specific discussion of the laws described in *Section 1902(a)(68)(A)*, the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste, and abuse.

To meet all requirements, you must adopt our fraud, waste and abuse policies and distribute them to all employees and contractors who work with us. If you have any questions or need more information, please contact the Chief Compliance Officer.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
    - Automatic disbarment
    - Prison time

Mandatory Database Review for Government Programs Exclusion

Wellpoint is required to check the Office of the Inspector General (OIG) Exclusion Database, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, State of New Jersey debarment list, Federal exclusions database, NJ Treasurer's exclusion database, NJ Division of Consumer Affairs licensure database, N.J. Department of Health licensure database, Certified nurse aide and personal care assistant registry (if applicable), and any other such databases as the New Jersey Division of Medical Assistance and Health Services (DMAHS) may prescribe.

Wellpoint does not participate with or enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers and/or who have been terminated from the Medicaid or any programs by DMAHS for fraud, waste or abuse. The provider must agree to assist Wellpoint as necessary in meeting our obligations under the contract with the DMAHS to identify, investigate and take appropriate corrective action against fraud, waste and/or abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Providers and Managed Care Organizations (MCOs) are responsible for ensuring that any payments received from the State of New Jersey are not for items or services that are directly or indirectly furnished, ordered, directed, managed or prescribed in whole or in part by an excluded, unlicensed or uncertified individual or entity. Excluded individuals or entities are those identified by the State or federal government as not being allowed to participate in State or federally-funded health benefit programs, such as Medicaid, NJ FamilyCare, or Pharmaceutical Assistance to the Aged and Disabled (PAAD).

Providers and MCOs are responsible for verifying that any current or prospective employees (regular or temporary), contractors or subcontractors who directly or indirectly will be furnishing, ordering, directing, managing or prescribing items or services in whole or in part are not excluded, unlicensed or uncertified by searching the following databases on a monthly basis:

Additional Resources

- **http://www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC54.pdf**
- **http://www.nj.gov/oag/dcj/njmedicaidfraud/**
- **http://oig.hhs.gov/hotline.html**
- **http://www.nj.gov/comptroller/divisions/medicaid/disqualified/**
- **https://exclusions.oig.hhs.gov/**
- **http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml**
- **http://www.njconsumeraffairs.gov/Pages/verification.aspx**
- **http://www.state.nj.us/health/guide/find-select-provider/**
- **http://njna.psiexams.com/search.jsp**
- **https://www.npdb.hrsa.gov/hcorg/pds.jsp**
- **To report fraud call the NJ Insurance Fraud Prosecutor Hotline – 877-55-FRAUD or https://njinsurancefraud2.org/#report**

2 QUICK REFERENCE INFORMATION

Provider website: **provider.wellpoint.com/nj/ https://provider.wellpoint.com/new-jersey-provider/home**
Our provider self-service website contains a full complement of resources to help you do business with us quickly and easily, including *Medical Policies and Clinical Practice Guidelines*, reimbursement policies, prior authorization and notification requirements, drug formulary, referral directories, PCP panel listings, and the Quick Reference Guide.

Availity Essentials: **https://www.availity.com** — 800-282-4548
Availity Essentials offers a variety of online functions to help providers reduce administrative resources by reducing paperwork and phone calls. Transactions include eligibility and benefit inquiries, claim status and submissions, medical attachments submission, prior authorization requests, and Patient360 to quickly retrieve treatment and pharmacy history to facilitate care coordination.

Provider Communications
To keep you up-to-date with information required to work effectively with us and our members, we send you messages through a variety of channels: broadcast faxes, provider manual updates, newsletters and information posted to the website.

For dental, therapy, and vision providers, see the section *Our Service Partners.*

Additional contact information is located in the Quick Reference Guide (QRG) on our website **provider.wellpoint.com/nj/** under Resources.

2.1 Member Enrollment

The New Jersey Division of Medical Assistance and Health Services (DMAHS) administers the NJ FamilyCare program. There are approximately 1.8 million residents enrolled in Medicaid in New Jersey. This includes Medicaid recipients, NJ FamilyCare members (including Managed Long-Term Services and Supports [MLTSS]), Supplemental Security Income (SSI) members and clients of the DDD in New Jersey. Individuals that do not select a managed care organization (MCO) will be auto-assigned to a MCO with available capacity that accepts new enrollees in the county where the recipient resides. 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 from October 1-November 15. Members may need to renew their coverage annually with NJ FamilyCare to ensure they continue to have access to care. If members are not sure if they are up for renewal, they may call a State of New Jersey Health Benefits Coordinator at **800-701-0710 (TTY 800-701-0720)** or Wellpoint at **877-453-4080 (TTY 711)**.

You can help identify potential recipients who may qualify for coverage. Potential recipients who may be entitled to NJ FamilyCare coverage may call a State of New Jersey Health Benefits Coordinator at **800-701-0710 (TTY 800-701-0720)** or Wellpoint at **877-453-4080 (TTY 711)**.

In order to maintain continuity of care, we encourage our members to remain with their PCP. However, members may request to change their PCP for any reason by contacting our Member

Services department at **833-731-2147 (TTY 711)**. A member may request a new PCP, and we will accommodate his or her request immediately. This means PCPs may receive new members on any day of the month rather than just on the first of the month. Please note the member must initiate the request for a PCP change. PCPs will be reimbursed for services according to their Wellpoint provider agreement. If PCPs are capitated, their reimbursement will be adjusted on a pro rata basis for those members who select or leave their PCP on any day other than the first of the month.

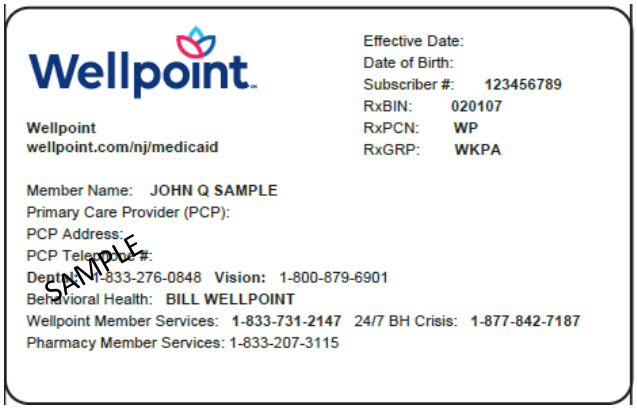
2.2 Member Identification Cards

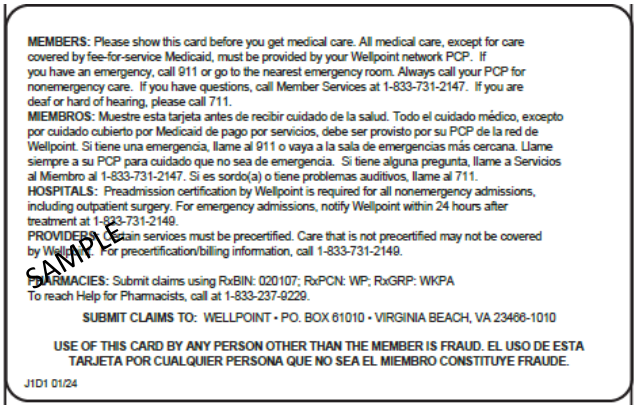
- Each of our members will be provided an identification card within 10 calendar days of notification of enrollment into Wellpoint. To ensure immediate access to services, enrollment may be verified with New Jersey's fiscal agent, Gainwell Technologies **https://www.njmmis.com**, **833-731-2149** through **Availity.com**. **To verify member eligibility, log on to Availity.com, and from the Provider Registration tab, select Eligibility & Benefits, or by contacting us at 833-731-2149.** The holder of the member ID card issued by Wellpoint is a member or guardian of the member. Presentation of an Wellpoint member ID card does not guarantee eligibility. Eligibility should be verified at every visit.

Wellpoint member ID cards provide the following information:

- Wellpoint health plan name and logo
- Effective date of Wellpoint membership
- Member name, date of birth, and member number
- PCP name and telephone number
- Carrier and group number (RXGRP #) for injectables
- Vision and Dental telephone numbers
- Wellpoint Member Services telephone number

Wellpoint member ID card example:





For those NJ FamilyCare members who are not responsible for copayments or who are responsible for copayments and have met their copayment maximum, the member ID card will list $0 copayment.

2.3 Provider Grievance Procedure

Providers may ask questions and resolve problems by contacting Provider Services at **833-731-2149**. When we receive an inquiry via the telephone, our representatives will attempt to immediately resolve the matter to the provider's satisfaction.

A grievance is a written expression of concern or dissatisfaction with a nonclinical issue. Providers have the right to express dissatisfaction with any aspect of Wellpoint operations with respect to administrative matters not related to payment disputes or utilization management decisions. Grievances must be accompanied by supporting documentation and mailed to:

Wellpoint
VP of Provider Relations
101 Wood Ave. South, 8th Floor
Iselin, NJ 08830

Provider grievances will be resolved fairly, consistent with our policies and covered benefits. All provider grievances will be kept confidential to the extent allowed under state and federal rules, regulations and laws. You won't be penalized for filing a grievance.

Upon receipt, we immediately inform the appropriate Wellpoint department head and/or medical director. Grievances of an emergent nature will be resolved immediately, and grievances of an urgent nature will be resolved within two business days from the time of receipt. When the investigation is complete, the New Jersey Vice President of Provider Relations will send a resolution letter to the provider. If the grievance was received from a regulatory agency, the resolution letter will be submitted to the regulatory agency. The resolution letter will be sent no later than 60 calendar days from the receipt of the grievance by Wellpoint or by the date specified in the regulatory agency notice.

Note: If you disagree with the adjudication or outcome of a finalized claim, a dispute should be submitted, not a grievance. See the Claim Payment Disputes section for the dispute submission process.

3 PROVIDER ENROLLMENT AND DISENROLLMENT PROCESS

3.1 Enrollment

Wellpoint complies with the New Jersey Department of Banking and Insurance (DOBI) physician credentialing requirements for Medicaid health plans. The *21st Century Cures Act 114 P.L. 255* requires that all Medicaid managed care network providers to enroll with the state Medicaid program or risk being removed from the managed care network. Apply at New Jersey's fiscal agent, Gainwell Technologies **https://www.njmmis.com**, . While MCO providers are not required to participate in the Medicaid Fee-for-Service (FFS) Medicaid, it is important for continuity of care as beneficiaries may have periods of Medicaid eligibility when they are not active in an MCO such as during initial eligibility determinations and during temporarily lapses in coverage. Questions may be directed to the New Jersey Medicaid Management Information System Provider Enrollment unit at 609-588-6036.

Providers that are interested in contracting with Wellpoint may submit an application request by visiting the Wellpoint provider website at **provider.wellpoint.com/nj/** and selecting *Join our network*. Contact your Provider Experience Consultant, Provider Services at **833-731-2149 833-731-2149** if further assistance is needed.

Dental providers: To request an application, please call **833-276-0854** or visit Liberty Dental Plan at **https://www.libertydentalplan.com/Providers/Join-Our-Network.aspx**.

Vision providers: To request an application, please call **844-585-2020** or visit Superior Vision at **https://superiorvision.com/eye-care-professionals** and select *Join our network*.

Therapy providers: To request an application, please call **855-825-7818** or visit The Therapy Network of New Jersey's website **https://www.mytnnj.com/** and select *Join our network*.

Credentialing Process
Our credentialing policies and procedures incorporate the current NCQA Standards and Guidelines for the Accreditation of Health Plans as well as the New Jersey Division of Medical Assistance and Health Services (DMAHS) requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom it contracts. Each provider, applicable ancillary, facility and hospital will remain in full compliance with all our credentialing criteria as set forth in its Credentialing Policies and Procedures and all applicable laws and regulations.

We encourage providers to use the *Council for Affordable Quality Healthcare (CAQH) Provider Application* **https://www.caqh.org/solutions/caqh-proview** for both initial and recredentialing. ProView, a free online service, allows health care providers to fill out one application to meet the credentialing data needs for multiple organizations. If you are unable to use ProView, you may download the *NJ Universal Physician Credentialing Form* from the State of New Jersey Department of Banking & Insurance at **https://www.state.nj.us/dobi/division_insurance/managedcare/mccred.htm**. All applicable practitioners and HDOs in our network are required to be recredentialed at least every three years.

Application Status and Decisions
Each provider has the right to inquire about the status of his or her application and to review the information submitted in support of the credentialing process, to review information obtained from primary verification sources to the extent permitted by law, and to correct any errors in the documentation by submitting a written request to Wellpoint., 101 Wood Avenue South, 8th Floor, Iselin, NJ 08830, by contacting their Provider Experience Consultant, or Provider Relations at **833-731-2149**.

3.2 Credentialing

Wellpoint's Discretion
The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Wellpoint's discretion in any way to amend, change or suspend any aspect of Wellpoint's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Wellpoint further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope
Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint
    - An independent relationship exists when Wellpoint directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Wellpoint's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
    - That are part of Wellpoint's primary Network and include Wellpoint Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors

- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Wellpoint credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics

    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)

End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission

- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

3.3 Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Wellpoint's networks or plan programs is conducted by a peer review body, known as Wellpoint's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Wellpoint medical director designee and the vice-chair must be a lead medical officer or an Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed

for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Wellpoint may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

3.4 Nondiscrimination Policy

Wellpoint will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Wellpoint will take appropriate action to track and eliminate those practices.

3.5 Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Wellpoint when applying for initial participation in one or more of Wellpoint's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at **www.CAQH.org**.

Wellpoint will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Wellpoint will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education

Verification Element
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

3.6 Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

3.7 Health Delivery Organizations

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Wellpoint Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

3.8 Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Wellpoint has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Wellpoint departments
- Any other information received from sources deemed reliable by Wellpoint.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

3.9 Appeals Process

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Wellpoint's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Wellpoint may wish to terminate practitioners or HDOs. Wellpoint also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Wellpoint's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Wellpoint will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Wellpoint's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Wellpoint's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the

practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

3.10 Reporting Requirements

When Wellpoint takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Wellpoint may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

3.11 Wellpoint Credentialing Program Standards

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Wellpoint.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;

ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or

iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Wellpoint's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

<u>Initial</u> applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under

federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Wellpoint's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.

b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:

a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.

b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.

c. Practitioners with PhD training as a clinical psychologist can be reviewed.

d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.

e. Licensure to practice independently or in states without licensure or certification:

i. Marriage & Family Therapists with a master's degree or higher:

a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

ii. Mental Health Counselors with a master's degree or higher:

a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:

a. Master's or doctoral degree in a mental health discipline.
b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:

a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing

Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and

d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

(b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:

a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

8. Process, Requirements and Verifications – Certified Nurse Midwives:

a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.

b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All CNM applicants will be certified by either:

iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
k. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
l. Upon completion of the credentialing process, the CNM may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
m. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Physician's Assistants (PA):

a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions.

Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint Health Plan and submitted for individual review by the CC.

f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. PA's will be clearly identified:

iv. On the credentialing file;

v. At presentation to the CC; and

vi. Upon notification to network services and to the provider database.

Certified Midwife (non-nurse)

Process, Requirements and Verifications – Certified Midwives:

- The Certified Midwife (CM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
- The required educational/training will be at a minimum that required for Masters with subsequent additional training for licensure as a Certified Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification

of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with Credentialing Policy #6, Attachment A.

- The license status must be that of CM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

- All CM applicants will be certified by: The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.
- This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by the Company is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8 and submitted for individual review by the geographic Credentialing Committee.
- Upon completion of the credentialing process, the CM may be listed in the Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy #6.1.
- CMs will be clearly identified as such:
    - On the credentialing file;
    - At presentation to the Credentialing Committee; and
    - On notification to Network Services and to the provider database.

Doulas

- The Health Plan is required to perform expedited credentialing of Doulas who meet Certification requirements. Requirements include:
- Enroll as Individual Providers
- Must enroll in Medicaid FFS and have a Medicaid ID before submission to Workflow
- Must pass a NJ State Police fingerprint-based criminal background check through DHS' Central
- Fingerprint Unit- will need to complete NJ CBC form
- Secure and maintain liability insurance consistent with requirements described in B.7.2 of the
- managed care contract
- Complete and maintain certification of doula training from the one of the following:

- AMAR Doulas (HealthConnect One)
- Children's Futures (Uzazi Village)
- Community Doulas of South Jersey (Uzazi Village)
- Sister to Sister (Uzazi Village)

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Wellpoint's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;

d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Wellpoint may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Wellpoint standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Wellpoint standards.

1. General Criteria for HDOs:

a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
b. Valid and current Medicare certification.
c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Wellpoint's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.
d. Liability insurance acceptable to Wellpoint.

e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Wellpoint's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

3.12 HDO Type and Wellpoint Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

3.13 Americans with Disabilities Act Requirements

Our policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to lavatory that accommodates a wheelchair.
- Access to examination room that accommodates a wheelchair.
- Clearly marked handicap parking, unless there is street-side parking.

3.14 Delegated Credentialing

We will ensure the quality of our credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations with state approval. Where a provider group is believed to have a strong credentialing program, we may evaluate a delegation of credentialing and recredentialing.

3.15 Notification Requirements

Providers must notify Wellpoint in writing within five days, unless otherwise stated below, following the occurrence of any of the following events:

- The provider's license to practice in any state is suspended, surrendered, revoked, terminated or subject to terms of probation or other restrictions. Notification of any such action must be furnished in writing to Wellpoint immediately.
- The provider learns that he or she has become a defendant in any malpractice action relating to a member who also names Wellpoint as a defendant or receives any pleading, notice or demand of claim or service of process relating to such a suit or is required to pay damages in any such action by way of judgment or settlement. Notification must be furnished in writing to Wellpoint immediately.
- The provider is disciplined by a board of medicine or a similar agency.
- The provider is sanctioned by or debarred from participation with Medicare or Medicaid.
- The provider is convicted of a felony relating directly or indirectly to the practice of medicine. Notification must be furnished in writing to Wellpoint immediately.
- There is a change in the provider's business address or telephone number.
- The provider becomes incapacitated in such a way that the incapacity may interfere with patient care for 21 consecutive days or more.
- There is any change in the nature or extent of services rendered by the provider.
- There is any material change or addition to the information and disclosures submitted by the provider as part of the application for participation with Wellpoint.
- The provider's professional liability insurance coverage is reduced or canceled. Notification must be furnished in writing to Wellpoint no less than five days prior to such a change

- There is any other act, event, occurrence or the like that materially affects the provider's ability to carry out his or her duties under the *Participating Provider Agreement*.
- The provider is no longer enrolled in the Vaccines for Children (VFC) program
- There is any change to hours of operation or staffing levels.
- There is an inability to meet timely access to care and services

Changes are to be reported to:
Wellpoint
101 Wood Avenue South, 8th Floor
Iselin, NJ 08830

The occurrence of one or more of the events listed above may result in the termination of the *Participating Provider Agreement* for cause or other remedial action as Wellpoint in its sole discretion deems appropriate.

3.16 Disenrollment

Providers may cease participating with Wellpoint for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include but are not limited to death and loss of license. Members are auto-assigned to another PCP to ensure continuous access to Wellpoint covered services, as appropriate. We will notify members of any termination for PCPs or other providers from whom they receive ongoing care.

We will provide notice to affected members if you disenroll for voluntary reasons, such as retirement. You must provide written notice to us within the time frames specified in your *Participating Provider Agreement* with us. Members who are linked to a PCP that has disenrolled for voluntary reasons will be notified to self-select a new PCP.

Should a provider be terminated from the network or otherwise not approved for participation through the recredentialing process, the provider has the right to appeal the Wellpoint decision consistent with Wellpoint credentialing policies and procedures in most cases.

4 PROVIDER RESPONSIBILITIES

At Wellpoint, we are committed to treating our members in a manner that affirms their rights and responsibilities. We have a written policy that complies with federal and state laws affecting the rights of enrollees.

All providers are required to:

- Comply with all applicable statutory and regulatory requirements of the Medicaid program.

    - Provide all Medicaid covered services using the most current diagnosis and treatment protocols and in accordance with our *Clinical Practice Guidelines* and *Preventative Health Guidelines.*
    - Inform Wellpoint if a member objects to provision of any treatment, counseling, or referral services for religious reasons.
    - Provide services ethically and legally and in a culturally competent manner, meet the unique needs of members with special health care requirements, and foster respect for enrollees' cultural backgrounds.
- Make provisions to communicate in the language or fashion primarily used by his or her members.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
    - Comply with all applicable federal and state laws regarding the confidentiality of patient records and allow members the opportunity to approve or refuse their release as allowed under applicable laws and regulations .
    - Participate in any system established by Wellpoint to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
    - Transfer patients' medical records to other providers when required; requests must be fulfilled within 10 days and at no charge.
- Coordinate care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance use disorders.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Notify members about lab and radiology results within twenty-four (24) hours of receipt of results in urgent or emergent cases and within ten (10) business days for non-emergent cases.
- Participate and cooperate with Wellpoint in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Wellpoint; this includes providing information or documentation as needed to administer health care operations or to verify compliance with mandatory screenings/participating standards as determined by the New Jersey Medicaid program.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.
- Participate in and cooperate with the Wellpoint complaint and grievance processes and procedures; Wellpoint will notify the provider of any member grievance brought against them
- Have an exposure control plan regarding blood-borne pathogens in compliance with OSHA standards. Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch related care

4.1 Role of the PCP

A PCP is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with state certification/licensure requirements, standards and practices, is responsible for the complete care of his or her patient and serves as the entry point into the health care system for the member. PCPs provide all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, initiation of referrals to specialty providers, and maintenance of continuity of patient care. A PCP shall include general/family practitioners, pediatricians and internists and may include specialist physicians, physician assistants (PAs), certified nurse midwives or certified nurse practitioners, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements. PCPs may practice in a solo or group setting or in an outpatient clinic such as a federally qualified health center (FQHC) or rural health center (RHC).

A **Primary Care Dentist (PCD)** is a licensed dentist who is the health care provider responsible for supervising, coordinating and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

PCP responsibilities include:

- Providing 24-hour-a-day, 7-day-a-week coverage; regular hours of operation should be clearly defined and communicated to members.
- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on a FFS basis; provide coordination necessary to refer to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
- Advising and performing recommended preventive care screenings and routine well-care services.
- Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid Fee-for-Service (FFS).
- Maintaining a medical record of all services rendered by the PCP and other referral providers.

Specialist as a PCP

Under certain circumstances, when a member requires the regular care of the specialist, we may approve a specialist to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:

- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.
- The need for multiple hospitalizations exists.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing); provide access to care 24 hours a day, 7 days a week; and coordinate the member's health care, including preventive care. When such a need is identified, the member or specialist must

contact our Health Care Management department and submit the *Specialist as PCP Request Form* located in the back of this manual. We will notify the member and the provider of the determination in writing within 30 days of receipt. Should the request be denied, we will provide written notification to the member and provider outlining the reasons for the denial of the request within one day of the decision.

4.2 Member Eligibility Listing

PCPs will receive a list of his or her panel of assigned members monthly. If a member calls to change his or her PCP, the change will be effective the next business day. The PCP should verify that each Wellpoint member receiving treatment in his or her office is on his or her membership list. If a PCP does not receive the lists in a timely manner, he or she should contact a Provider Services representative. For questions regarding a member's eligibility, you can visit our provider website or call the automated Provider Inquiry Line at **833-731-2149**.

4.3 Medical Home

As a Primary Care Provider (PCP), you serve as the entry point into the health care system for the member — you are the foundation of the collaborative concept known as a Patient-Centered Medical Home (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.

Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all of the patient's health care needs and appropriately arranging care with other qualified professionals. A medical home is a collaborative relationship that provides high levels of care, access and communication, care coordination and integration, and care quality and safety, including provision of preventive services and treatment of acute and chronic illness. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements, recognize areas for improvement and ultimately develop more efficient, effective and patient-centered care processes.

We acknowledge and support practices that participate in and align with various accrediting organizations. The National Committee for Quality Assurance (NCQA) offers a Physician Practice Connections (PPC) PCMH program to recognize practices as PCMHs. There are six standards containing 27 individual elements. Six of these elements are designated as must-pass. The four primary care specialty societies that developed the Joint Principles — American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association — recommended these must-pass elements because they were seen as essential building blocks of a medical home. There are three levels of NCQA PCMH recognition; each level reflects the

degree to which a practice meets the requirements of the elements and factors that comprise the standards. Practices seeking PPC-PCMH recognition complete a web-based data collection tool and provide documentation that validates responses.

We offer the following support to practices that achieve PCMH status:

- Suite of reports to assist with management of your patient population
- Opportunities for frequent interaction with our medical director
- Dedicated, local medical-practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including case managers who work with your practice and may collaborate with you onsite
- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives

4.4 Specialty Care Providers

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing the specialized care for members. Members are not required to obtain a referral form from their PCP in order to attend a specialty care provider visit however, members are encouraged to discuss plans to see a specialist with their PCP.

Specialist providers will treat members and will render covered services only to the extent and duration that is medically necessary. Examples of obligations of the specialists include the following:

- Accepting all members referred to them
- Submitting required claims information including source of referral to Wellpoint
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and prior authorization of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval

4.5 Second Opinions

A member, parent and/or legally appointed representative or the member's PCP, PCD and/or specialist has the opportunity to obtain a second opinion for diagnosis or treatment of medical or dental conditions and/or elective surgical procedures, when a provider recommends a treatment other than what the member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The second opinion shall be provided at no cost to the member. For dental conditions, these are conditions treated within a dental specialty or by a provider who treats intellectually and developmentally disabled individuals. The second opinion must be obtained from a network provider (see Provider Referral Directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once the second opinion by a non-network provider has been approved, the PCP or specialist will notify the member and schedule an appointment and is encouraged to forward copies of all relevant records upon request to the

consulting provider rendering the second opinion. The provider giving the second opinion may also require additional diagnostic images. The PCP, PCD, or specialist will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever we discover potential risks or outcomes of recommended or requested care during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform the member and the PCP or PCD of the results of the second opinion and the consulting provider's conclusion and recommendations regarding further action.

4.6 Specialty Referrals

In order to reduce the administrative burden on your office staff, we have established procedures designed to permit a member with a condition requiring ongoing care from a specialist physician or other health care provider to request extended authorization when required.

You can request extended authorization by contacting us. You must supply the necessary clinical information for us to review. Note: Members are not required to obtain a referral form from their PCP in order to attend a specialty care provider visit however, members are encouraged to discuss plans to see a specialist with their PCP.

On a case-by-case basis, we will approve extended authorization. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with us will apply. The provider may renew the authorization by submitting a new request to us. Additionally, we require the specialist physician or other health care provider to provide regular updates to the member's PCP (unless acting also as the designated PCP for the member).

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in our network, the referring physician shall request authorization from Wellpoint for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through our medical appeals process.

Dental Referrals and Second Opinions
We will not impose an arbitrary number of attempted dental treatment visits by a PCD or PCP as a condition prior to the PCD or PCP initiating any specialty referral requests. Also, we will not obligate

the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request, nor obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. We have a second opinion program that can be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the member may receive the second opinion within the contractor's network or the contractor may arrange for the member to obtain a second opinion outside the network at no cost to the member. We shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. Members are not required to obtain a referral form from their PDC/PCP in order to attend the visit however, members are encouraged to discuss plans to see a specialist with their PCD/PCP.

For a listing of our participating dental providers, go to the Liberty Dental Plan Directory: **www.libertydentalplan.com/wellpoint**.

4.7 Non-Network Specialist Referrals

If the member has a medical need that cannot be met by a network provider, a Care Manager will arrange access to needed services by a non-network provider within the service area, including coordination of transportation. We will provide for review by a specialist of the same or similar specialty as the type of PCP or provider to whom a referral is requested before denying any request for non-network care. Prior authorization is required for all non-network care (members are not required to obtain a referral form from their PCP in order to attend a specialty care provider visit. Members are encouraged to discuss plans to see a specialist with their PCP). We reimburse non-network providers at rates comparable to those of our network providers; an amount negotiated between the non-network provider and Wellpoint or the Medicaid FFS amount.

4.8 Access and Availability

Wellpoint has established access and availability standards to ensure timely health services are available to all members. We routinely monitor providers' adherence to the access to care standards. Providers are required to ensure the availability of appointments in accordance with the following standards.

We require our members to contact their PCPs in situations where urgent, unscheduled care is necessary. Prior authorization with Wellpoint is not required for a member to access a participating urgent care center.

Emergency services are to be provided immediately upon presentation at a service delivery site.

Urgent and symptomatic care		Appointments made available
Urgent care	Presentation of medical signs that require immediate attention but are not life-threatening	Within 24 hours
Symptomatic acute care	Presentation of medical signs that are acute but do not require immediate attention	Within 72 hours

Urgent specialty care	An encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's PCP	Within 24 hours of referral

Routine and preventative care		Appointments made available
Routine physicals		Within four weeks as needed for school, camp, work or similar setting
Routine care	Non-symptomatic care such as well/preventative care appointments, annual gynecological examinations, or pediatric and adult immunization visits	Within 28 days
Specialist referrals	An encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's PCP	Within four weeks or shorter as medically indicated

Prenatal care	Appointments made available
Initial visit	Within three weeks of positive pregnancy test (home or laboratory)
Prenatal high risk	Within three days of identification of high risk
First and second trimester	Within seven days of request
Third trimester	Within three days of request

Behavioral health/substance abuse	Appointments made available
Care for non life-threatening emergency	Within six hours
Urgent care	Within 24 hours
Initial visit for routine care	Within 10 days
Follow-up routine care	Within 30 days

Laboratory and radiology services	Appointments made available
Routine services	Within three weeks
Urgent services	Within 48 hours

Please note:

- Waiting time in office must be less than 45 minutes.
- Intermediate/limited patient encounters must not exceed four per hour.

You must answer telephone calls in a timely manner:
Appointments are prioritized; follow-up appointments are scheduled as needed, missed appointments are rescheduled; members with special needs are accommodated (e.g., wheelchair and interpretive

linguistic needs); noncompliant members with behavioral health issues are triaged for medical/dental conditions and behavioral health needs.

Emergency dental treatment is to be provided no later than 48 hours or earlier as the condition warrants, urgent dental care appointments within three days of referral and routine nonsymptomatic dental care appointments within 30 days of referral; if the member is in need of emergency care, he/she must contact his/her dentist right away. If the dentist's office is closed, the member should leave a message with his/her name and telephone number and will receive a call back within **45 minutes** for instruction; if the dentist is not able to see the member, the **provider should inform the** member **to** call Liberty Dental Plan at **833-276-0848 (TTY 711)** for help in scheduling an appointment or finding another dentist; if the member is out of town and in need of emergency dental care, he/she can go to any dentist for treatment to address an emergency only, or call Liberty Dental Plan for help to find a dentist. **Treatment of dental emergencies in the emergency room should be limited to severe trauma related injury or infection that is not localized. Members should be encouraged to contact a dentist for most dental emergencies or Member Service for assistance in locating a dentist.**

Liberty Dental Plan Directory: **www.libertydental.com/wellpoint**

4.9 After-hours care

PCPs are required to provide members with access to covered services 24 hours a day, 7 days a week. Access includes regular office hours on weekdays and availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays.

When unavailable, providers must arrange for on-call coverage by another participating provider. The covering provider may not sign out of the emergency room during his or her shift.

Answering services must either connect the caller directly to the provider; contact the PCP or designated agent on behalf of the caller, and the provider returns the call; or provide a telephone number to reach the PCP/covering provider. If using an answering machine, it must provide a telephone number to contact the PCP/covering provider. The message must not instruct the caller to go to the emergency room for care (regardless of the exigencies of the situation) without enabling the caller access to speak with the provider for nonemergent situations.

4.10 Initial visits for new enrollees

We will ensure each new member (for SSI and New Jersey Care — ABD aged, blind, and disabled members) or authorized person is contacted to offer an initial visit to the member's PCP within 45 days of enrollment or according to the needs of the member. Those members identified with special needs will be contacted within 10 days of enrollment and offered an expedited appointment.

4.11 Covering Physicians

During your absence or unavailability, you must arrange for coverage for our members in your care. Please either make arrangements with one or more network providers to provide care for your members, or make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. Upon your request, Wellpoint is responsible for coordinating referrals with a non-network provider when medically necessary covered services cannot be provided by a network provider. In addition, Wellpoint will coordinate with the non-network provider with respect to payment.

4.12 Continuity of Care

If a member's physician is terminated from the network for any reason, he or she may, under certain circumstances, continue to provide medically necessary services to the member for four months or longer for certain types of treatment. A member will continue care with the treating physician under the following conditions:

- A pregnancy that requires the treating physician to continue the postpartum evaluation of the member for up to six weeks after delivery
- Postoperative care that requires the treating physician to continue care for a period up to six months
- Oncology treatment that requires the treating physician to continue care for a period up to one year
- Psychiatric treatment that requires the treating physician to continue care for a period up to one year

4.13 Minor Members

Our policy on treatment of minors is designed to comply with federal, state and NCQA requirements and guidelines. We communicate the policy to staff, members and providers.

No minor member will need to have parental permission for services such as family planning, prenatal care or substance use counseling. Only the minor member, not the member's parents or any other individual, may consent to the provision of services. However, counseling should be offered to adolescents to encourage them to discuss their needs with a parent, an adult family member or other trusted adult. Minor members may also be treated for life-threatening conditions without parental permission.

4.14 Reporting Domestic Violence, Child Abuse, Sex Abuse, and Elder Abuse

Suspected abuse, neglect and exploitation of members must be immediately reported to the appropriate state, county or local authorities.

Domestic Violence

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. The *Domestic Violence Screening Tool* is available for provider utilization at the end of this manual. Providers should report all suspected domestic violence. Individuals can access the National Domestic Violence Hotline by calling **800-799-7233**; for text telephone assistance, call
800-787-3224. Member Services is available to assist members to identify resources to protect themselves from further domestic violence.

Child Abuse
State law requires reporting of child abuse. Report suspected child abuse or neglect immediately to the Division of Child Protection and Permanency (DCP&P) at **800-792-8610**. To report abuse that occurred in an institution, call the DCP&P at **800-215-6853**. These agencies are open 24 hours a day, 7 days a week. Reports can be made anonymously. 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.

Sex Abuse
It is required that each provider contact DCP&P at **800-792-8610** when sex abuse is suspected. Referrals should be made to the DCP&P-designated sex abuse specialty centers. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Wellpoint Member Services at **833-731-2147** for a list of the specialty centers near them.

Elder Abuse
Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them. It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.

The types of adult abuse include:

- **Neglect** occurs when the basic needs of a dependent adult are not met by a caregiver. Neglect may be unintentional, resulting from the caregiver's lack of ability to provide or arrange for the care or services the adult requires. Neglect also may be due to the intentional failure of the caregiver to meet the adult's needs.
- **Self-neglect** occurs when a dependent adult is unable to care for him/her or to obtain needed care. The impairments result in significant danger to the adult, and in some situations, deterioration can occur to the point that the adult's life may be at risk.
- **Abuse (physical, sexual and emotional)** generally involves more extreme forms of harm to the adult, including the infliction of pain, injury, mental anguish, unreasonable confinement or other cruel treatment.
- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of the adult. These are funds paid to the adult or to the caregiver by a governmental agency.

State law encourages individuals to report suspected cases of elder or partner abuse, neglect or exploitation that occurs in the community to the State's Division of Aging and Community Services at **800-792-8820** or to the particular county Adult Protective Services office.

5 COORDINATION OF PHYSICAL AND BEHAVIORAL CARE

We recognize treatment and recovery can be complicated by comorbid conditions. We've designed processes to ensure the coordination of physical and non-emergency covered behavioral health care for DDD, MLTSS and FIDE SNP members and members receiving behavioral health care services covered under FFS.

The PCP or other care coordinator is responsible for:

- Engaging the patient (and caregiver, if appropriate) in the development of an individualized care plan that reflects their health care needs and priorities.
- Keeping an open dialogue with the patient to ensure that they understand their role in the care plan and feel equipped to fulfill their responsibilities.
- Anticipating care needs and ensuring that routine screenings are performed when they are due.
- Identifying psychological, social, financial and environmental barriers that can affect the patient's ability to adhere to treatments or maintain health.
- Assembling the appropriate team of health care professionals to address the patient's needs.
- Recognizing when a patient has a co-occurring physical or behavioral health care need that should be addressed by another health care professional.
- Providing clear communication to the patient when coordinating care with other health professionals about the need for referral and what to do after seeing the provider.
- Coordinating treatment, especially medication management, with other physical and behavioral health providers throughout the course of treatment.
- Sharing of information with other health care professionals and ensuring that the patient's medical record reflects the most up-to-date information and is accessible to all care team members.
- Following up with the patient periodically to ensure their needs are being met and that their circumstances and priorities have not changed.

Sharing of information

We require that physical and behavioral health providers share relevant case information in a timely, useful and confidential manner. The sharing of information applies whether the behavioral health services are covered by Wellpoint or Medicaid FFS. We require that the behavioral health provider be notified of the member's physical examination and laboratory and radiological tests within 24 hours of receipt for urgent cases and within five business days in nonurgent cases. This notification will be made by telephone and followed by the written report.

When a member who is being treated for a comorbid behavioral health condition is admitted for treatment of a physical or behavioral health condition, the attending physician should review the admission with the PCP and coordinate an appropriate medical and behavioral health care plan.

Physical and behavioral health providers should exchange health information at the following junctures:

- When the member first accesses a physical or behavioral health service
- When a change in the member's health or treatment plan requires an alteration of the other provider's treatment plan (e.g., when a member who has been taking lithium becomes pregnant)
- When the member is admitted to or discharged from the hospital

- When the member discontinues care
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required

Information should contain, at a minimum: Provider's name and contact information; member's name, date of birth, gender, ID number and contact information; reason for referral (initial contact only); current diagnosis, history of the presenting illness and other relevant medical and social histories (initial contact only); level of suicide, homicide, physical harm or threat; current treatment plan; special instructions (e.g., diagnostic questions to be answered, treatment recommendations).

Health Care Management is available to assist providers in developing individualized care plans and providing help with identifying referral providers to coordinate physical and behavioral health care. Contact Provider Services at **833-731-2149** for assistance.

Our nurse Care Managers are able to work with members to provide health education, monitor compliance with treatment plans, identify community resources and ensure that members have access to supportive services. Additionally, care management can assist providers with coordination of care for members with special needs through the development of care plans that consider members' unique service requirements with respect to specialist physician care, behavioral health and substance use services, durable medical equipment, medical supplies, home health services, social services, transportation and other necessary services. The care management system is designed to ensure all required services are furnished on a timely basis and that communication occurs between all providers, regardless of network participation status.

Member Authorization

The provider will obtain a release of information from any member or his or her legal representative (e.g., parent, guardian or conservator) before releasing confidential health information. The provider will maintain a copy of the *Release Of Information Form* and document care coordination in the member's medical record. The release of information must contain, at a minimum, the following:

- Name and identification number of the member whose health information is being released
- Name of provider releasing the information
- Name of provider receiving the information
- Information to be released
- Period for which the authorization is valid
- Statement informing the signatory that he or she can cancel the authorization at any time
- Printed name of the signatory
- Signature or mark of the signatory
- Date of signature

Coordination of Care and Referrals

Wellpoint does not require a paper referral process. Wellpoint recommends that PCPs and other providers use an industry screening tool such as the PHQ-9, SBIRT, CAGE, etc., for all members.

If a PCP or other care coordinator feels a member needs a referral to a behavioral health (BH) care specialist, he or she can refer the member to any participating provider. If the PCP/provider cannot find a participating specialist or wants a member to go to a nonparticipating BH specialist, he or she

must request an out-of-network (OON) authorization from Wellpoint, documenting medical necessity and the reason for the OON request. For assistance with finding a specialist, providers can call Provider Services and members can call Member Services. In addition, all DDD, MLTSS and FIDE SNP members are eligible for care management, and the Care Manager can assist the member or provider with finding specialists.

Providers can refer members without Wellpoint BH benefits to any participating Medicaid provider or to Rutgers University Behavioral Health Care Addiction Hotline 24 hours a day, 7 days a week at **844-276-2777**. Members eligible for care management will be assisted by the Care Manager.

A non-network provider who recognizes concomitant physical health needs requiring treatment by a physical health provider is expected to facilitate the member's access to a primary provider by contacting us.

For DDD, MLTSS and FIDE SNP members who are hospitalized and receive both behavioral and physical health services, primacy (i.e., the form of care that is primary) will be determined by admittance to a BH unit. Either type of provider may initiate consultation with the other and coordinate further and/or ongoing care.

For members who are not clients of DDD or enrolled in MLTSS or FIDE SNP, we will coordinate inpatient behavioral health consultations and services, as well as discharge planning and follow-up with the member's behavioral health provider (both network and non-network).

6 WELLPOINT HEALTH CARE BENEFITS AND COPAYMENTS

6.1 Services that don't need referrals

NJ FamilyCare benefits do not require referrals from Wellpoint if the service is provided by a participating Wellpoint provider. These services include:

- Emergency care.
- Annual well-woman exam, routine and preventive women's health care services when the PCP is not a women's health specialist.
- Mammograms (with a prescription).
- Maternity care provided by a network obstetrician or certified nurse midwife.
- EPSDT services from an Wellpoint provider.
- Dental care from a Liberty Dental Plan general dentist, pedodontist (children's dental specialist), or other participating dental specialist.
- Family planning (FP) services provided by a network or non-network Medicaid-approved FP provider.
- Services provided by the member's assigned PCP or an approved Wellpoint provider for special needs care.
- Screening or testing for sexually transmitted diseases, along with HIV, from an Wellpoint PCP or state-approved Medicaid provider of the member's choice.
- Routine vision care provided by a Superior Vision provider.
- Medicaid services that are not covered by Wellpoint.

Members may self-refer for specialty care services provided by a network specialist but it is recommended that Members be referred by their PCP for specialty care. There are some treatments and services the PCP must ask Wellpoint to approve.

6.2 Cost-Sharing Information

For NJ Medicaid members and NJ FamilyCare A, B, ABP and MLTSS members, no copayment or deductible is required or may be collected for medically necessary covered services.

In certain instances, MLTSS members receiving nursing facility or assisted living services have patient pay liability (PPL). The member's cost share will be determined by the county welfare agency, which will subsequently enter the cost share amount in the New Jersey Medicaid Management Information System (NJMMIS) and send notification to the NF or AL provider. In addition, the notification will be sent to the member and/or the member's designee. Further details can be found in the MLTSS FAQ at **www.nj.gov/humanservices/dmahs/home/MLTSS_Provider_FAQs.pdf**.

NJ FamilyCare C and D members may be responsible for a copayment or Personal Contribution to Care (PCC) for services dependent upon their State-assigned program status code. Native American Indians and Alaskan Natives under age 19 in NJ FamilyCare C and D are not responsible for copays. Review the member ID card for copayment information.

6.3 Medical Benefits

For all covered nonemergency services, members must see their primary care provider (PCP) or an Wellpoint plan provider. For emergency care 24 hours a day, 7 days a week, members may go to the closest hospital emergency room or call 911.

Some services may require medical orders by the member's PCP. The chart below shows the copay amounts for services with copays for NJ FamilyCare C and D members. See the section *Services Provided Under Fee-for-Service (FFS) for NJ FamilyCare Members* for more information, limits and exclusions.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered by Wellpoint.			
Autism Services	Covered by Wellpoint and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include Applied Behavioral Analysis (ABA) treatment, augmentative and alternative communication services and devices, Sensory Integration (SI) services, allied health services (physical therapy, occupational therapy and speech therapy), and Developmental Relationship based services including but not limited to DIR, DIR Floortime and the Greenspan approach therapy.			
Blood and Blood Products	Covered by Wellpoint. 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 Wellpoint. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Cardiovascular Screenings	Covered by Wellpoint. 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 Wellpoint. Covers manipulation of the spine.			
Colorectal Screening	Covered by Wellpoint. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.			
• Barium Enema	Covered by Wellpoint. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.			
• Colonoscopy	Covered by Wellpoint. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.			
• Fecal Occult Blood Test	Covered by Wellpoint. Covered once every 12 months.			
• Flexible Sigmoidoscopy	Covered by Wellpoint. Covered once every 48 months.			
Dental Services	Covered by Wellpoint. 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		Covered by Wellpoint. 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	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	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 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. Children should have their first dental exam when they are a year old, or when they get their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through the age of five (5) years old.		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 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. Children should have their first dental exam when they are a year old, or when they get	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
			their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through the age of five (5) years old. NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).	
Diabetes Screenings	Covered by Wellpoint. Screening is covered (including fasting glucose tests) if you have 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 you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.			
Diabetes Supplies	Covered by Wellpoint. 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 Wellpoint. 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.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered by Wellpoint. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered by Wellpoint.			
Emergency Care	Covered by Wellpoint. Covers emergency department and physician services.		Covered by Wellpoint. Covers emergency department and physician services. NJ FamilyCare C members have a $10 copayment.	Covered by Wellpoint. Covers emergency department and physician services. NJ FamilyCare D members have a $35 copayment.
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered by Wellpoint. Coverage includes (but is not limited 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	Covered by Wellpoint. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic 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
	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.			
Family Planning Services and Supplies	Covered by Wellpoint. The plan shall 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. Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).			
Federally Qualified Health Centers (FQHC)	Covered by Wellpoint. Includes outpatient and primary care services from community-based organizations.			
Hearing Services/Audiology	Covered by Wellpoint. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	hearing aids, exams for the purpose of fitting 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 Wellpoint. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.			
Hospice Care Services	Covered by Wellpoint. 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 Wellpoint. 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 Wellpoint. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private 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 Wellpoint. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies,			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	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	For coverage details, please refer to the Behavioral Health chart.			
Mammograms	Covered by Wellpoint. 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 Wellpoint. Covers medical services for perinatal care, and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, 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 Wellpoint. A program that provides preventive, diagnostic, therapeutic and rehabilitative services under 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.	✓ Not covered for NJ FamilyCare B, C, or D members.		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Nurse Midwife Services	Covered by Wellpoint.		Covered by Wellpoint. $5 copayment for each visit (except for prenatal care visits)	
Nursing Facility Services	Covered by Wellpoint. Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.		
• Long Term (Custodial Care)	Covered by Wellpoint. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.		
• Nursing Facility (Hospice)	Covered by Wellpoint. Hospice care can be covered in a Nursing Facility setting. *See Hospice Care Services.	Not covered for NJ FamilyCare B, C, or D members.		
• Nursing Facility (Skilled)	Covered by Wellpoint. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	Not covered for NJ FamilyCare B, C, or D members.		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Nursing Facility (Special Care)	Covered by Wellpoint. 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 members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	Not covered for NJ FamilyCare B, C, or D members.		
Organ Transplants	Covered by Wellpoint. 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 Wellpoint.			
Outpatient Hospital/ Clinic Visits	Covered by Wellpoint.		Covered by Wellpoint. $5 copayment per visit (no copayment if the visit is for preventive services).	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered by Wellpoint. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered by Wellpoint. Covers physical, occupational, and speech/language therapy.		
Pap Smears and Pelvic Exams	Covered by Wellpoint. 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 Wellpoint. 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.	Covered for NJ FamilyCare B, C, or D members through EPSDT.		
Podiatry	Covered by Wellpoint. Covers routine exams and medically necessary podiatric services, as well as 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,		Covered by Wellpoint. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.		$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 Wellpoint. 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 Wellpoint. 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. For NJ FamilyCare C and D members, there is a $1 copayment for generic drugs, and a $5 copayment for brand name drugs.	
Physician Services - Primary and Specialty Care	Covered by Wellpoint. Covers medically necessary services and certain preventive services in outpatient settings.		Covered by Wellpoint. Covers medically necessary services and certain preventive services in outpatient settings.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
			$5 copayment for each visit (except for well-child 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 Wellpoint. 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, and to members with MLTSS (of any age).			
Prostate Cancer Screening	Covered by Wellpoint. 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 Wellpoint. 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 Wellpoint.			
Routine Annual Physical Exams	Covered by Wellpoint.		Covered by Wellpoint. No copayments.	
Smoking/Vaping Cessation	Covered by Wellpoint. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resource is available to support you in quitting smoking/vaping: • **NJ Quitline**: Design a program that fits your 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 9 p.m. (except holidays), Saturday, from 8 a.m. to 7 p.m., and Sun 9 a.m. to 5 p.m. ET. The program supports 26 different languages. Learn more at **njquitline.org**.			
Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)	Covered by Wellpoint. 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)	Covered by FFS. 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. May require medical orders or other coordination by the health plan, PCP, or providers. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. Modivcare transportation services are covered for NJ FamilyCare A, ABP, B, C, and D members. All transportation including livery is available for *all* members including B, C and D.			
Urgent Medical Care	Covered by Wellpoint. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor		Covered by Wellpoint. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).		health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your 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 Wellpoint. 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 Wellpoint. 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.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
			$5 copayment per visit for Optometrist services.	
• Corrective Lenses	Covered by Wellpoint. 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.			

6.4 Medically Necessary Services or Supplies

Covered services or supplies must meet the New Jersey managed care contract definition of medically necessary. **Medically necessary** health services or supplies are those that:

- Prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate or cure a physical or mental illness or condition.
- Maintain health.
- Prevent the onset of an illness, condition or disability.
- Prevent or treat a condition that endangers life or causes suffering or pain, or results in illness or infirmity.
- Prevent the deterioration of a condition.
- 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 appropriate for individuals of the same age.
- 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 member.

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.
- Consistent with the diagnosis of the condition.

- Appropriate to the specific medical needs of the member and not solely for the convenience of the member or provider of service in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

Note: We only cover the use of experimental procedures or experimental medications under certain circumstances (e.g., clinical trials); prior authorization must be obtained before rendering these services.

Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary. Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical and/or pediatric community acceptance.

For **pediatric members**, medically necessary also means services that:
- Are needed by a member as a result of a comprehensive screening visit or an interperiodic encounter, whether or not they are ordinarily covered services for all other Medicaid members.
- Are appropriate for the age and health status of the member.
- Will aid in the overall physical and mental growth and development of the member.
- Will assist in achieving or maintaining functional capacity.

6.5 Behavioral Health Benefits

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

Some services are covered by Wellpoint, while some are paid for directly by Medicaid Fee-for-Service (FFS). When requesting prior authorization for a service covered by Wellpoint, providers should call **833-731-2149 833-731-2149**. For services covered by FFS, providers should contact NJ FamilyCare at **800-701-0710** for prior authorization.

Please Note: Autism Services are detailed in the main Benefits Chart on page <insert page number here>.

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					

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
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered by Wellpoint.	Covered by FFS.	Not covered for NJ FamilyCare B, C, and D members.		
Inpatient Psychiatric	Inpatient Psychiatric services are covered by Wellpoint for members in DDD, MLTSS, or FIDE SNP.	Covered by Wellpoint. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital.			
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered by Wellpoint.	Covered by FFS.			
Outpatient Mental Health	Covered by Wellpoint.	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 Wellpoint.	Covered by FFS. Limited to 25 hour per week (5 hours per day, 5 days per week). Prior authorization required.			

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
Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization	Covered by Wellpoint.	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 Wellpoint.	Covered by FFS.			
Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital-based) ASAM 4 - WM	Covered by Wellpoint for all members.				

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
Long Term Residential (LTR) ASAM 3.1	Covered by Wellpoint.	Covered by FFS.			
Office-Based Addiction Treatment (OBAT)	Covered by Wellpoint. 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.				
Non-Medical Detoxification/Non-Hospital Based Withdrawal Management ASAM 3.7 – WM	Covered by Wellpoint.	Covered by FFS.			
Opioid Treatment Services	Covered by Wellpoint.	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 Wellpoint.	Covered by FFS.			

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
Substance Use Disorder Outpatient (OP) ASAM 1	Covered by Wellpoint.	Covered by FFS.			
Substance Use Disorder Partial Care (PC) ASAM 2.5	Covered by Wellpoint.	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) ASAM 3.7	Covered by Wellpoint.	Covered by FFS.			

6.6 Mental Health/Substance Use Disorder (MH/SUD) Services

Behavioral health and detoxification services in acute care inpatient settings (acute and stand-alone psychiatric hospitals) is covered for all NJ FamilyCare members. Hospital-based inpatient psychiatric and inpatient medical detoxification has been added to the benefit package.

The following all-inclusive list of services must be precertified or coverage may be denied:

- Acute inpatient admissions
- Inpatient administrative days following an acute inpatient psychiatric admission, per regulatory requirements
- Electroconvulsive therapy (ECT)
- Psychological and neuropsychological testing
- Acute partial hospitalization for mental health
- Adult mental health rehab (AMHR)
- Partial care for mental health

In the case of an admission, members should receive an outpatient follow-up encounter within seven days of hospital discharge. We will contact members who have been discharged within the same seven-day period to monitor and facilitate access to follow-up care. For all categories of members, we

will also cover certain diagnoses or diseases of organic origin categorized as altering the mental status of a member.

Outpatient behavioral health and substance use disorder services is covered for clients of the Division of Developmental Disabilities (DDD), Managed Long Term Services and Supports (MLTSS), and Fully-Insured Dual-Eligible Special Needs Plan (FIDE SNP) members. Substance Use Disorder Long Term Residential has been added to the benefit package.

The following all-inclusive list of services must be precertified or coverage may be denied:

- Ambulatory withdrawal management/ambulatory detox — ASAM 2.0 WM
- Nonmedical detoxification/non-hospital based withdrawal management — ASAM 3.7 WM
- Substance use disorder intensive outpatient (IOP) — ASAM 2.1
- Substance use disorder partial care — ASAM 2.5
- Substance use disorder short-term residential – ASAM 3.7
- Substance Use Disorder long term Residential (LTR) – ASAM 3.1

Behavioral health services remaining in FFS for non-DDD, MLTSS, and FIDE SNP populations include: Targeted Case Management (TCM) services provided by or through Justice Involved Services (JIS), Children's System of Care (CSOC) Care Management Organizations (CMOs), Integrated Case Management (ICMS), Projects for Assistance in Transition from Homelessness (PATH), Programs in Assertive Community Treatment (PACT), Behavioral Health Homes (BHH), and Community Support Services (CSS).

All other members with behavioral health benefits are managed under Medicaid FFS. Wellpoint will assist members with referrals for nonemergency behavioral health services whether covered by Wellpoint or Medicaid FFS. PCPs and members may call Member Services at **833-731-2147 (TTY 711)** to speak with a behavioral health Care Manager for consultation and/or to furnish the name of an appropriate provider. Behavioral health providers can call the toll-free number on the member's identification card and request prior authorization for an Wellpoint member who has requested services from the provider directly.

Medication-assisted treatment (MAT) provided by *PCP and Specialty Care* prescribers and Navigator services provided in an office-based setting is covered for all NJ FamilyCare members.

Free *DATA 2000 Waiver*/buprenorphine training courses and continuing medical education units are offered by the following institutions:
Rutgers New Jersey Medical School Department of Psychiatry
Phone: 973-972-2977
Website: **www.njms.rutgers.edu/psychiatry**

Cooper Addiction Medicine
Phone: 856-342-2439
Website: **https://www.cooperhealth.org/services/addiction-medicine**

Rowan Medicine NeuroMusculoskeletal Institute (NMI)
Phone: 856-566-7010

Website: https://centers.rowanmedicine.com/nmi/services.html
https://marketplace.rowanonline.com/store/events/listings/22433

The **MAT Provider Hotline 866-221-2611** is open Monday-Friday from 8 a.m.-8 p.m., excluding holidays. Staffed by pharmacists, nurses and physicians, clinicians offer MAT-related clinical advice and can connect providers with board-certified addiction specialists and other specialists where needed.

The Division of Medical Assistance and Health Services (DMAHS), in collaboration with the Division of Mental Health and Addiction Services, has developed the **Office-Based Addiction Treatment (OBAT)** program to cover and support medication-assisted treatment (MAT) for members with substance use diagnoses including opioid, alcohol, or poly-substance abuse. The OBAT program enhances access to and improves the use of nonmethadone MAT services for Medicaid beneficiaries through the establishment additional supports and reduction of administrative barriers for PCPs providing these addiction services.

OBAT providers are PCP or Specialty Care providers who prescribe approved MAT medications and employ Navigators. OBAT providers follow standard best practice guidelines for prescribing; provide education consistent with the patient's and/or family's needs related to substance use, MAT and associated health conditions; develop and maintain integrated care relationships; establish referral relationships for Social Services; provide or arrange for substance use counseling as needed consistent with American Society of Addiction Medicine (ASAM) guidelines; assess and maintain risk management criteria such as Prescription Monitoring Program (PMP) checks, random drug screening and managing client service plans for adherence; use multidisciplinary staff to provide MAT, counseling and care management; and participate in training or consultation offered through the Centers of Excellence as needed.

Navigators work in the MAT provider's practice and may provide separate encounters with the patient to develop a comprehensive, individualized patient-driven care plan that addresses nonmedical factors that impact substance use disorder (SUD) treatment. Navigators assist with obtaining outside specialist treatment, such as with behavioral health providers and other medical specialists, and connect the patient with social service organizations in the community. Navigators are registered nurses, licensed practical nurses, social workers or individuals with a bachelor's or associate degree and life experience related to SUD. The Navigator and the MAT provider work as a team to provide integrated care that ensures the patient's SUD needs are being addressed.

For additional information about the program and rate schedule, please see the March 2019 State of New Jersey DHS DMAHS Newsletter at **https://www.njmmis.com**, call Provider Services at **833-731-2149** to speak to your Wellpoint representative.

6.7 Services Not Covered by Wellpoint or Medicaid Fee-For-Service for NJ FamilyCare Members

There are other services that are not part of our member's Wellpoint benefits. These services are not covered by Medicaid FFS either. These services are listed below:

- All services your PCP or Wellpoint says are not medically necessary

- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental and investigational services
- Infertility diagnosis and treatment services, along with sterilization reversals and related office services (medical or clinical), drugs, lab, radiological and diagnostic services, and surgeries
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient including guest meals and lodging, telephone charges, travel expenses, take-home supplies, and similar costs
- Respite care (except for MLTSS and DDD members)
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by New Jersey law
- All claims that come directly from services provided by or in federal institutions
- Free services provided by public programs or volunteers
- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military
- Payments for services provided outside of the United States and territories (pursuant to *N.J.S.A.* 52:34-13.2 and section 6505 of the *Affordable Care Act of 2010*, which amends section 1902(a) of the *Social Security Act)*
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker's compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or gets benefits and whether or not a third party gets a recovery for damages
- Any benefit covered or payable under any health, accident or other insurance policy
- Any services or items furnished that the provider normally provides for free
- Services furnished by a relative or member of the member's household (except for members in the Personal Preference Program)
- Services billed when the health care records do not correctly mirror the provider's procedure code
- Services or items paid back based on a cost study or other proof taken by the state of New Jersey

6.8 Prenatal Care

Prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. The prenatal care provider, PCP and Wellpoint are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome, including referrals for diagnosis and treatment of a mental health or substance use disorder. Effective July 1, 2020, no reimbursement can be made for a non-medically indicated early elective delivery performed inpatient on a pregnant enrollee earlier than 39 weeks gestation.

Pregnant women who are already under the care of an out-of-network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from Wellpoint. If the practitioner is not contracted with us, a Care Manager and/or Member Services representative will coordinate services necessary for the practitioner to continue the member's care until postpartum care is completed.

New Jersey P.L. 2019, Chapter 88, requires that any obstetrical provider, nurse midwife or other licensed health care professional, approved as a provider under the Medicaid program, shall complete the *Perinatal Risk Assessment form*, as used by the Division of Medical Assistance and Health Services in the Department of Human Services, for each pregnant Medicaid recipient and for each individual eligible for Emergency Medical Services for Non-Qualified Aliens who receives prenatal care from the provider. The form shall be completed by the provider during the recipient's first prenatal visit with the pregnant Medicaid recipient or other eligible individual and updated by the provider in the third trimester of the recipient or other eligible individual. Effective May 7, 2020, Providers shall not receive authorization for reimbursement for prenatal services provided to a pregnant Medicaid recipient until a *Perinatal Risk Assessment form* is submitted for that recipient. Maternity care providers must register with the PRA|SPECT portal **www.praspect.org**. For assistance, please call **856-665-6000** or email PRA@fhiworks.org.

Taking Care of Baby and Me® is a proactive case-management program for all expectant mothers and their newborns. The program uses extensive methods to identify pregnant women as early in their pregnancy as possible. Through state enrollment files, claims data, hospital census reports, Availity and *Perinatal Risk Assessment* forms as well as provider and member self-referrals, when pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me® program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups

As part of the Taking Care of Baby and Me program, members are offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. For more information on My Advocate visit **www.myadvocatehelps.com**.

We encourage providers to complete the Maternity Form in Availity:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.

- Before the benefit results screen, you will be asked if the member is pregnant. Choose "Yes", if applicable. If you indicate "Yes" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.

NICU Care Management

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Case Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Highly skilled and specialized NICU case managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge.

Once discharged, NICU case managers continue to work with parents to foster best outcomes, prevent unnecessary/avoidable health care expenses, and drive whole health.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

Our case managers are here to help you. If you have a member in your care that would benefit from OB or NICU Case Management services, please call us at **833-731-2149**. Members can also call our 24-Hour Nurse Helpline at **833-731-2147 (TTY 711)**, available 24 hours a day, 7 days a week.

6.9 WIC Program

Under New Jersey state law, Medicaid recipients eligible for WIC benefits include the following classifications:

- Pregnant women
- Women who are breast feeding their infant up to one year postpartum
- Women who are not breastfeeding up to six months postpartum
- Infants under age one
- Children under age five

Please use the *New Jersey WIC form* located at the end of this manual if any of your Wellpoint members meet these criteria. The referral includes information needed by WIC programs to provide

appropriate services. The referral must be completed with the current (within 60 days) height, weight, hemoglobin or hematocrit, and any identified medical/nutritional problems for the initial WIC referral and for all subsequent certifications.

Members may apply for WIC services at their local WIC agency service. Please call Provider Services at **833-731-2149** for the agency nearest to the member.

Network providers are expected to coordinate with the WIC Program. Coordination includes the referral of potentially eligible women, infants and children and the reporting of appropriate medical information to the WIC Program.

6.10 Newborn care

Newborn care is covered only if the mother was enrolled with us at the time of the baby's birth and is subject to the following guidelines:

- Coverage of newborn infants will be our responsibility from the date of birth and for a minimum of 60 days after the birth through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby hospitalized during the first 60 days of life will remain our responsibility until discharge. This includes hospital readmissions within 48 hours of discharge for the same diagnosis (other than live born infant). We will notify DMAHS when a newborn who has been hospitalized has not been added to our enrollment roster after 12 weeks from the date of birth. DMAHS will take action with the appropriate County Welfare Agency (CWA) to have the infant added to the eligibility file and subsequently the enrollment roster, following this notification. The mother's managed care organization (MCO) is responsible for the hospital stay for the newborn following delivery and for subsequent services based on enrollment.
- A newborn whose mother is covered under SSI and does not apply or is not eligible for Temporary Assistance for Needy Families (TANF) will remain our responsibility from the date of birth and for a minimum of 60 days after the birth, and for any readmits for the same diagnosis for 48 hours through the period ending at the end of the month in which the 60th day falls, unless the newborn is determined eligible beyond that point. Any newborn who is hospitalized during the first 60 days of life will remain our responsibility until discharge, as well as for hospital readmissions within 48 hours of discharge for the same diagnosis (other than live born infant). We will notify DMAHS when a newborn has been hospitalized and not added to our enrollment roster after 12 weeks from the date of birth.
- A newborn placed in the Division of Child Protection and Permanency (DCP&P) will remain our responsibility from the date of birth for medically necessary newborn care. Once the child is medically stable and awaiting placement in a DCP&P-approved home, the newborn is covered under Medicaid FFS.
- A newborn whose mother is enrolled in NJ FamilyCare B, C or D is our responsibility from the date of birth through the end of the month in which the 60th day of coverage occurs unless the newborn is determined to be eligible beyond this period.

If a member relocates outside the Wellpoint service area and is otherwise still eligible for benefits, we will continue to provide or arrange care to the member until DMAHS can disenroll him or her.

6.11 Early and Periodic Screening, Diagnostic and Treatment Services

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) is a federally mandated comprehensive and preventative child health program for children from birth through age 20 who are eligible for Medicaid. The goal of EPSDT is to assess a child's health care needs through initial and periodic screening examinations to prevent and/or diagnose health problems as early as possible and to provide treatment and referral services as necessary. The program provides regular medical checkups, dental checkups, treatment and services and health education and guidance at no cost. It is required for the first dental visit by age one, an establishment of the dental home by age two, use of supplemental fluoride, bidirectional referral (PCP-PCD) and the NJ Smiles program.

Services must be rendered within due date spans in accordance with federal EPSDT and State Department of Health guidelines. Please note that services received prior to the specified periodicity date do not fulfill EPSDT requirements. The NJ Periodicity Schedule can be found here: https://www.state.nj.us/humanservices/dmahs/clients/periodicity_of_dental_services.pdf.

EPSDT screenings must include:

- **Screening services**: A comprehensive, unclothed physical examination, including vision and hearing screening, dental inspection, and nutritional assessment that includes a comprehensive health and developmental history, assessment of both physical and mental health development, and provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate identified physical or mental conditions
- **Appropriate immunizations:** In accordance with the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines; immunizations must be reviewed at each screening examination as well as during acute-care visits, and necessary immunizations must be administered when not contraindicated; deferral of administration of a vaccine for any reason must be documented
- **Laboratory tests:** Appropriate screening laboratory tests, including, but not limited to, hemoglobin/hematocrit/EP; urinalysis; tuberculin intradermal test, administered annually and when medically indicated
- **Lead toxicity screenings:** Lead screenings at 12 and 24 months of age, at under 6 years of age if not previously tested
- **Health education:** and/or anticipatory guidance
- **Vision services:** Vision screenings for infants that include eye examination and observation of responses to visual stimuli; screenings for distant visual acuity and ocular alignment children beginning at age 3 and vision services, including diagnosis and treatment for defects in vision and the provision of eyeglasses when medically necessary
- **Dental services:** Dental screenings which include observation of tooth eruption, occlusion pattern, presence of caries, or oral infection; a referral to a primary care dentist soon after the eruption of the first primary tooth but no later than 12 months of age; dental visits twice a year through age 20 with confirmation by the PCP during well child visits to ensure that all needed dental preventive and treatment services are provided

  Liberty Dental Plan Directory: **www.libertydentalplan.com/wellpoint**

- **Other necessary health care:** Further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy, uncovered or suspected or referral to another provider as appropriate

We require participating PCPs to encourage child members to receive EPSDT and adult members to receive an annual physical. PCPs are required to contact members to arrange for an appointment for a well visit and to document efforts to contact members in the medical record.

A list of members who, based on our claims data, may not have received specific EPSDT services according to the periodicity schedule is provided to the PCP each month. Providers are required to schedule members for EPSDT services and to follow up with members that have missed appointments or referrals. Additionally, we mail information to members to encourage them to contact their PCP to set up appointments for needed services. Please note that reports are based only on services not received during the time the member is enrolled with us. As the report is based on historical data, appropriate services may have been provided after the report run date. To ensure accuracy in tracking preventive services, please submit a claim form.

NJ Smiles Program
Non-dental primary care physicians, physician assistants, nurse practitioners and other trained medical office staff may apply fluoride varnish for children through the age of **five (5)**. Proof of training for this service must be submitted. Fluoride varnish application provided at well child visits will be combined with risk assessment, oral exam, and anticipatory guidance services linked to referral to a dentist that treats children under the age of **six (6)** will be reimbursed as an all-inclusive service billed using a CPT code and can be provided up to four times a year. This frequency does not affect the frequency of this service by the dentist. Written referrals are not required. PCPs and PCDs should coordinate care.

Oral health education and training is available to all PCD and PCPs on prescribing fluoride supplements (based on access and use to fluoridated public water) and responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.

- American Academy of Pediatrics oral health education and training: **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Education-and-Training.aspx .**
- Smiles for Life courses: **https://www.smilesforlifeoralhealth.org**.

Caries risk assessment
The caries risk assessment (CRA) must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. It may be provided a second time with prior authorization and documentation of medical necessity. The caries risk assessment forms are available at:

Samples are located in the back of the Provider Manual:

- **For use by PCP:** The American Academy of Pediatrics (AAP) *Oral Health Risk Assessment Tool* **https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx**
- For use by PCD Ages 0-6: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/oral-health-

topics/topics_caries_under6.pdf?rev=adb3b45683794a2bbcb91f4c6e056b25&hash=45FF2CDB955
53C95B1F3C642BA7B527C

- **Ages 6 and older:** American Dental Association (ADA) *Caries Risk Assessment Form* **http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx**

Hearing services
Hearing services include, at a minimum, diagnosis and treatment for 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 three 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 age three and older. Speech and hearing assessments will be part of each preventive visit for an older child.

MH/SUD care includes an assessment documenting pertinent findings. When there is an indication of a possible MH/SUD issue, the *Well-Being Screening Tool* or a New Jersey Department of Human Services (DHS)-approved equivalent will be used to evaluate the member. Such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental health/substance use disorder illnesses and conditions discovered by the screening services must be provided to the member.

6.12 Dental Services

Liberty Dental Plan administers dentals benefits for our members. See the Dental Provider Manual **www.libertydentalplan.com/wellpoint** or call **833-276-0854** for more detailed information.

All NJ FamilyCare Plans A, B, C, D, ABP, MLTSS and FIDE SNP have the same comprehensive dental benefit package which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical and other general adjunctive services. For the most recent listing of the CDT codes included in the NJ FamilyCare dental benefit, refer to **www.njmmis.com** and click on "Rate and Code Information". This information may also be found on the Wellpoint website at **provider.wellpoint.com/nj/** and the Liberty Dental Plan website at **https://www.libertydentalplan.com/Members/Welcome-to-Member-Services.aspx. The Liberty Dental Plan directory includes the ability to search for dental providers treating children under six years of age and providers who treat adults or children with intellectual and developmental disabilities (IDD).**

Liberty Dental Plan Directory: **www.libertydentalplan.com/wellpoint**

We require participating PCDs to encourage members to receive bi-annual dental services beginning at 12 months. A list of members who, based on our claims data, may not have received or are overdue for bi-annual dental services is provided to the PCD each quarter. PCDs are required to contact members to arrange for an appointment for a dental visit and to document efforts to contact members in the medical record.

Treatment of dental emergencies in the emergency room should be limited to severe injury or infection. Members should be encouraged to contact a dentist for most dental emergencies. See 4.8- Access and Availability, for additional information on the treatment of dental emergencies.

Wellpoint has a dental director on staff. The dental director is a Doctor of Dental Surgery or a Doctor of Dental Medicine licensed by the New Jersey Board of Dentistry with experience in the practice of dentistry in New Jersey. The dental director oversees the provision of the Wellpoint dental program as managed by Liberty Dental Plan and exercises general supervision over the provision of dental services. Responsibilities include:

- Reviews surgical cases
- Develops, reviews and administers dental policies
- Reviews dental provider application
- Directs dental provider orientation to the Wellpoint dental network
- Directs dental quality activities
- Works with the State through the Dental Advisory Counsel of the DMAHS

Liberty Dental Plan administers dentals benefits for our members. Some procedures may require prior authorization with documentation of medical necessity. In considering prior authorization of services, we may 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.

Clinical criteria:

Dental versus medical: Network specialty providers (physician specialist, maxillofacial oral surgeon or prosthodontist) are required to submit a completed prior authorization request for surgical cases with appropriate diagnostic and medical and/or dental necessity rationales. Here is a reference for dental criteria.

https://www.libertydentalplan.com/Resources/Documents/NJ_FamilyCare_Dental_Services_Clinical_Criteria_Policy_2023.pdf

For procedures that may be considered either medical or dental, such as maxillofacial prosthetics, surgical procedures for a fractured jaw or removal of tumors, cysts and neoplasms, we have written policies and procedures that clearly and definitively indicate whether a physician specialist or oral surgeon may perform the procedure and when, where and how authorization shall be promptly obtained if needed. Dental treatment in a hospital operating room or ambulatory surgical center is available with prior authorization when medical necessity can be documented. Policies can be found on our website at **https://provider.wellpoint.com/NJ** and are available in hard copy upon request.

When there are mixed medical and dental services required, that is, the care has medical and dental components, Wellpoint will be responsible for the medical services and the dental services will be covered through the applicable contracted dental vendor. The setting of care may or may not be a consideration in determining whether it will be considered medical or dental and Wellpoint will make that determination. If the primary reason for using a medical setting for a dental procedure is medical, even though the primary procedure is dental, then the medical component, that is, the hospital facility,

anesthesia and other medical costs, such as preadmission testing or medical evaluation, will be considered medical. The dental component will be considered dental.

Orthodontic services are age restricted and only approved with adequate documentation of handicapping malocclusion or medical necessity.

For members, including members with special needs, who require dental services to be provided in an operating room or surgical center, (e.g., dental work under anesthesia), our Prior Authorization and/or Care Management team will work with the PCD to obtain the proper clinical information to review the request for medical necessity. The following codes are used for the hospital and anesthesia benefits from Wellpoint.

CPT codes	
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than five years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age five years or older
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intraservice time
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than five years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes of intraservice time
CPT physical status modifiers	
P1	A normal healthy patient (Class I)
P2	A patient with mild systemic disease (Class II)
P3	A patient with severe systemic disease (Class III)

P4	A patient with severe systemic disease that is a constant threat to life (Class IV)
HCPCS	
D9220-D9221	Deep sedation/general anesthesia

Below are listed the ICD-10-CM diagnosis codes that meet the medical exception requirement for an operating room visit by a dentist to provide dental services. The medical exception diagnosis codes must be reported on outpatient hospital claims with service dates on or after October 1, 2015.

ICD-10-CM Diagnosis codes for Medical Exception Requirements	
E75 – E756	Disorders of Sphingolipid Metabolism and Other Lipid Storage Disorders
F03 – F0391	Unspecified Dementia
F06 – F068	Other Mental Disorders Due to Known Physiological Condition
F07 – F079	Personality and Behavioral Disorders Due to Known Physiological Condition
F09	Unspecified Mental Disorder Due to Known Physiological Condition
F48—F489	Nonpsychotic Mental Disorders
F53	Puerperal Psychosis
F60 – F609	Specific Personality Disorders
F70	Mild Intellectual Disabilities (IQ 50-55 to ~70)
F71	Moderate Intellectual Disabilities (IQ 35-40 to 50-55)
F72	Severe Intellectual Disabilities (IQ 20-25 to 35-40)
F73	Profound Intellectual Disabilities (IQ level below 20-25)
F78	Other Intellectual Disabilities
F79	Unspecified Intellectual Disabilities
F84 – F849	Pervasive Developmental Disorders
F88	Other Disorders of Psychological Development
F89	Unspecified Disorder of Psychological Development
F90 – F909	Attention-Deficit Hyperactivity Disorder
F91 – F919	Conduct Disorders
G10	Huntington's Disease
G25 – G259	Other Extrapyramidal and Movement Disorders
G31 – G319	Other Degenerative Diseases of Nervous System, Not Otherwise Classified
G40 – G409	Epilepsy and Recurrent Seizures
G71 – G719	Primary Disorders of Muscles
G72 – G729	Other and Unspecified Myopathies
G73 – G737	Disorders of Myoneural Junction and Muscle in Diseases Classified Elsewhere
G80 – G809	Cerebral Palsy
G93 – G939	Other Disorders of Brain
G04 – P049	Newborn (Suspected to be) Affected by Noxious Substances Transmitted via Placenta or Breast Milk (Does Not Include P042 (Maternal Use of Tobacco)
Q86	Congenital Malformation Syndromes Due to Known Exogenous Causes, Not Elsewhere Classified
Q90 – Q99	Down Syndrome
R56 – R569	Convulsions, Not Otherwise Classified
S06 – S069X9	Intracranial Injury

F819	Developmental Disorder of Scholastic Skills, Unspecified
I6783	Posterior Reversible Encephalopathy Syndrome (PRES)
P154	Birth Injury to Face (Facial Congestion Due to Birth Injury)
P158	Other Specified Birth Injuries
P159	Birth Injury, Unspecified

All claims with dates of service of October 1, 2015 or later must be submitted with a valid ICD-10 code. A valid ICD-10-CM diagnosis code is composed of 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided.

6.13 Orthodontia

Liberty Dental Plan administers orthodontic benefits for our members. Orthodontic treatment is covered for children 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.

Liberty Dental Plan Directory: **www.libertydentalplan.com/wellpoint**

A consultation to visually assess a member's needs is recommended and does not require prior authorization. A pre-orthodontic treatment visit to complete the Handicapped Labiolingual Deviation assessment is required for consideration of comprehensive treatment and does not require prior authorization. Updated criteria for Orthodontic Services and the Assessment Form is located at **https://www.njmmis.com/downloadDocuments/29-16.pdf**. All orthodontic treatment requires prior authorizationprior authorization.

If orthodontic work is started but not completed when eligibility is lost, member will be responsible for remaining treatment.

6.14 Immunizations

Immunizations must be given to members in accordance with the most current recommendations for vaccines and periodicity schedule of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Pediatric Dentistry (AAPD), and the American Academy of Family Physicians (AAFP).

Providers are encouraged to participate in the statewide immunization registry, NJ Immunization Information System (NJIIS) at **https://njiis.nj.gov/njiis**.

Vaccines for Children Program

New Jersey VFC is a federally funded, state-operated vaccine supply program that provides vaccines for some children under age 19 at no cost to providers who serve children who might not otherwise be vaccinated because of inability to pay.

All providers are required to enroll and maintain participation in this program. Providers must use the free vaccines for NJ Medicaid/NJ FamilyCare (Plan A only) members if the vaccine is covered by VFC. Providers are required to notify us if no longer enrolled in the VFC program.

Wellpoint will provide coverage for covered vaccines and related administration fees provided to NJ FamilyCare Plans B, C and D members. Providers are required to obtain required vaccines from traditional market sources.

Many vaccines involve more than one component or antigen (e.g., MMR, DTaP and DTaP/IPV. Wellpoint will reimburse providers an administration fee per vaccine, not per component or antigen. To code administration, use 90460 for the first vaccine and 90461 for each additional vaccine. The serum, even if covered by VFC, must be billed.

6.15 Lead Screening

Lead screening using blood level determinations must be performed between nine 9 months and 18 months, preferably at 12 months of age, and again at 18-26 months, preferably at 24 months of age. Additionally, any child not previously tested must have a lead screening between 27-72 months of age. Providers are required to perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of 6 months and 72 months. For more information about testing for lead exposure, please visit the NJ Department of Health's website at **https://www.state.nj.us/health/childhoodlead**. Providers may utilize th*e Lead Care Management PCP Fo*rm an*d Verbal Blood Lead Risk Assessme*nt forms on the provider website **provider.wellpoint.com/nj/** under Provider Resources & Documents: Forms.

Blood lead-level screening may be performed by a capillary sample (e.g., finger stick), venous sample or the use of a filter-paper method. Use of the filter paper lead-screening method is encouraged as finger stick collection can be readily performed in the office with minimal clinical expertise required and serves to remove one of the patient's largest barriers to obtaining the service — locating and securing an appointment at a lab. Supplies are provided by MedTox **www.medtox.com** at no cost to providers. Please note that all elevated blood lead-levels (e.g., equal to or greater than 5 micrograms per one deciliter) obtained through a capillary sample and filter paper must be confirmed by a venous sample.

PCPs with lead screening rates less than 80 percent for two consecutive six-month periods will be placed on a corrective action plan and monitored to document improvement.

When laboratory results are received, Wellpoint requires PCPs to report all children with blood lead levels > 5 µg/dl. When a provider other than the PCP has reported the lead screening test to Wellpoint, Wellpoint will ensure that this information is transmitted to the PCP. The provider should recommend a follow-up venous blood screening for the child and blood lead testing for the other children and

pregnant women living in the household and use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing.

When a child is found to have a confirmed blood lead level equal to or greater than 5 µg/dl, or two confirmed consecutive tests one to four months apart with results between 5-9 µg/dl, Wellpoint will ensure that the PCP cooperates with the local health department in the jurisdiction where the child resides to facilitate the environmental evaluation to determine and remediate the source of lead and to share information regarding the child's care, including the scheduling and results of follow-up blood lead tests.

Children with blood lead levels ³ 5 mg/dL and members of the same household who are between 6 months and 6 years of age are enrolled in the Wellpoint Lead Case/Care Management (LCM) program, which consists of the following:

- Education for the family regarding all aspects of lead hazard and toxicity including materials that explain the sources of lead exposure; the consequences of elevated blood lead levels; preventive measures, including housekeeping, personal hygiene and appropriate nutrition; and an explanation of why following a prescribed medical regimen is necessary.
- Development of a written care management plan with the PCP, the child's family and other interested parties. The plan will be reviewed and updated on a regular basis.
- Noncompliant members will be pursued for follow-up tests/appointments
- Coordination of the various aspects of the affected child's care (e.g., Women, Infants and Children [WIC] Program, support groups, and community resources).

6.16 Hysterectomy and Sterilization

Federal law requires providers to provide hysterectomies and sterilizations to Medicaid members in ways designed to ensure those members consider their options and make informed choices. We cover sterilizations only under the following conditions:

- The individual is at least 21 years old at the time of consent to be sterilized
- The individual is mentally competent
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery; informed consent must have been given at least 30 days before the expected date of delivery and at least 72 hours before emergency abdominal surgery
- The individual has voluntarily given informed consent and has been provided with the following information:
    - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled
    - A description of available alternative methods of family planning and birth control
    - Advice that the sterilization procedures are considered irreversible
    - A thorough explanation of the specific sterilization procedure to be performed
    - A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used

- A full description of the benefits or advantages that may be expected as a result of the sterilization
- Advice that the sterilization will not be performed for at least 30 days, except under certain circumstances described above
- The person who obtained consent must have offered to answer all questions
- The information must be effectively communicated to all individuals, including persons who are blind, deaf or otherwise handicapped. An interpreter must be provided if the individual does not understand the language on the consent form or the language used by the person who is obtaining consent. The individual must be permitted to have a witness of his or her choice when consent is given.

The *Consent for Sterilization Consent* form is required and may be downloaded from the federal HHS website at **https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf** or from the provider website at **provider.wellpoint.com/NJ** under Provider Resources & Documents -> Forms. The form must be placed in the member's medical record and attached to any claim (hospital, operating physician, anesthesiologist, clinic, etc.) for the hysterectomy or sterilization procedure in order for the claim to be adjudicated.

6.17 HIV Testing and Voluntary Counseling

We collaborate with community-based agencies that educate, test and treat pregnant women with HIV/AIDS to reduce perinatal transmission of HIV from the mother to the infant. All pregnant women will receive HIV education and counseling and HIV testing with their consent as part of their regular prenatal care. A refusal of testing must be documented in the member's medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (e.g., the use of Zidovudine or the most current treatment accepted by the medical community for treating the disease) for the mother and newborn infant will be made available during the pregnancy and/or to the infant within the first months of life. We arrange for treatment for HIV-positive pregnant women in collaboration with the member's obstetrician in accordance with the CDC and NJ State Department of Human Services, Division of Epidemiology and AIDS Program.
The following forms are located in the back of the Provider Manual: *Counsel for HIV Antibody Blood Test*, *Consent for HIV Antibody Blood Test* and *Results of HIV Antibody Blood Test*.

6.18 Outpatient Laboratory Services

We allow laboratory testing in the office. PCPs and specialists will be reimbursed according to their provider agreement. For offices with limited or no office laboratory facilities, lab tests should be referred to one of our preferred lab vendors. Preadmission laboratory tests may be referred to the hospital and must be ordered and completed within 72 hours of admission. All laboratory services furnished by nonparticipating providers require prior authorization by Wellpoint, except for hospital laboratory services in the event of an emergency medical condition.

Clinical Laboratory Improvement Amendment Reporting
The federal *Clinical Laboratory Improvement Amendment* (*CLIA*) requires that all laboratories servicing Medicaid recipients must have a certificate of waiver or a certificate of registration.

The laboratories with a certificate of waiver may only provide the following eight tests:

1. Fecal occult blood
2. Dip-stick or tablet reagent urinalysis for the following: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen
3. Ovulation tests
4. Erythrocyte sedimentation rate, nonautomated
5. Hemoglobin, copper sulfate, nonautomated
6. Blood glucose by glucose-monitoring device cleared by the U.S. Food and Drug Administration (FDA) specifically for home use
7. Spun hematocrit
8. Hemoglobin by single analyte instruments with self-contained features to perform specimens' reagents interaction, providing direct measurement and readout (e.g., Hemocue)

6.19 Radiology Services

Physicians will use Carelon Medical Benefits Management, Inc. for the management of certain diagnostic imaging studies. Carelon Medical Benefits Management will perform prior authorization services for Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA), Positron Emission Tomography (PET) scan, Computed Tomography (CT) and nuclear cardiology performed in an outpatient setting. Physicians who order any of the tests listed above must obtain prior authorization by contacting Carelon Medical Benefits Management at **800-714-0400**, Monday-Friday, 8 a.m.-8 p.m. ET. In addition to reviewing clinical appropriateness and issuing prior authorizations for these studies, Carelon Medical Benefits Management will locate a preferred imaging facility from our network of radiology service providers. Any of these tests performed in conjunction with an inpatient stay are not subject to prior authorization by Carelon Medical Benefits Management .

When both a PCP and a radiologist read an X-ray, only the radiologist will be reimbursed for reading the film. If the PCP feels there is a concern with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

NJ HMO D-SNP plans, Wellpoint Full Dual Advantage (HMO D-SNP) & Wellpoint Full Dual Advantage Secure (HMO-POS D-SNP): All such requests for prior authorization are to be directed to the Medicare Prior authorization team for assistance.

6.20 Therapy Services

Physical therapy (PT), occupational therapy (OT) or speech-language pathology therapy (SPT) services are available as an integral part of a comprehensive medical program. Such rehabilitative services are for the purpose of attaining maximum reduction of physical or mental disability and restoration of the individual to his or her best functional level. Cognitive rehabilitative therapy (CRT) services are available for our NJ FamilyCare A, B, C, D and ABP members with nontraumatic brain injuries.

Outpatient therapy care (including PT, OT and SPT services) are arranged through the Therapy Network New Jersey (TNNJ). Each person in a family can choose a different therapist. Therapy providers should

call TNNJ at **855-825-7818** for **more information regarding** prior approvals for outpatient therapy services.

6.21 Chiropractic Services

Covered services are limited to treatment by means of manual manipulation of the spine. Use PLUTO to verify eligible services.

6.22 Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Our pharmaceutical management procedures, provided below, are updated and provided at least annually and when changes are made.

Monthly Limits
All prescriptions are generally limited to a 30-day supply per fill.

Covered Drugs
Our Pharmacy program uses a *Preferred Drug List* (*PDL*). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* comprises drug products reviewed and approved by the Wellpoint pharmacy and therapeutics (P&T) committee. The P&T committee is comprised of network physicians, pharmacists and other health care professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. The *PDL* also includes several over-the-counter (OTC) products recommended as first-line treatment where medically appropriate. **To prescribe medications that do not appear on the *PDL*, please contact Provider Services at 833-731-2149. Please refer to the *PDL* on our website at https://client.formularynavigator.com/Search.aspx?siteCode=1501420370.**

The following are examples of covered items:

- Formulary legend drugs
- Insulin
- Continuous glucose monitors
- Disposable insulin needles and syringes
- Disposable blood, urine glucose and acetone testing agents (e.g., Chemstrips, Clinitest tablets, Diastix Strips, Tes-Tape)
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and is listed on the Wellpoint *Medication Formulary*
- Any other drug, which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Wellpoint *Medication Formulary*
- Formulary legend contraceptives

Under the New Jersey Medicaid program (*P.L. 1996, c42, the State Fiscal Year 1997 Appropriations Act*), unless the provider writes in ink in his own handwriting at the bottom of the prescription brand medically necessary, the prescription will be filled with a generic substitution in every case. When a prescriber writes brand medically necessary, these prescriptions will require prior authorization.

Drugs Requiring Prior Authorization

We strongly encourage you to write prescriptions for preferred products as listed on the *PDL*. If for medical reasons a member cannot use a preferred product or when it is medically necessary that the member receive a brand name medication not on the PDL, you're required to contact Wellpoint Provider Services to obtain prior authorization. Prior authorization may be requested:

- Online at **https://provider.Wellpoint.com/NJ**.
- By fax to **844-509-9863** for retail pharmacy or **844-509-9865** for medical injectable.
- By phone at **833-731-2149** (24 hours per day, 7 days per week).

Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria. Prior authorization determinations shall be made within 24 hours of receipt of all necessary information.

Our *Pharmacy Prior Authorization Form* can be found on our website at: **https://provider.Wellpoint.com/docs/gpp/NJNJ_CAID_PriorAuthForm.pdf?v=202008211649**.

Wellpoint only restricts or requires a prior authorization for prescriptions or pharmacy services prescribed by MH/S providers if one of the following exceptions is demonstrated:

1. The drug prescribed is not related to the treatment of substance use, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by our PCPs or specialists in our network.
2. The prescribed drug does not conform to standard rules of our pharmacy plan.
3. Wellpoint may require a prior authorization (PA) process if the number of prescriptions written by the MH/SUD provider for MH/SUD-related conditions exceeded four per month per member. For drugs that require weekly prescriptions, these prescriptions shall be counted as one per month and not as four separate prescriptions.

Mental health/substance use disorder (MH/SUD)-related conditions

All pharmacy services are covered by Wellpoint. Methadone and its administration when prescribed for substance use treatment will adjudicate under the member's medical benefit. Prior authorization is not needed for MH/SUD drugs written by MH/SUD providers, regardless of whether they are/are not on the Wellpoint formulary.

Atypical antipsychotic and anticonvulsant drugs ordered by a nonparticipating or participating Wellpoint provider will always be covered regardless of the treatment plan established by Wellpoint.

The Wellpoint medication formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed.

At our option, we may require a prior authorization process if the number of prescriptions written by the MH/SUD provider for MH/SUD-related conditions exceed four per month per member. For drugs that require weekly prescriptions, these prescriptions are counted as one per month and not as four separate prescriptions.

We will only restrict or require prior authorization for prescriptions or pharmacy services prescribed by MH/SUD providers if one of the following exceptions is demonstrated:

- The drug prescribed is not related to the treatment of substance use, dependency, addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the members' PCPs or specialists in our network
- The prescribed drug does not conform to standard rules of our pharmacy plan

Over-the-Counter (OTC) Drugs
We have an enhanced OTC benefit for our members. OTC drugs are covered for all members. The benefit limit is $15 per quarter per member.

Our complete formulary and *PDL* includes coverage of several OTC drugs when accompanied by a prescription. The following are examples of OTC medication classes covered: analgesics and antipyretics; antacids; antibacterials, topical; antidiarrheals; antiemetics; antifungals, topical; antifungals, vaginal; anti-inflammatories, topical; antihistamines; contraceptives; cough and cold preparations; decongestants; laxatives; pediculocides; respiratory agents (including spacing devices).

Excluded Drugs
The following drugs are examples of medications that are excluded from the pharmacy benefit: Anti-wrinkle agents (e.g., Renova); Agents used for cosmetic reasons or hair growth; Drugs used for experimental or investigational indication; Erectile dysfunction drugs; Experimental or investigational drugs; Immunizing agents; Implantable drugs and devices (Norplant, Mirena IUD); Infertility medications; Weight-control products (except Alli which requires prior authorization).

6.23 Specialty Drug Program

We contract with CarelonRxSpecialty Pharmacy to be our preferred specialty pharmacy vendor for high-cost, specialty and injectable drugs that treat a number of chronic or rare conditions, including:

- Anemia
- Crohn's disease
- Cystic fibrosis
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Immunologic disorders
- Multiple sclerosis
- Neutropenia
- Primary pulmonary hypertension
- Respiratory Syncytial Virus (RSV) disease
- Rheumatoid arthritis

When prescribing a specialty drug, please call CarelonRx Specialty Pharmacy at **833-255-0646** or fax your request to **833-263-2871**, and they will coordinate shipment to your office or to the member's home. You should not provide these drugs from your office stock without first obtaining prior authorization from us.

Certain medications require prior authorization:

- To determine whether the medication you are prescribing under the **pharmacy benefit** requires prior authorization, please refer to the Wellpoint *Medication Formulary* located at **https://provider.Wellpoint.com/NJ** under *Eligibility & Pharmacy: Pharmacy Information*. Please note that the *PDL* guide does not contain a complete list of drugs (as does the Wellpoint *Medication Formulary*); rather it lists the preferred drugs within the most commonly prescribed therapeutic categories
- To determine whether the medication you are prescribing under the **medical benefit** requires prior authorization, please refer to the Prior authorization Lookup Tool on the provider website at **https://provider.Wellpoint.com/NJ** under Provider Resources & Documents -> Quick Tools.

6.24 Out-of-Area Coverage

We will provide or arrange for out-of-area coverage of covered benefits in emergency situations and non-emergency situations when travel back to the service area is not possible or practical or when medically necessary services can only be provided elsewhere.

- We're not responsible for out-of-state coverage for routine care if the member resides out of the state for more than 30 days.
- For full-time students attending school and residing out of the country, we're not responsible for health care benefits while the member is in school.
- We're not responsible for services provided outside of the United States or its territories.

In order to provide timely services to patients, when Wellpoint is notified that care is needed for a Medicaid beneficiary in a county where Wellpoint is unable to certify that it meets, or has received a waiver of the network adequacy standards, Wellpoint shall initiate negotiations with non-participating providers of that service, and shall 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 shall be prohibited. Any copayments or other forms of cost sharing imposed on services rendered under this paragraph shall be limited to the maximum amount allowed under State law for the Medicaid program.

7 MEMBERS WITH SPECIAL NEEDS

Adults with special needs include those members with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental, substance use and/or developmental disabilities and persons who are homeless or who are eligible for the MLTSS program or are at risk for nursing home level of care.

Children with special health care needs are those members 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 that required generally by children. This group also includes all children who are MLTSS members and members who are at risk for nursing home placement or who may require other long-term services and supports.

Wellpoint will arrange for the provision of EPSDT services. Wellpoint provides written notification to its members under twenty-one [21] years of age when appropriate periodic assessments or needed services are due and will assist, as required, in coordinating appointments.

Wellpoint will arrange for the provision of appropriate EPSDT services, including:

a) A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit. Procedures are in place for referral to the State or its agent for non-covered mental health/substance abuse services.
b) A comprehensive unclothed physical examination including:
    i) Vision and hearing screening;
    ii) Dental inspection; and
    iii) Nutritional assessment.
c) Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
d) Lead screening using blood lead level determinations will be done for every eligible NJ FamilyCare child.
e) Appropriate laboratory tests: Screening laboratory examinations will be provided. The following list of screening tests is not all inclusive:
    i) Hemoglobin/Hematocrit/EP
    ii) Urinalysis
    iii) Tuberculin test – intradermal, administered annually and when medically indicated
    iv) Lead screening using blood level determinations
        (1) Between the ages of nine [9] and eighteen [18] months, preferably at twelve [12] months of age
        (2) Between the ages of eighteen [18] and twenty-six [26] months, preferably at twenty-four [24] months of age, and
        (3) Between the ages of twenty-seven [27] and up to seventy-two [72] months, not previously tested.
    v) Additional laboratory tests as appropriate and medically indicated (e.g., for ova and parasites).

f) Health education/anticipatory guidance.
g) Referral for further diagnosis and treatment or follow-up of all abnormalities, which are treatable/correctable or require maintenance therapy uncovered or suspected. (Referral may be to the provider conducting the screening examination or to another provider, as appropriate.)
h) EPSDT screening services will reflect the age of the child and be provided periodically according to the American Academy of Pediatrics/Bright Futures' published recommendation or when considered medically necessary.
i) Vision Services - At a minimum, vision screening includes diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment will be done for each child beginning at age three.
j) Dental Services - Dental services will not be limited to emergency services. Dental screening 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 referral to a dentist at one [1] year of age or soon after the eruption of the first primary tooth is mandatory. Therefore there must be, at a minimum, dental visits twice a year with confirmation by the Primary Care Physician during well child visits to ensure that all needed dental preventive and treatment services are provided through age twenty [20] years.
k) Hearing Services - At a minimum, hearing services include diagnosis and treatment for 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 three [3] months of age using professionally recognized audio logical 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 three [3] years of age and older. Speech and hearing assessment will be a part of each preventive visit for an older child.
l) Mental Health/Substance Use Disorder (MH/SUD) - Mental Health/Substance Use Disorder services include a MH/SUD assessment documenting pertinent findings. When there is an indication of possible MH/SUD issues, a MH/SUD screening tool(s) found in Section B.4.9 of the NJ Medicaid Contract Appendices or a DHS-approved equivalent will be used to evaluate the member.
m) Autism Spectrum Disorder: For all members with an Autism Spectrum Disorder (ASD) diagnosis, Wellpoint will provide Applied Behavioral Analysis (ABA), augmentative and alternative communication services and devices, Sensory Integration (SI) services, allied health services (i.e., physical therapy, occupational therapy, and speech therapy), and Development Relationship based services, including, but not limited to, DIR, DIR-Floortime and the Greenspan approach therapy. Wellpoint will make appropriate referrals to the Department of Children and Families (DCF) Children's System of Care (CSOC). CSOC will be responsible for the provision of "Clinical Interventions" and "Skill Acquisition" and "Capacity Building" services that may be beneficial in the treatment of ASD. Wellpoint will work with DCF to ensure individuals with ASD receive the proper, medically necessary services required to treat their ASD diagnosis, which may include making or receiving referrals as well as participation in a CSOC multidisciplinary team meeting to address the individual's needs.
n) Such other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental/substance abuse illnesses and conditions discovered by the screening services.

o) Lead Screening - A lead screening program to assess for the presence of lead toxicity in children will consist of two [2] components: verbal risk assessment and blood lead testing.

For members, including members with special needs, who require dental services to be provided in an operating room or surgical center, (e.g., dental work under anesthesia), our Prior Authorization and/or Care Management team will work with the PCD to obtain the proper clinical information to review the request for medical necessity. The following codes are used for the hospital and anesthesia benefits from Wellpoint.

We allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. To ensure members have access to needed providers, Wellpoint will procure a Single Case Agreement (SCA) with the out of network provider after receiving the prior authorization from medical management.

Services for members with special needs must be provided in a manner responsive to the nature of a person's disability/specific health care need and include adequate time for the provision of the service. Wellpoint honors enrollees' beliefs, is sensitive to cultural diversity, and fosters respect for enrollees' cultural backgrounds.

Reasonable efforts and accommodations to ensure that services provided to members with special needs are equal in quality and accessibility to those provided to all other members. Providers must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Our Nurse HelpLine **833-731-2147 (TTY 711)** is a service available 24 hours a day, 7 days a week, and is designed to support members by offering information and education about medical conditions, health care and prevention after normal physician practice hours. The Nurse HelpLine provides triage and crisis management services and helps direct members to appropriate levels of care. Features of the Nurse HelpLine include the following:

- Information provided is based upon nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing
- Education about appropriate alternatives for handling nonemergent medical conditions
- A nurse will fax the member's assessment report to the provider's office within 24 hours of receipt of calls to the Nurse HelpLine

7.1 Comprehensive Needs Assessment

With the assistance of network providers, we will identify members who are at risk of or have special needs. The identification will include the application of screening procedures (Comprehensive Needs Assessment) for new members. These will include a review of hospital and pharmacy utilization. We will develop care plans that address the member's service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. The care management system is designed to ensure all required services are

furnished on a timely basis and that communication occurs between network and non-network providers (if applicable).

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The planning will be completed within a time frame appropriate to the member's condition, but in no case later than 10 business days from the effective date of enrollment when indicated on the *Plan Selection Form* or within 30 days after special conditions are identified by a provider. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan
- Coordination and follow-through to ensure the member receives the necessary DME if it was ordered prior to the member's enrollment with us and it was not received by the date of enrollment with us

Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns, to be able to converse in the different languages common among the members, and to be able to converse using different means of communication common among the members, including TTY service for the hearing impaired and American Sign Language, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's PCP and may authorize such referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no additional cost to the member.

We have developed methods for:

- **Well-child care:** Includes recommendations around weight assessment, nutrition counseling, physical activity, Pharyngitis testing, immunizations, vaccinations, lead screening, dental visits and doctor visit frequency for children under 15 months old, 3 to 6 years old and adolescents.
- **Health promotion and disease prevention:** Centered on ensuring that members and their families get the health care they need. We accomplish this by managing health benefits such as primary care services, hospital care, specialist referrals, prescriptions, immunizations and wellness checkups. Additional services and programs are also offered such as Taking Care of Baby and Me®, a 24-hour nurse helpline and health education classes. Disease prevention is based on a system of coordinated care management interventions and communications assigned to assist physicians and others in managing members with chronic conditions. This includes a holistic, member-centric approach to condition care, motivational interviewing techniques used in conjunction with member self-empowerment and programs focused on behavioral health conditions, substance use disorders, heart conditions, diabetes, HIV/AIDS, pulmonary conditions and obesity.
- **Specialty care for those who require such care:** Member requiring special care from a doctor, such as a surgeon, OB-GYN or podiatrist, to focus on a certain illness or part of the body).
- Diagnostic and interventional strategies
- Home therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of New Jersey for diagnosis and treatment of rare disorders
- **Continuity of Care:** We allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. To ensure members have access to needed providers, Wellpoint will procure a Single Case Agreement (SCA) with the out of network provider after receiving the prior authorization from medical management.

Referral for eligibility for Managed Long Term Services and Supports

- Wellpoint Care Managers are able to screen and refer members who may need the additional services provided under the Managed Long Term Services and Supports program. The State of New Jersey ultimately determines eligibility for the MLTSS program.
- If the member is a Nursing Facility resident, providers can both receive an authorization and refer the member for enrollment in MLTSS by providing notification of admission by phone to **732-452-6050** or fax to **877-244-1720**.
- Other providers wishing to refer members for the MLTSS program should speak with the member's acute case manager or call the MLTSS Department at **855-661-1996 (TTY 711)**.
- Members self-referring can also call the MLTSS Department at **855-661-1996 (TTY 711)** and state that they are interested in enrolling in the MLTSS program.

If an MLTSS member with special needs requires assistance for a crisis situation after hours, they can call the toll-free number at **855-661-1996 (TTY 711)** and select the option to speak with an associate. The call is then answered by a live representative who will screen the call to determine if it is a crisis situation and if so, the call is warm transferred to the manager on duty.

7.2 Special Needs Dental Services

Liberty Dental Plan administers dentals benefits for our members. We will arrange for the provision of dental services and reimbursement to providers for members with special needs. At a minimum, these include the following:

- Providing oral hygiene instructions, consultations and assistance to the member's caregivers to maintain a member's overall oral health between dental visits.
- In situations where the treating dentist recommends a nonstandard, specialized tooth brush to improve a member's oral hygiene, we include these devices as a benefit.
- 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
- Providing adequate time for members with developmental disabilities; initial and follow-up dental visits may require up to 60 minutes (which includes units of behavior management) on average to allow for a comprehensive dental examination and other services; standards allow for up to four visits annually without prior authorization
- Additional diagnostic, preventive and periodontal services are available beyond the frequency limitations of every six months and are allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration; documentation must include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service
- Providing home visits when medically necessary and where available
- Providing adequate support staff to meet the needs of the members
- Providing for the use and replacement of fixed, as well as removable prosthetic devices as medically necessary and appropriate
- Providing a reimbursement system for the cost of preoperative and postoperative evaluations associated with dental surgery

- Providing a dental management plan
- Coordinating authorizations for dental required hospitalizations by consulting with our dental and medical consultants in an efficient and time-sensitive manner

For members with special health care needs, who are intellectually or developmentally disabled or are under the age of five (5) who require dental services to be provided in an operating room or surgical center, all dental procedures (except anesthesia) should be preauthorized and coordinated by the primary care dentist (PCD), as required, through the normal process with Liberty Dental Plan while all hospital-related charges including anesthesia are provided through the medical plan. These hospital-related charges are automatically approved by Wellpoint in regards to any plan limitations. **Refer to 6.12 Dental Services for additional information**.

7.3 Care management and referral assistance

Wellpoint Care Managers and member services staff are able to support providers in serving members with physical and behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

Wellpoint Care Managers use a holistic, member-centric approach to the care management of members. They coordinate services as required based on information provided via the following:

- Comprehensive Needs Assessment (CNA)
- PCP/Specialist contact
- External Case Workers, such as DCP&P and DDD as needed
- Ongoing revision of the IHCP (Individual Health Care Plan) based on member needs
- Referrals based on member needs upon discharge from in-patient facilities. Care management is initiated and the member is followed to ensure care needs are met

Care managers frequently refer members to services available in the community based on their medical diagnosis, such as diabetes self-management programs, nutritionists/dieticians, education programs being given at local hospitals, etc.

Providers may contact Provider Services for assistance with referrals to providers experienced with servicing enrollees with special needs. Contact Liberty Dental Plan for assistance with dental referrals.

Liberty Dental Plan Directory: **www.libertydentalplan.com/wellpoint**

8 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

Managed Long-Term Services and Supports (MLTSS) is a program for managing long-term care services. Long-term care includes help doing everyday tasks that members may no longer be able to do for themselves as they grow older or if they have a disability. These include bathing, dressing, getting around the home, preparing meals or doing household chores. Long-term care also includes care in a member's own home or in the community that may keep members from having to go to a nursing home for as long as possible. These are called home and community-based services, or HCBS. Long-term care services also include care in a nursing home.

MLTSS Services include:

- Adult Day Health Services
- Adult Family Care
- Assisted Living Services — Assisted Living Residence & Comprehensive Personal Care Home
- Assisted Living Program
- Behavior Management (TBI) (Group & Individual)
- Caregiver/Participant Training
- Chore Service
- Cognitive Therapy (Group & Individual)
- Community Residential Services
- Community Transition Services
- Home Based Supportive Care
- Home Delivered Meals (for individuals 18 years and older)
- Medical Day Services — above the state plan limit
- Medication Dispensing Device
- MLTSS PCA — above the state plan limit
- Non-Medical Transportation
- Nursing Facility Services (Custodial)
- Occupational Therapy (Group & Individual)
- Personal Emergency Response System (for individuals 18 years and older)
- Private Duty Nursing (for individuals over the age of 21)
- Residential Modifications
- Respite
- Social Adult Day Care
- Speech, Language and Hearing Therapy (Group & Individual)
- Structured Day Program
- Supportive Day Services
- Physical Therapy (Group & Individual)
- Vehicle Modifications

To ensure person-centered planning, requests for MLTSS services must be communicated to the member's Care Manager. MLTSS services such as PCA, medical day care, hospital, and other MLTSS services require prior authorization. Providers should fax MLTSS service requests to **888-826-9762**.

8.1 MLTSS Eligibility Requirements

The State of New Jersey ultimately determines eligibility for the MLTSS program. Members utilizing 15 or more hours of personal care assistance (PCA) a week or attending as an Adult Medical Day Care program are potentially MLTSS eligible.

Wellpoint care managers are able to screen and refer members that may need the additional services provided under the Managed Long-Term Services and Supports program. The individual will then be contacted by a staff member of our Enrollment Team to schedule a visit.

If the member is a nursing facility resident, providers can both receive an authorization and refer the member for enrollment in MLTSS by providing notification of admission by phone to **732-452-6050** or by fax to **877-244-1720**. Other providers wishing to refer members for the MLTSS program should speak with the member's acute care manager or call the MLTSS Department at **855-661-1996 (TTY 711)**. Members may also self-refer by calling the MLTSS Department at **855-661-1996 (TTY 711)**.

An existing Wellpoint member can qualify for Managed Long Term Services and Supports (MLTSS) by meeting these established Medicaid requirements:

- **Financial requirements:** These include confirming monthly income, as well as total liquid assets. For detailed financial eligibility information, please visit **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/abd**.
- **Clinical eligibility:** A person meets the qualifications for nursing home level of care, which means that he/she requires limited assistance with a minimum of three activities of daily living (ADL) such as bathing, toileting and mobility or the consumer has cognitive deficits and ADL needs of supervision in greater than three ADL areas.
- **Age and/or disability requirements:** These involve age requirements whereby one must be 65 years or older; and/or disability requirements whereby one must be under 65 years of age and determined to be blind or disabled by the Social Security Administration or the State of New Jersey.

It is our MLTSS members' responsibility for working with those providing health care services to:

- Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the health plan's care manager in order to identify care needs and develop of a plan of care.
- Understand their health care needs and work with the care manager to develop or change goals and services.
- Work with the care manager to develop and/or revise the plan of care to facilitate timely authorization and implementation of services.
- Ask questions when additional understanding is needed.
- Understand the risks associated with decisions about care.
- Report any significant changes on their health condition, medication, circumstances, living arrangements, informal and formal supports to the care manager.
- Notify the care manager should any problem occur or if they are dissatisfied with the services being provided.
- Follow health plan rules and /or those rules of Institutional or residential settings (including any applicable cost share).

8.2 MLTSS Patient Pay Liability

The Division of Medical Assistance and Health Services (DMAHS), through the County Welfare Agency (CWA), is in charge of making decisions about patient pay liability. DMAHS will tell Wellpoint about any patient pay liability amounts owed. Except for cost-sharing and patient pay liability, Wellpoint will make sure members don't pay for services they are not responsible for.

Collection of Patient Pay Liability

If members have pay liability amounts that they owe, here is how it will be collected:

- For members who live in nursing facilities (NFs), special care nursing facilities (SCNFs) or community-based residential alternatives, Wellpoint will have the providers in these facilities collect patient pay liability.
- Wellpoint will pay these facilities the balance of the amount that applies.
- The patient pay liability amount applied to the claim will be shown on your Explanation of Payment.

Nonpayment of Patient Pay Liability

Upon notice from the nursing facility/community-based residential provider that the patient pay liability has not been paid, the Care Manager will help by:

- Looking at the efforts made by nursing facility/community-based residential provider to collect the patient pay liability and documenting this in a member's electronic medical record
- Stressing the importance of paying the patient pay liability and what happens if the member does not, including letting the Office of Community Choice Options know if the provider wants to pursue an Involuntary Transfer and documenting this in a member's case file

Upon notice from the nursing facility/community-based residential provider that the facility/provider is thinking about an Involuntary Discharge (per NJAC 8:85) due to nonpayment, the Care Manager will work to find an another nursing facility/residential provider for. These efforts will be documented in the member's case file. If a member is in a NF or SCNF and the Care Manager can't find another NF/SCNF for, the Care Manager will:

- Determine if needs can safely and cost-effectively be met in the community by doing a transition assessment
- Find out if the provider is willing to continue serving a member who has failed to pay his or her patient pay liability

If a member lives in Assisted Living or Adult Family Care and the Care Manager can't find an alternate community-based residential provider that will serve the member, Wellpoint will submit a request to DMAHS for guidance**.**

8.3 MLTSS Care Management

Our MLTSS Care Management model promotes cross-functional collaboration in the development of a member's Plan of Care. Members enrolled in MLTSS receive service coordination and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. MLTSS nurses and Care Managers accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, provider, caregiver and natural supports.

Since many Wellpoint members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of

life and functionality of members and to make efficient use of available healthcare and community-based resources.

The scope of the MLTSS Care Management Model includes but is not limited to:

- Initial and ongoing assessment identifying the needs of member populations and relevant subpopulations.
- Annual reassessments to identify any change in member's status and potential modifications to the Plan of Care. Problem-based, comprehensive service planning to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and reassessments.
- Coordination of care with PCPs and specialty providers.
- A service coordination approach that is "member-centric" and provide support, access, and education along the continuum of care.
- A Plan of Care that is personalized to meet a member's specific needs and identifies:
    - Prioritized goals.
    - Time frames for re-evaluation.
    - Resources to be utilized including the appropriate level of care.
    - Planning for continuity of care and family participation.
- Obtaining member/family/caregiver input and level of participation in the creation of a Plan of Care which includes the development of self-management strategies to increase the likelihood of improved health and outcomes.

Discharge to the Community

Wellpoint assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests. If the member or responsible party requests a discharge to the community, the MLTSS Care Manager will:

- Collaborate with the facility Social Worker to convene a planning conference with the nursing facility/special care nursing facility staff to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge.
- Convene a discharge planning meeting with the member and family, using the data complied through discussion with the nursing facility/special care nursing facility staff as well as home visit, to identify member preferences and goals.
- Involve and collaborate with community originations such as Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community.

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the nursing facility/special care nursing facility and the Wellpoint MLTSS Care Manager.

8.4 Money Follows the Person

The Money Follows the Person (MFP) demonstration program not only allows residents to receive Home- and Community-Based Services (HCBS) in the community but also enhanced services that allow for

payment of rent and utility deposits and reasonable expenses to re-establish a residence in lieu of continued institutional care.

Additional information about the program can be found on the New Jersey Department of Human Services Division of Developmental Disabilities website at:
http://www.state.nj.us/humanservices/ddd/programs/olmstead/mfp.html.

MFP funding is available to members who meet the functional criteria for one of the following HCBS waivers:

- Frail Elderly
- Physically Disabled
- Traumatic Brain Injury

To be eligible for this program, a member must meet the following criteria:

- Be a current resident of a nursing facility (NF) with a 90-day continuous stay (The 90 days **cannot** include Medicare skilled rehabilitation days.)
- Be Medicaid-eligible 30 days prior to receiving MFP services
- Meet the clinical level of care eligibility for the MLTSS program
- Have an interest in transitioning back into the community

All MFP services require prior authorization (PA) through the Plan of Care (POC) process.

Some Services Offered Under the MFP Demonstration
In addition to the above services, the MFP demonstration has additional services and funding available to address barriers to successful transition of individuals to community based settings rather than institutional settings (not a complete list):

- Transition services
- Transition Coordination Service
- Therapeutic Support (TBI only)
- Options Counseling for Community Transitions

8.5 Critical Incident Reporting and Management

We have a critical incident reporting and management system for incidents that occur in a home and community-based long term care services and supports delivery setting.

We will identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. We will regularly:

- Review the number and types of incidents (including, for example, the number and type of incidents across settings, providers and provider types).
- Review the findings from investigations (including findings from APS and CPS if available).
- Identify trends and patterns.
- Identify opportunities for improvement.
- Develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS.

Critical incidents include the following incidents when they occur in a home- and community-based setting:

- Unexpected death of a member
- Media Involvement or the potential for media involvement
- Physical abuse (including seclusion and restraints both physical and chemical)
- Psychological/verbal abuse
- Sexual abuse and/or suspected sexual abuse
- Fall resulting in the need for medical treatment
- Medical emergency resulting in need for medical treatment
- Medication error resulting in serious consequences
- Psychiatric emergency resulting in the need for medical treatment
- Severe injury resulting in the need from medical treatment
- Suicide attempt resulting in need for medical attention
- 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
- Failure of member's back-up plan
- Elopement/wandering from home or facility
- Inaccessible for initial/on-site meeting
- Unable to contact
- Inappropriate or unprofessional conduct by a provider involving member
- Cancellation of utilities
- Eviction/loss of home
- Facility closure, with direct impact to member's health and welfare
- Natural disaster, with direct impact to member's health and welfare
- Operational breakdown
- Other

Providers must report critical incidents to Wellpoint in accordance with applicable requirements. The maximum time frame for reporting an incident to Wellpoint is 24 hours. The initial report of an incident within 24 hours may be submitted orally, in which case the person/agency/entity making the initial report will submit a follow-up written report within 48 hours.

Providers must immediately (i.e., within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

MLTSS providers with a critical incident must conduct an internal critical incident investigation and must submit a report on the investigation. The time frame for submitting the report on the investigation:

- Must be as soon as possible.
- May be based on the severity of the incident.
- Will be no more than 30 days after the date of the incident except under extenuating circumstances.

Wellpoint will review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Providers must cooperate with any investigation conducted by Wellpoint or outside agencies (e.g., Department of Human Services, Adult Protective Services, Child Protective Services and law enforcement).

For members participating in self-directed services, we will:

- Review all of the Fiscal Intermediary's (FI) reports regarding investigations of critical incidents and follow-up with the FI as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.
- Provide appropriate training and take corrective action as needed to ensure staff, contract HCBS providers, the FI-EA and workers comply with critical incident requirements.
- Conduct oversight, including oversight of staff, contract HCBS providers and the FI-EA to ensure the Wellpoint policies and procedures are being followed and necessary follow-up is being conducted in a timely manner.

Unable to Contact

Wellpoint requires that all MLTSS providers develop and implement a policy and process for addressing situations where the provider and its staff are unable to contact a member. "**Unable to contact**" shall be defined as an MLTSS member who is absent, without notification, from any program or service offered under MLTSS and Wellpoint, its staff members, including Care Managers, or its contracted MLTSS providers are unable to identify the location of the Member using contact information available in the member's Care Management record. If an MLTSS member is unable to be contacted for 30 days or more, that member will then be disenrolled from the MLTSS program.

8.6 Personal Care Assistants

Personal care assistant (PCA) services, including personal care, household duties and health-related tasks, are available from a home health agency or homemaker agency to accommodate long-term chronic or maintenance health care. This also includes services for members with mental illnesses. Not all members are eligible for PCA services.

Pursuant to legislation *P.L. 2017, c.237, 1*, the Medicaid managed care reimbursement rate for personal care services must be at least the minimum state Medicaid FFS hourly rate established by law as of July 1, 2018. Funds received as a result of this increased rate **must be used exclusively** for salary increases for workers who directly provide personal care services. Providers of PCA services are required to submit an annual report detailing the use of the increased reimbursement to DMAHS.

8.7 Medical Day Care

Adult Day health services (ADHS) provide medically necessary services in an ambulatory care setting for individuals who don't live in a facility but require such services to support their community living due to physical and/or cognitive impairment.

Pediatric medical day care (PMDC) provide medically necessary services in an ambulatory care setting for children who reside in the community and require continuous care because their needs cannot be met in a regular day care or preschool program for the handicapped.

9 MEMBER RIGHTS AND RESPONSIBILITIES

9.1 Member Rights and Responsibilities

Members have a right to:

1. Obtain a current directory of doctors within the Wellpoint network including addresses, telephone numbers and a list of providers accepting members who speak languages other than English.
2. Choose any of the Wellpoint network specialists.
3. Be referred by the PCP to a specialist who has treated chronic disabilities.
4. Be able to get in contact with the PCP or a backup PCP 24 hours a day, 365 days a year for urgent care.
5. Call **911** without getting an approval from Wellpoint for an emergency medical condition.
6. Discuss with their doctors medical treatments they can have, even if not covered, as well as information on other care options.
7. File a grievance or appeal with Wellpoint or the State without penalty.
8. Be treated with respect and recognition of their dignity and right to privacy.
9. Have information about Wellpoint services, policies and procedures, network providers, member rights and responsibilities, and any changes made.
10. Refuse treatment to the extent of the law and be aware of the results. This includes the right to refuse
    to be a part of research.
11. Have an advance directive in effect.
12. Expect confidentiality of their records and communications.
13. Choose a PCP in the Wellpoint network, choose a new network PCP and have privacy when seeing the provider.
14. Have a choice of specialists and information on how to obtain referral to a specialist or other provider.
15. Have their medical information given to a person of their choice, or to a person who is legally authorized, when concern for their health makes it inadvisable to give such information to them.
16. Assistance from an interpreter or TTY line.
17. Be free from being billed by providers for covered services that are medically necessary and were authorized by Wellpoint unless there is a copay.
18. Offer suggestions for changes in the way Wellpoint does business.
19. Be free of hazardous procedures.
20. Be fully informed by the PCP, care/case manager or other Wellpoint network providers and help make decisions about their health care.
21. Take part in developing and implementing a plan of care that promotes the best results and encourages independence.
22. Have services that promote quality of life and independence. Wellpoint wants to help keep and encourage their natural support systems.
23. Have your PCP decide if your benefits are medically necessary and should be covered.
24. Voice grievances or appeals about Wellpoint or the care provided, and recommend changes to policies and services to Wellpoint staff, providers and outside representatives of their choice free of limits, interference, force, discrimination or attack by Wellpoint or Wellpoint providers.

Wellpoint will not discriminate against an enrollee or attempt to disenroll a member for filing a complaint or grievance/appeal against the HMO.
25. Refuse care from specific providers.
26. Have access to their medical records in accordance with federal and state laws.
27. Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse, or neglect.
28. Make recommendations regarding the member rights and responsibilities policy.
29. Receive a second opinion.

Members have a right to get information each year on:
1. Member rights and responsibilities.
2. Wellpoint benefits and services and how to obtain them.
3. Provisions for after-hours and emergency coverage.
4. Charges to members, if charges apply, including paying charges, copays and fees, and the process if a bill is received.
5. Termination of or changes in benefits, services, health care facilities or providers.
6. How to appeal decisions that affect their coverage, benefits or relationship with Wellpoint.
7. How to change PCPs.
8. How to disenroll from Wellpoint.
9. How to file a complaint or grievance and how to recommend changes.
10. The percentage of Wellpoint network providers who are board-certified.
11. A description of how to get services, including authorization requirements, special benefit rules that may apply to services out-of-network, services covered by fee-for-service Medicaid, and out-of-area coverage and policies on referrals for specialty and ancillary care.

Members have a responsibility to:
1. Inform the family doctor after getting emergency treatment.
2. Treat their doctors, staffs and Wellpoint employees with respect and dignity.
3. Get information and consider treatments prior to receiving them.
4. Discuss any problems with their doctor's directions.
5. Know what refusing treatment recommended by a doctor can mean.
6. Assist the current family doctor in obtaining medical records from their previous doctor and assist the current doctor in completing the new record.
7. Get permission from the family doctor or the doctor's associates before seeing a consultant or specialist.
8. Call Wellpoint and change the doctor before seeing a new doctor.
9. Keep following Wellpoint policies and procedures until disenrolled with Wellpoint.
10. Make and keep appointments, be timely and call if needing to cancel an appointment or are late for an appointment.
11. State grievances, concerns and opinions in an appropriate and courteous way.
12. Learn and follow the policies and procedures outlined in the Member Handbook.
13. Supply information, to the extent possible, that the organization and its providers need to provide care. Become involved in their health care, work with the doctor about recommended treatment, and follow the plans and instructions for care agreed upon with the provider.
14. Carry the Medicaid and Wellpoint ID cards at all times. Inform Wellpoint if cards are lost or stolen, if ID card information is incorrect, or if there are changes in name or address.

15. Provide, to the extent possible, information needed by Wellpoint, the doctor and professional staff involving their care including the names of any doctors they are currently seeing.
16. Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

It is the member's responsibility to keep their address and phone number information current so that Wellpoint can send updated information or contact the member.

9.2 MLTSS Member Rights and Responsibilities

In addition to the above, the MLTSS program, offered by Wellpoint in New Jersey, has additional member rights, which include the following:

1. To request and receive information on choice of services available.
2. Have access to and choice of qualified service providers.
3. Be informed of your rights prior to receiving chosen and approved services.
4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability.
5. Have access to appropriate services that support your health and welfare.
6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made.
7. To make decisions concerning your care needs.
8. Participate in the development of and changes to the plan of care.
9. Request changes in services at any time, including add, increase, decrease or discontinue.
10. Request and receive from your care manager a list of names and duties of any person(s) assigned to provide services under the plan of care.
11. Receive support and direction from your care manager to resolve concerns about your care needs and/or grievances about services or providers.
12. Be informed of, and receive in writing, facility specific resident rights upon admission to an institutional or residential setting.
13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the institutional or residentialal setting and any charges not covered by the managed care plan while in the facility.
14. Not be transferred or discharged out of a facility, except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or, because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment.
15. Have your health plan protect and promote your ability to exercise all rights identified in this document.
16. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian.

Wellpoint's MLTSS Program, has additional Member Responsibilities which include the following Member Responsibilities:

1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care;
2. Understand your health care needs and work with your Care Manager to develop or change goals and services;
3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services;
4. Ask questions when additional understanding is needed;
5. Understand the risks associated with your decisions about care;
6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager;
7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and
8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).
9. Notify your assigned Care Manager if there are any gaps in services/care
10. Let your family doctor know as soon as you can after you get emergency treatment
11. Talk about any problems about following your provider's directions
12. Know what saying no to treatment recommended by a provider means
13. Carry your HBID, Medicare and Wellpoint NJ FamilyCare ID card at all times
14. Report any lost or stolen cards to Wellpoint as soon as you can
15. Call Wellpoint if information on your ID card is wrong or if you have changes in name or address
16. Report any changes to your address and phone number by calling the Medicaid Hotline at **800-356-1561 (TTY 877-294-4356)**. If you have NJ FamilyCare, call **800 701-0710 (TTY 800-701-0720)**.
17. Complete the NJ FamilyCare renewal process every year to ensure you keep your NJ FamilyCare benefits.
18. And remember, it's your job to keep your address and phone number current so we can send you updated information or contact you.

9.3 Member Grievance Procedure

Members (or provider, with the member's written consent) have the right to voice dissatisfaction of any aspect of the Wellpoint or a provider's operations and may file a grievance by fax, mail, in-person or by telephone to Member Services at **833-731-2147 (TTY 711)**. **Member Handbook Wellpoint (my.wellpoint.com)** A grievance may be filed for any cause other than adverse medical management action or interpretation of medically necessary benefits to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of Wellpoint which impair the quality, timeliness or availability of such benefits. A member will not be penalized by Wellpoint or by its providers for filing a grievance. At no time will Wellpoint cease care pending a grievance investigation. Member grievances are kept confidential to the extent permissible under federal or state laws, regulations and/or contractual requirements. The mailing address for medical and dental grievances is:

Grievance/Appeals Representative

Wellpoint
101 Wood Ave. South, Suite 800
Iselin, NJ 08830
Phone: 800-452-7101 (TTY 711)
Fax: 877-271-2409

A member may receive assistance from the State with a grievance by writing to the following address:

NJ Medicaid/NJ FamilyCare
P.O. Box 712
Trenton, NJ 08625-0712

Please note that providers cannot file a grievance on behalf of a member unless the member has granted the provider written permission to act as his or her personal representative.

The member has the right to file a grievance in their language. If they ask, we'll tell them in their primary
language of their rights to file grievances and will give the decision in their primary language. If they need help filing a grievance in their language, call Member Services at 833-731-2147 (TTY 711). In handling grievances and appeals, Wellpoint will provide enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Level I Grievance Review
Upon receipt of a Level I grievance, supporting documentation may be requested by Wellpoint. This may include consultation with the member and/or providers, review of medical records, or other relevant documents and discussions with other persons having knowledge of the issue. A Level I grievance acknowledgement letter will be sent to the member within five business days of the initiation of the grievance. A resolution letter will be sent to the member and provider if the provider requests the grievance on the member's behalf within 30 calendar days from the time of the initiation of the grievance. Also, the member will be notified in writing of his or her right to a Level II grievance review.

Level II Grievance Review

If the member (or provider with the member's written consent) expresses dissatisfaction with the Level I grievance resolution, he or she can request a Level II grievance review within 60 days of the date of the Level I grievance resolution letter.

A Grievance Acknowledgement Letter will be sent to the member within five business days of the initiation of the Level II grievance. The Quality Management associate will consult with pertinent department heads (QM, Provider Services, and Medical Director) and members of senior staff that were not involved in the review or decision of the original grievance as necessary to address the member's concern.

A Level II grievance resolution letter will be sent to the member and provider, if the provider requests the grievance on the member's behalf, within 30 calendar days from receipt of the Level II grievance.

Grievance Tracking and Reporting

Grievances will be tracked and trended by the Quality Management department and kept readily available for state inspection. Records will include, but information is not limited to:

- The date the grievance was filed
- The dates and outcomes of all actions and findings
- The date and decision of any grievance proceeding
- The dates and proceedings of any litigation
- All letters and documentation submitted regarding the grievance

10 MEMBER MANAGEMENT SUPPORT

10.1 Welcome Call

We give new members a welcome call to educate them about our services, help them schedule initial checkups, and identify any health issues (e.g., pregnancy or previously diagnosed diseases).

10.2 Nurse HelpLine

Our Nurse HelpLine **833-731-2147 (TTY 711)** is a service available 24 hours a day, 7 days a week, and is designed to support members by offering information and education about medical conditions, health care and prevention after normal physician practice hours. The Nurse HelpLine provides triage and crisis management services and helps direct members to appropriate levels of care. Features of the Nurse HelpLine include the following:

- Information provided is based upon nationally recognized and accepted guidelines
- Free translation services for 170 different languages and for members with difficulty hearing
- Education about appropriate alternatives for handling nonemergent medical conditions
- A nurse will fax the member's assessment report to the provider's office within 24 hours of receipt of calls to the Nurse HelpLine

10.3 Communication Access

Our policy is designed to ensure meaningful access to health care services for members with Limited-English Proficiency (LEP) and supports members with LEP to overcome language barriers and fully use services and benefits.

Upon request, written member materials are available in Braille, in large print, on tape and in languages other than English. Member materials are written at the appropriate reading level.

Language assistance options are available at no cost to the member or provider. Providers are required to offer interpretive services to members who may require services, document the offer and the member's response, and advise members that interpretive services are available at no cost to the member.

Family members, especially minor children, should not be used as interpreters in assessments, therapy or other medical situations in which impartiality and confidentiality are critical, unless specifically requested by the member. The provider should help the member to use a nonfamilial interpreter and should help the member understand his or her concerns regarding the use of minor children as interpreters, even at the member's request.

Interpreter services are available if needed. Over-the-telephone interpreter services are available 24 hours a day, 7 days a week. For immediate needs, we have Spanish language interpreters available

without delay and can provide access to interpreters of other languages within minutes. Please call our Member Services department at **833-731-2147 (TTY 711)** to access an interpreter. For in-office interpreter services, call our Provider Services line at **833-731-2149** to arrange for the service.

For members who are deaf or hard of hearing, we can also help you telephonically communicate with them via a translation device. Call **TTY 711**. Also, in-office sign language assistance is available. Call Member Services at **833-731-2147** to arrange for the service.

Below are a few guidelines that may result in better communication when using an interpreter:

- Keep your sentences short and concise; the longer and more complex your sentences, the less accurate the interpretation
- Avoid use of medical terminology when possible, which is unlikely to translate well
- Ask key questions in several different ways; this increases the chance you'll get a response to exactly what you need to know
- Be sensitive to potential member embarrassment, reticence or confusion; It is possible your questions or statements were not understood
- Ask the member to repeat the instructions you have given as this is an effective review of how well the member has understood what you told them

10.4 Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Wellpoint wants to help, as we all work together to achieve health equity.
The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.
Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.

- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Wellpoint encourages providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice- Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Wellpoint requires and provides training on cultural competence, including tribal awareness, to behavioral health network providers for a minimum of three hours per year and as directed by the needs assessments.

In addition, Providers should attempt to collect member demographic data, including but not limited to, ethnicity, race, gender, sexual orientation, and religion. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Wellpoint appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

10.5 Health Promotion

We strive to encourage healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members; health education classes are coordinated with Wellpoint-contracted community organizations and network providers.

We manage projects that offer our members education and information regarding their health including:

- Our annual member newsletter
- Creation and distribution of Ameritips, our health education tools used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- A monthly calendar of health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations, faith-based organizations, schools, local businesses, special needs organizations and health centers to enhance opportunities for members

10.6 Wellpoint in the Community

We're a community-focused managed health care company that works to improve the lives of uninsured and low-income parents, children and persons with disabilities. Through our NJ FamilyCare managed care programs, we ensure access to quality health care for those who otherwise might go without medical coverage. We work with respected, community-based organizations to sponsor outreach events across the service area including:

- Sponsoring summer technology camps for youth
- Holding free Summer Family Fun Nights to help strengthen family bonds
- Providing free hats and mittens to keep children warm in the winter
- Offering a free, safe, violence-free and fun environment for local teens to learn life skills, job training, and alcohol and drug prevention
- Supporting the health of elderly community members
- Curtailing the effects diabetes and asthma have on our community's people through education and support
- Providing health education workshops in the community on a variety of topics to children, parents and staff members.

Head Start is a national program that provides comprehensive developmental services for preschool children ages 3-5 years from low-income families and under the Early Head Start program for infants,

toddlers and pregnant women. We collaborate with the community Head Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

We work collaboratively with School-based Youth Service Programs and Local Health Departments to provide health education workshops on a variety of topics including adolescent health, nutrition, conflict resolution, personal hygiene, and healthy relationships. The School-based Youth Services Program (SBYSP), developed by the New Jersey Department of Human Services, provides adolescents and children primarily between ages 13-19, many of whom are at risk of dropping out of school, becoming pregnant, using drugs, developing mental illness, being unemployed, or are most at risk of being dependent for long periods on state-assistance programs with the opportunity to complete their education, to obtain skills that lead to employment or additional education, and to lead a mentally and physically healthy life.

We strive to contribute to the community's overall quality of life for substantial and long-lasting impact by forming networks in which community organizations, health care professionals and community members work together.

10.7 Health Education Advisory Committee

The Health Education Advisory Committee develops outreach programs and provides advice to our members regarding health education. The committee strives to ensure materials and programs meet cultural competency requirements, are understandable to the member and address the member's health education needs.

The Health Education Advisory Committee's responsibilities are to:

- Identify health education needs of the membership based on review of demographic and epidemiologic data
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program
- Review the health education plan and make recommendations on health education strategies
- Identify barriers to obtaining appropriate health care services and develop ways to address those barriers

10.8 Care Management

Care Management is a comprehensive set of member-centered, goal-oriented, culturally relevant, and logical steps to assure that members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Management emphasizes prevention and early identification of members who have or may have special needs, assessment of risk factors, development of a plan of care, referral assistance and coordination and continuity of care to advocate for and link members to timely medical, social, residential and other support services as necessary.

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. Care Managers are available during normal business hours from 8 a.m.-5 p.m. ET at 1 is **800-452-7101** or **732-452-6000** ext. **106-134-2111**. For urgent issues, assistance is available after normal business hours, on weekends and on holidays through Provider Services at **833-731-2149**.

We encourage providers to refer members to us that may potentially be appropriate for comprehensive Care Management.

Once we have identified a member's needs, our nurse will work with the member and the member's PCP to identify the:

- Level of Care Management needed
- Appropriate alternate settings to deliver care
- Equipment and/or supplies and health care services
- Community-based services

For members who are hospitalized, our nurse Care Managers will also work with the member, the Utilization Review team, and PCP or hospital to develop a discharge plan of care and link the member to community resources, outpatient programs and our Condition Care team.

Assessment and Plan of Care

The Care Manager will conduct a comprehensive assessment through communication with members or members' representatives and information from PCPs and specialists to determine current medical and non-medical needs by evaluating:

- Medical condition, functional status, emotional status, and ability for self-care
- Previous pregnancy history and current pregnancy status
- Current treatment plan and goals
- Life environment and support systems

After the assessment 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; and coordinate medical and nonmedical services, including social, educational, and therapeutic services and other nonmedical support services, such as personal care, WIC and transportation.

Our Care Manager nurses collaborate with social workers and coordinate with member advocates or outreach associates to coordinate physical, behavioral health, pregnancy and social services. We forward all written care plans to you by fax or mail.

10.9 Condition Care Programs

Our Condition Care (CNDC) services are based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. CNDC services include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing

techniques used in conjunction with member self-empowerment, and the ability to manage more than one condition to meet the changing health care needs of member population. Our condition care programs include:

- Asthma
- Bipolar disorder
- Chronic Obstructive Pulmonary Disorder (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive disorder — Adult
- Major Depressive Disorder — Child and Adolescent
- Schizophrenia
- Substance Abuse Disorder

In addition to our condition-specific disease management programs, our approach also allows us to assist members with smoking cessation and weight management education.

Program Features

- Proactive population identification process
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Condition care clinical practice guidelines are located at **https://provider.Wellpoint.com/NJ**.

Who Is Eligible?
Members diagnosed with one or more of the above listed conditions are eligible for Condition care services.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/monitoring as well as case/care management for high-risk members.. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care Provider Rights and Responsibilities
You have the right to:

- Have information about Wellpoint, including:
  - Provided programs and services
  - Our staff
  - Our staff's qualifications

  - Any contractual relationships
- Decline to participate in or work with programs and services for your patients.
- Be informed of how we coordinate interventions with your patients' treatment plans
- Know how to contact the and communicates with your patient
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about CNDC as outlined in the Wellpoint provider complaint and grievance procedure

Contact Information

You can email us at Condition-Care-Provider-Referrals@Wellpoint.com or call a CNDC team member at **888-830-4300,** Monday-Friday 8:30 a.m. to 5:30 p.m. Confidential voicemail is available 24 hours a day.. Refer to our provider website for additional information about CNDC **https://provider.Wellpoint.com/NJ.**

10.10 Missed Appointments

Our members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. We require providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

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. In these cases, please call Provider Services at our National Customer Care Department at **833-731-2149** to address the situation. Our staff will contact the member and provide more extensive education and/or case/care management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

10.11 Noncompliant Members

We recognize providers may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation or completion, or making or appearing for appointments, please contact Provider Services at **833-731-2149**. 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.

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 he or she is being removed from the provider's panel. To remove a member from your panel, you must send a certified letter to the member or head of household and indicate that the

member must select a new provider within 30 days of the notice. You must continue to provide care until the effective date for assignment to the new PCP. A copy of the letter must be sent to:

Wellpoint
101 Wood Ave. South, 8th Floor
Iselin, NJ 08830

In extreme situations in which a member consistently refuses to cooperate with Wellpoint and/or network providers, we may request DMAHS to 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.

Members may be disenrolled in any of the following circumstances:

- We determine the willful actions of the member are inconsistent with membership in our plan, and we have made and provided DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude a member's right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for nonemergency care, willful refusal to comply with reasonable administrative policies of Wellpoint, fraud, or making a material misrepresentation to Wellpoint. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socioeconomic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs.
- We become aware the member has become ineligible for enrollment or has moved to a residence outside of the covered enrollment area.
- We learn the member is residing outside the state of New Jersey for more than 30 days. This does not apply to situations when the member is receiving out-of-state care provided and/or authorized by Wellpoint. This does not apply to full-time students.

Prior to recommending disenrollment of a member, we will make a reasonable effort to identify for the member those actions that have interfered with effective provision of covered medical care and services and to explain what actions or procedures are acceptable. We must allow the member sufficient opportunity to comply with acceptable procedures prior to recommending disenrollment. We will provide at least one oral and at least one written warning to the member regarding the implications of his or her actions. An authorized person may be able to act on behalf of a member in the above situations.

If the member fails to comply with acceptable procedures, we will give at least 30 days' prior written notice to the member of our intent to recommend disenrollment. The notice will include a written explanation of the reason we intend to request disenrollment and will advise the member of his or her right to file a disenrollment grievance. We will give DMAHS a copy of the notice and advise DMAHS immediately if the member files a disenrollment grievance. An authorized person may be able to act on behalf of a member in the above situations.

Wellpoint and its network providers will not request a member's disenrollment based on an adverse change in the member's health status or utilization of services which are medically necessary for treatment of a member's condition.

11 UTILIZATION MANAGEMENT

11.1 Medical Review Criteria

Wellpoint uses nationally recognized medical policy process. MCG Criteria (Milliman Care Guidelines) is used only for medical necessity review for medical inpatient concurrent review, and inpatient site of service appropriateness. McKesson InterQual criteria is used for post-acute admissions. Wellpoint Medical Policy is used for home health services and Carelon Rehab: Outpatient Rehabilitative and Habilitative Services criteria are used for outpatient rehabilitation. Since July 1, 2018, MCG Criteria (Milliman Care Guidelines) are used for all behavioral health reviews related to mental health, and American Society of Addiction Medicine (ASAM) criteria are used for all levels of care related to substance use disorder. Wellpoint Behavioral Health Medical Necessity Criteria is used for autism services such as Applied Behavioral Analysis (ABA) and Development Services (DIR).

Medical Policies are available on the provider website at **https://provider.Wellpoint.com/NJ** under Provider Resources & Documents > Quick Tools and should be reviewed to determine benefit plan policies for whether services are considered to be medically necessary, investigational/experimental, or cosmetic/reconstructive. They can also be obtained in hard copy by request. Our utilization reviewers use these criteria as part of the prior authorization of scheduled admission, concurrent review and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization. Additionally, these policies will support claims edits and retrospective review.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in some cases, state Medicaid contracts or CMS requirements will supersede other medical policy criteria listed above. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

11.2 Prior authorization/Notification Process

Prior authorization is defined as the **prospective** process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

Please refer to the *Prior Authorization Lookup Tool*, *Medical Policies and Clinical UM Guidelines*, and *Pharmacy Information* sections of the provider website at **https://provider.Wellpoint.com/NJ** for requirements. Members are not covered for the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

Wellpoint Digital prior authorizations using Interactive Care Reviewer (ICR) on Availity.com is the preferred method for submitting preauthorization requests. Digital prior authorization submissions are the most efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for Wellpoint members.

- **Initiate preauthorization requests online**, eliminating the need to fax or call. Submit detailed text, photo images, and attachments along with your digital request through ICR.
- **Make inquiries** about requests previously submitted, even if they were not digitally submitted through ICR.
- **Instant accessibility**, including after business hours.
- **Utilize the dashboard** for a complete view of all requests with real-time status updates. Receive email notifications when requested using a valid email address.
- **Real-time results** for some common procedures, with immediate decisions.

Access ICR under Authorizations and Referrals via the secure online provider portal https://www.availity.com. For an optimal experience with Wellpoint ICR, use a browser that supports 128-bit encryption such as Internet Explorer 11, Chrome, Firefox or Safari. Additionally, providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or other online tool). Please note that ICR is not currently available to request transplant services or services administered by vendors such as AIM Specialty Health and OrthoNet LLC.

Wellpoint continues to accept requests received by phone **833-731-2149 or fax. The required clinical information should be included with the submission. Fax forms are available on the provider website** https://provider.**Wellpoint**.com/NJ **under *Resources: Forms*.** For prior authorizations requiring additional time for review, call **800-452-7101** or **732-452-6000, ext. 106-134-2111**, Monday- Friday from 8 a.m.-5 p.m.

Wellpoint continues to accept requested received by phone **833-731-2149 or fax. Required clinical information should be included in the submission. Fax forms are available on the provider website https://provider.Wellpoint.com/NJ under *Resources: Forms*.** For questions regarding services that require prior authorization, please call **800-452-7101** or **732-452-6000, ext. 106-134-2111**, Monday-Friday from 8 a.m.-5 p.m.

11.3 Emergent Admission Notification Requirements

Network hospitals must notify us about emergent admissions within one business day by calling **833-731-2149**. Our Medical Management staff will verify eligibility and determine benefit coverage.

Prior notification is defined as, prior to rendering covered medical services to a member, the provider must notify Wellpoint by telephone, fax or the provider website of the intent to do so. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. In some instances (e.g., like emergency visits), providers should notify Wellpoint within 24 hours of the visit.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets MCG Criteria, an Wellpoint reference number will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, we will notify the hospital to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member's PCP and member.

11.4 Non-emergent Inpatient, Outpatient and Ancillary Services

We require prior authorization of all **inpatient elective admissions**. The referring primary care or specialist physician is responsible for prior authorization. Requests for prior authorization with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial. The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at **833-731-2149**. If coverage of an admission has not been approved, the facility should call us at **833-731-2149**. We will contact the referring physician directly to resolve the issue.

We require prior authorization for coverage of selected **non-emergent outpatient and ancillary services** (see chart) when performed by a participating provider. All non-emergent outpatient and ancillary services referred to a nonparticipating provider require prior authorization by the referring provider.

Some specialty services require prior authorization. Wellpoint encourages members to consult with their PCPs prior to accessing non-emergency specialty services.

11.5 Utilization Management Decision Making

Wellpoint as a corporation and individual persons involved in UM decisions are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage
- We do not specifically reward practitioners or other individuals for issuing denial of coverage or care; decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service
- All final decisions regarding denials of referrals, PAs, treatment and treatment plans for nonemergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services

Prior authorization determinations
Wellpoint will notify providers of approved prior authorization determinations for non-urgent services by telephone or in writing. Prior authorization decisions for non-emergency services shall be made within 14 calendar days or sooner as required by the needs of the enrollee. 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 **833-731-2149** to discuss any denial decision with the practitioner.

Wellpoint has appropriate staff available to accept prior authorization requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will then be forwarded to the prior authorization nurse who will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history. When appropriate, the prior authorization nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

We will authorize provision of a drug not on the formulary and requested by the PCP or referral provider on behalf of the member if the approved prescriber certifies medical necessity for the drug for a determination. If the formulary includes generic equivalents, we will provide for a brand-name exception process for prescribers to use when medically necessary.

In the case of an Wellpoint member who was receiving a service (from Wellpoint or another managed care organization, or the Medicaid Fee-for-Service program) prior to the determination, Wellpoint will continue to provide the same level of service while the determination is in appeal. However, Wellpoint may require the member to receive the service from within the Wellpoint provider network, if equivalent care can be provided within network.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with medical review criteria, an Wellpoint reference number will be issued to the requesting physician. If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, member's PCP and member.

An **administrative denial** is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or failure by the provider to submit clinical when requested. Appeals for administrative denials must address the reason for the denial such as why prior authorization was not obtained or why the clinical was not submitted.

If Wellpoint overturns its administrative decision, then the case will be reviewed for medical necessity and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken. This will allow us to verify benefits and process the prior authorization request. For services that require prior authorization, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with medical review criteria.

We are staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept prior authorization requests. When a request for

medical services is received from the physician via fax, the prior authorization assistant will verify eligibility and benefits and will forward the request to the nurse reviewer.

The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director. All determinations to deny or limit an admission, service procedure or extension of stay shall be rendered by a physician.

When the clinical information received meets medical necessity criteria, an Wellpoint reference number will be issued to the referring physician.

If the request is a stat/urgent request (expedited service authorizations), the decision will be made within 24 hours of receipt of the necessary information but no later than three business days after receipt of the request for services.

If the prior authorization documentation is incomplete or inadequate, the nurse will not approve coverage of the request but will instead notify the provider to submit the additional necessary documentation.

If the medical director denies the request for coverage, the appropriate Notice of Action will be mailed to the requesting provider, the member's PCP, the facility and the member.

Peer to Peer Reviews
This discussion affords a peer clinician the ability to provide/discuss clinical that may not have been provided on initial review and/or the ability to explain or clarify clinical that the peer provider believes is important in consideration of meeting medical necessity criteria.
The following providers can participate in a peer-to-peer conversation:

- Attending/treating/ordering physician
- A covering physician for the attending/treating/ordering physician
- The physician's nurse practitioner or physician assistant
- The facility medical director or chief medical officer

Providers will have seven (7) business days from the time of denial notification to request a peer-to-peer review. A provider should call **1-732-744-6304** and leave a voicemail to request a peer-to-peer review and clearly provide the case information.

When a peer-to-peer review is requested within the seven (7) days of denial notification, the health plan medical director will make a minimum of two attempts to contact the attending/treating/ordering physician in response to the request within those seven (7) days.

If the peer-to-peer was initiated timely (within 7 business days) and denial notification was sent, but the Medical Director — despite attempts — was unable to complete the call within one (1) business day, then one additional day will be allowed for a reconsideration.

For peer-to-peer reviews that result in a denial being upheld, the provider may communicate that they would like an expedited appeal, and the medical director will refer the provider back to their denial letter for instructions on how to request an expedited appeal.
A reversal or overturn of an adverse determination can be done during the peer-to-peer review conversation. At this time, the denial letter will be rescinded and an approval notification/log will be faxed. If the denial is upheld, the provider is directed to the appeal process noted in the denial letter.

11.6 Medical Necessity Appeal Procedure

An **appeal** is a request for reconsideration of a Utilization Management decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services or reconsideration by an independent review organization administered by the DOBI.

The provider and the member will receive a notification letter within 2 business days of any Utilization Management decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, the member or the provider, with the member's written permission, can challenge it by requesting an appeal. Please reference the Wellpoint Member handbook Wellpoint pages 70-76 Grievances and Appeals: Member Handbook Wellpoint (my.Wellpoint.com)

Prohibited Actions. Neither the UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

The provider shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a complaint or grievance/appeal against Wellpoint.

See the summary below for the timeframes to request an appeal.

Stages	Timeframe for Member/ Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services

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 healthcare professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.	60 calendar days from date on initial notification/denial letter	• 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***
External/IURO Appeal The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO).	60 calendar days from date on Internal Appeal notification letter	• 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***
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	• Whichever is the latest of the following: • 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

Appeals must be submitted in writing along with required medical documentation through Essentials. Log onto Availity.com and from the Patient Registration tab select Authorizations & Referrals and Auth/Referral Inquiry. Locate the prior authorization you want to appeal and select Request Appeal from the case overview. To mail your appeal, send it to:

Wellpoint
Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

Internal Appeal Procedure

A member may request an appeal orally or in writing. In handling grievances and appeals, the Wellpoint will provide enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Dental appeals are reviewed by Wellpoint, not Liberty Dental Plan. If an appeal is submitted to Liberty Dental Plan it will be forwarded to Wellpoint for handling.

Internal appeals will be resolved within 30 calendar days or less in accordance with the medical exigencies of the case (including all situations in which the member is confined as an inpatient).

The **expedited appeal** is a request to change an adverse determination for urgent care. An urgent care request is any request for medical care or treatment with respect to which the application of the time period for making an appeal determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Expedited internal appeals are resolved as soon as possible in accordance with the medical exigencies of the case, which under no circumstances shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care, an admission, availability of care, continued stay, health care services for which the member received emergency services but has not been discharged from a facility. The resolution time frame may be extended if requested by the member (or provider acting on behalf of a member, with the member's written consent), or by Wellpoint if justified that additional information is needed and this is in the member's best interest and the member voluntarily agrees to the extension. We will orally deliver initial notice of the decision to the member and provider followed by written notice of the decision.

A health care professional reviewer with appropriate clinical experience in treating the member's condition or disease and/or a physician peer reviewer that was not involved in the initial determination and is not a subordinate of the original reviewer shall make the final determination in all adverse determinations. The health care professional reviewer may be a health plan medical director, a board-certified consultant, medical, behavioral health, pharmaceutical, dental, chiropractic or vision practitioner (as appropriate). Additionally, any provider acting on behalf of a member with the member's written consent will have the opportunity to speak with the medical director and/or health care professional that rendered the decision. Upon request, the member (or provider acting on behalf of a member, with the member's written consent), will be provided with the clinical criteria relied upon to make the determination and may also obtain a copy of the medical records relating to the appeal free of charge.

If the internal appeal is denied, Wellpoint will communicate this in writing to the member (or provider acting on behalf of a member, with the member's written consent), and will advise of the right to proceed to an external appeal, and will include the *Independent Health Care Appeals Program (IHCAP) Filing Form*, and the right for NJ FamilyCare A and NJ FamilyCare ABP members to request a Fair Hearing.

The external appeal process is limited to determinations regarding medical services and does not apply to: personal care services (PCA); adult family care; assisted living program; assisted living services (when the denial is not based on medical necessity); caregiver/participant training; chore services; community transition services; home based supportive care; home delivered meals; respite care; social day care; structured day program (when the denial is not based on medical necessity); and supported day services (when the denial is not based on the diagnosis of traumatic brain injury [TBI]). Wellpoint will notify the member (or provider acting on behalf of a member, with the member's written consent) in writing of the right to proceed to a Fair Hearing as the next level of appeal.

External/IURO Appeal Procedure
The member (or provider acting on behalf of a member, with the member's written consent) must comply with the internal appeal process before submitting an external appeal to the Independent Health Care Appeals Program (IHCAP), which will be conducted by an Independent Utilization Review Organization (IURO) (Maximus Federal Services) and administered by the New Jersey Department of Banking and Insurance (DOBI).

An appeal to the IHCAP must be submitted in writing and made within 60 days following the date of receipt of the internal appeal determination from Wellpoint. IHCAP submissions must include the following information:

- A copy of the internal appeal final written decision from Wellpoint
- A copy of the summary health coverage from the member handbook
- Copies of all pertinent medical records and correspondence to be reviewed by the IURO
- Providers that file on behalf of the member must attach a copy of the signed and dated member consent
- The appeal must be submitted using the *IHCAP Filing Form* included with the internal appeal denial response or available on the New Jersey DOBI website: Login Page (maximus.com) to:

Maximus
Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Wellpoint will submit copies of all pertinent medical records along with the medical record release signed by the member and correspondence for review by the IURO.

The IURO will complete its review within 45 calendar days of receipt of all documentation necessary for the review and issue its decision as soon as possible in accordance with the medical exigencies of the case. The IURO may extend its review for a reasonable period of time due to circumstances beyond its control. If this is necessary, the IURO will notify the member (or provider acting on behalf of a member, with the member's written consent) DOBI and Wellpoint in writing prior to the conclusion of the review, specifying the reasons for the delay.

For appeals involving care for an urgent case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

The IURO's determination is binding and will convey its decision to both the member and Wellpoint. Wellpoint will promptly provide coverage for the health care services found by the IURO to be medically necessary and will notify the IURO, member (or provider acting on behalf of a member, with the member's written consent) and DOBI, acceptance of the decision within 72 hours.

Medicaid Fair Hearing Procedure
NJ FamilyCare A and NJ FamilyCare ABP members *only* have the right to a Fair Hearing. Providers cannot request fair hearings. The internal appeal process must be completed prior to the initiation of the Fair Hearing process. NJ FamilyCare B, C or D members do not have the right to request a Fair Hearing.

The Fair Hearing must be requested within 120 days from the date of the notice of decision. The member has the right to represent himself or herself or to be represented by legal counsel, friend or other spokesperson. The department's Fair Hearing decision is binding on Wellpoint. Fair Hearing requests are to be submitted in writing to:
State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 0865-0712

The appeal procedures detailed above should not be used to address provider contracting issues. If you have concerns related to the terms, conditions or termination of your Wellpoint agreement, please contact the dedicated Network Management representative assigned to your service area or call Provider Services at **833-731-2149** for further assistance.

11.7 Continuation of Benefits

Wellpoint will automatically continue provision of services while the Internal Appeal, External/IURO Appeal, or Fair Hearing is being reviewed when all of the following are met:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an Wellpoint network provider
- The appeal is received timely on or before the final day of the previously approved authorization or within 10 calendar days from the date of the adverse benefit determination, whichever is later

Provision of services will be discontinued if the member withdraws the appeal or Fair Hearing request.

For those eligible members who have requested a Fair Hearing, continuation of benefits must be requested in writing within 10 calendar days from the date of the denial letter or prior to the intended effective date of the HMO proposed action, whichever is later.

If the determination of the appeal is in the member's favor, Wellpoint will authorize coverage and arrange for services promptly and as expeditiously as the member's health condition requires and will

pay for previously denied services. If the determination is not in the member's favor, the member may be liable for the cost of services.

12 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

12.1 Emergency Services

We provide a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do not discourage members from using the 911 emergency systems or deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency medical condition: A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- 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
- Serious dysfunction of any bodily organ or part

Emergency response is coordinated with community services, including the police, fire and emergency medical services departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services, and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. We will compensate the provider for the screening, evaluations and examination that are reasonable and calculated to help the health care provider determine whether or not the patient's condition is an emergency medical condition.

Emergency services will include an examination at an emergency room for suspected physical/child abuse and/or neglect. A medical examination at an emergency room is required by *N.J.A.C. 10:122D-2.5(b)* when a foster home placement of a child occurs after business hours.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Wellpoint. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission regardless of whether the hospital is

in-network or out-of-network. All transfers from out-of-network to in-network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, our concurrent review nurse will implement the concurrent review process to ensure coordination of care.

12.2 Inpatient Reviews

Inpatient Admission Reviews
All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. Our Utilization Review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of stay is documented, and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

Inpatient Concurrent Review
Each network hospital will have an assigned UM clinician. Each UM clinician will conduct a concurrent review of the hospital medical record by telephone to determine the authorization of coverage for a continued stay.

The UM clinician will conduct continued stay reviews daily and review discharge plans, unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

If the discharge is approved, our UM clinician will help coordinate discharge planning needs with the hospital utilizations review staff and attending physician. The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

We will authorize the covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment are likely to be several days or are predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation and C-section or vaginal deliveries. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of action will be mailed to the hospital, member's PCP and member. Providers will have seven (7) business days from the time of denial notification to request a peer-to-peer review. A provider should call **1-732-744-6304** and leave a voicemail to request a peer-to-peer review and clearly provide the case information. See Section 11.5 for additional information on peer to peer reviews.

Inpatient Retrospective Review
Inpatient admissions that were not notified or authorized (as applicable) will be reviewed retrospectively, if appropriate utilization management protocols have been followed. Please note that we require notification within one business day following an emergent or urgent admission. Elective admissions need to be authorized 72 hours prior to admission.

Medical records requested for the purpose of quality improvement audits are also reviewed retrospectively. Providers' Medical Records departments will be contacted to determine the procedure for securing access to medical records. Our authorized coordinator reviews the charts, obtaining copies of pertinent records for review by the medical director. If quality improvement criteria are not met, the case is referred to the medical director, who evaluates the case and renders a decision for hospitalization.

12.3 Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

- Hospice facility.
- Convalescent facility.
- Home health care program (e.g., home intravenous antibiotics).

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Depending on the service, discharge plan authorizations will follow InterQual Criteria or Wellpoint Medical Policies. Authorizations include and are not limited to transportation, home health, DME, pharmacy, follow-up visits to practitioners and outpatient procedures.

13 QUALITY MANAGEMENT

13.1 Quality Management Program

Overview
Our Quality Management (QM) program is committed to excellence in the quality of service and care our members receive and the satisfaction of our network providers, and we are constantly looking for ways to refine our program. Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services, which includes not only age/sex distribution, but also a review of utilization data by visit type, cost and volume, and compare our findings to national practice guidelines.

Clinical performance and service satisfaction are based upon results from:

- **Medicaid Healthcare Effectiveness Data and Information Set (HEDIS)** — A program developed by the National Committee for Quality Assurance (NCQA) to measure how effectively health plans and providers deliver preventive care
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** — Surveys evaluating member satisfaction with care and services received over the past six months; a random sample of New Jersey plan members answered questions about their doctors and the health plan

Our comprehensive QM program:

- Adheres to the New Jersey-modified Quality Assessment and Performance Improvement (QAPI) program standards which promotes and improve patient safety and objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members through quality-of-care studies and related activities and pursues opportunities for improvement on an ongoing basis.
- Objectively monitors and evaluates the care and services provided to members
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of the program
- Reflects the demographic and epidemiological needs of the population served
- Encourages both members and providers to weigh in with recommendations for improvement
- Identifies areas where we can promote and improve patient safety

Quality of Care
Our quality of care program includes review of quality of care issues identified for all care settings. QM staff uses member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members. All physicians, advanced registered nurse practitioners and Physician Assistants (PAs) are evaluated for compliance with pre-established standards as described in our credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements and contractual compliance. Reviews are accomplished by Quality Management (QM) coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. Results are submitted to our QM department and incorporated into a profile.

Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- Participate in the implementation of the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

Should investigation of a member grievance result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue or the level of severity, invites the cooperation of the provider, and consults and informs the provider advisory committee and peer review committee as appropriate. The medical director informs the provider of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the Quality Management Committee.

13.2 Quality Management Committee

The purpose of the Quality Management Committee (QMC) is to maintain quality as a cornerstone of our culture and to be an instrument of change through demonstrable improvement in care and service. The Quality Management Committee structure is overseen by the Wellpoint governing body and includes:

- A Quality Management Committee
- A Provider Advisory Committee
- A Credentialing Committee
- A Health Education Community Advisory Committee

The QMC's responsibilities are to:

- Review and approve the annual quality management program description and establish strategic direction and monitor and support implementation of the quality management program
- Establish processes and structure that ensure NCQA compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies and review and approve the annual work plans for each service delivery area
- Monitor Wellpoint operational indicators through Wellpoint senior staff
- Coordinate communication of quality management activities throughout Wellpoint
- Review HEDIS data and action plans for improvement
- Provide oversight and review of delegated services and subordinate committees
- Receive and review reports on utilization review decisions and take action when appropriate
- Analyze member and provider satisfaction survey responses

13.3 Provider Advisory Committee

The PAC is a state managed care contract-mandated committee comprised of providers that service Wellpoint Medicaid enrollees and representatives from the health plan. Providers actively collaborate with the health plan by sharing their input and recommendations regarding the health plan's activities.

Using nationally recognized standards of care, we work with providers to develop clinical policies and guidelines of care for our members. The PAC advises to our administration in any aspect of our policy or operation affecting network providers or members. The PAC approves and provides oversight of the peer review process, the Quality Management Program and the Utilization Review Program and oversees and makes recommendations regarding health promotion activities.

The Provider Advisory Committee (PAC) responsibilities are to:

- Direct us in formalizing, adopting and monitoring clinical protocols and guidelines which help ensure the delivery of quality care and appropriate resource utilization
- Identify opportunities to improve services and clinical performance by establishing, reviewing and clinical quality improvement studies using demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions.
- Evaluates and develop action plans and recommendations about quality and standards of care provided to members
- Utilize an ongoing peer review system to monitor practice patterns, to identify appropriateness of care and to improve risk prevention activities
- Conduct a systematic process for network maintenance, provide oversight of Credentialing Committee decisions, and approve credentialing and recredentialing policies and procedures
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

13.4 Medical Record Management and Confidentiality

We will release medical records of the member and/or facilitate the release of medical records in the possession of network providers. Release of medical records will be consistent with the provisions of confidentiality.

We require medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review. The medical records will include separate comprehensive medical records for each member as are necessary to record all clinical information pertaining to members, including notations of personal contacts, primary care visits and diagnostic studies. Each member's medical records will be kept in detail consistent with federal and state requirements and good medical and professional practice, based on the services required and provided. Medical records must be available at each encounter with a medical professional.

Records will also include appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and applications of funds determination of amounts payable under the contract and the capacity of the members or network providers, if relevant, to bear the risk of potential financial losses. Financial records will be consistent with applicable state and federal

regulations. Records, including member medical records, must be retained for the latter of 10 years from the date of service or after the final payment is made under the contract or subcontract and all pending matters are closed.

Medical records of members will be sufficiently complete as to permit subsequent peer review, medical audit or investigation. All required records, either originals or reproductions thereof, will be maintained in legible form and be readily available to appropriate state professional or investigative staff upon request for review and evaluation by professional medical, nursing and investigative staff. In addition, the New Jersey Department of Human Services/Division of Medical Assistance and Health Services has contracts with an External Quality Review Organization (EQRO) to perform federally required outside medical record audits.

We require that duly authorized representatives be granted access to all records the purposes of examinations, audit, investigation and copying of such records. The provider will give access to such records upon prior written notice during normal business hours, unless otherwise provided or permitted by applicable laws, rules or regulations.

If our members disenroll from Wellpoint, network providers are required to release medical records of members as may be directed by the member, Wellpoint and/or authorized representatives of the appropriate agencies of the state and federal government. Release of records will be consistent with confidentiality provisions expressed in this manual and at no cost to members. All records will be retained in accordance with the confidentiality requirements cited in this manual.

Medical records and management information data concerning members enrolled in Wellpoint are confidential and will be disclosed to other persons within Wellpoint only as necessary to provide medical care and quality, peer or grievance review of medical care and other necessary administrative duties.

Wellpoint and its participating network providers agree and understand that all information, records, data and data elements collected and maintained for the operation of Wellpoint insurance programs and pertaining to members must be protected from unauthorized disclosure. Access to such information, records, data and data elements will be limited to those who perform their duties in accordance with provisions of this contract and in accordance with applicable law.

13.5 Medical Record Audits

We use the New Jersey Medical Record Review Audit tool. In addition, our audits include Wellpoint-specific tools designed to collect information to support quality improvement focus studies and HEDIS® reporting. We will systematically review medical records to ensure compliance with the standards. We will institute actions for improvement when standards are not met.
We will report the findings to our network providers.

Medical Record Standards reflect all aspects of patient care, including ancillary services. Each encounter will, at a minimum, meet the following medical record documentation requirements:

1. Patient identification information — Each page or electronic file in the record must contain the patient's name or patient ID number.
2. Personal/biographical data — The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
3. Entry date and provider identification — All entries must be dated and author identified.
4. Legibility — Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. Allergies — Medication allergies and adverse reactions must be prominently noted on the record. In the absence of allergies, No Known Allergies (NKA) must be noted in an easily recognizable location.
6. Past medical history (for patients seen three or more times) — Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, past medical history related to prenatal care and birth.
7. Immunizations — For pediatric records of patients age 12 and under, a completed immunization record or a notation of prior immunization must be recorded and include vaccines and their dates of administration when possible.
8. Diagnostic information
9. Medication information
10. Identification of current problems — Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record.
11. Functional or cognitive deficits — For adult members age 66 or older, documentation must include an assessment of member's ability to perform ADL and IADL.
12. Smoking/alcohol/substance use — A notation concerning cigarettes, tobacco products, alcohol use and substance use must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
13. Consultations, referrals and specialist reports — Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
14. Emergency care — Copies of emergency treatment documentation such as ER summary sheet.
15. Hospital discharge summaries — Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate.
16. Advance directives — Providers are required to comply with federal and state law regarding advance directives for adult members. For medical records of adult patients, the medical record must document whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney that directs health care decision making for individuals who are incapacitated. The *New Jersey Advance Directive* form can be downloaded from CaringInfo, a program of the National Hospice and Palliative Care Organization, at **www.caringinfo.org**. A *Durable Power of Attorney* form is located in the back of the Provider Manual.
17. History and physical examination — The medical record must have history and physical examination.
18. Plan of treatment — Plan of treatment is appropriate to findings and member is not at risk by diagnostic or therapeutic problem.

19. Diagnostic tests
20. Therapies and other prescribed regimens — Documentation of therapies and other prescribed regimens such as (PT, OT, E-Stim, etc.) must be noted.
21. Follow-up — Notations about follow-up care, calls or visits, specific time of return noted in days, weeks or months documented in the medical record.
22. Timely record transfer (when applicable)
23. Unresolved problems — Documentation that unresolved problems from previous visits are addressed in subsequent visits.
24. Security — Providers are required to maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use.
25. Release of information — Written procedures are required for the release of information and obtaining consent for treatment.
26. Documentation — Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.
27. Multidisciplinary teams — Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
28. Integration of clinical care — Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when indicated.
    - Screening and referral by behavioral health providers to PCPs when appropriate.

For patients receiving behavioral health treatment, documentation that includes initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period, at-risk factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social health), and therapies and other prescribed regimens that include evidence of family involvement as applicable and include evidence that the family was included in therapy sessions, when appropriate.

13.6 Clinical Practice Guidelines

As part of its quality improvement process, Wellpoint adopts non-preventive and preventive *Clinical Practice Guidelines* for acute and chronic medical and behavioral health conditions that are scientific and based on valid and reliable clinical evidence as determined by scientific evidence, review of government research sources and clinical or technical literature, and the consensus of board-certified health care professionals from appropriate specialties.

The guidelines are adopted and approved in consultation with network health care professionals on our Physician Advisory Committee (PAC) and are reviewed and updated periodically as appropriate but at a minimum of every two years.

Recognized sources of the evidenced-based guidelines include national organizations such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH); professional medical specialty organizations such as the American Academy of Pediatrics (AAP),

American College of Obstetrics and Gynecologists (ACOG), and American Academy of Family Practice (AAFP); and voluntary health organizations such as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SAMHSA) and National Institute of Mental Health (NIMH).

The *Clinical Practice Guidelines* are available at **https://provider.Wellpoint.com/NJ**. A copy can be requested from Provider Services at **833-731-2149**.

Wellpoint decisions regarding disease management, case management, utilization management, member education, coverage of services and other areas included in the guidelines will be consistent with Wellpoint guidelines. Data is gathered and monitored using HEDIS, ad hoc medical records review, and other sources to measure performance against the guidelines and improve the clinical care process.

14 CLAIM GUIDELINES

14.1 Claim Submission

A clean claim is defined as a claim for reimbursement submitted to Wellpoint that contains the required data elements and any attachments requested by Wellpoint. Providers are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS® codes and/or revenue codes to denote the services and/or procedure performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. If the required information is not submitted, Wellpoint may delay or deny payment without being liable for interest or penalties or recover and/or recoup the claim payment. Wellpoint cannot accept claims with alterations to billing information. Altered claims will be returned to the provider or via the EDI clearinghouse with an explanation of the reason for the return.

A clean claim must include the following information (*HIPAA* compliant where applicable):

- Patient information (name, member ID number, address including ZIP code, date of birth, gender) and insured's information (name, relationship to patient, member ID number, and insurance group name and number)
- ICD-10 diagnosis code(s)/revenue codes
- Date(s) of service(s) rendered, day(s) or unit(s), itemized and total charge(s), amount paid, if applicable, and noncovered charge(s) of service(s) rendered and place of service
- Procedures, services or supplies (description of services rendered using CPT-4/HCPCS/DRG codes
- Federal TIN
- Billing and rendering providers (name, address including ZIP code, telephone number) and NPI numbers
- COB information and prior payments, if applicable
- Prior authorization PA number or copy of PA
- Name of referring physician or source NPI and other non-NPI identifier of the referring, ordering or supervising provider or attending and operating provider name and tax ID, if applicable
- National Drug Code(s) (NDC), unit price, quantity and composite measure per drug

Wellpoint may request further information to finalize a claim. Wellpoint makes requests for information through the EOP. zs claim or part of the claim may be denied because more information is required to process the claim. Once the information is received, Wellpoint will use it to finalize the claim.

EOP requests for supporting documentation such as Sterilization/Hysterectomy Consent Forms, itemized bills, invoices, itemized bills, primary carrier EOPs or medical records may be submitted by:

Electronic Data Interchange (EDI): Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.

Availity Essentials https://www.availity.com**:**

Log onto https://www.availity.com and select the Claims & Payments tab to access Claims Status. Locate your claim and attach your documentation. Your Availity Essentials user account will need the Claim Status and Medical Attachments roles, before getting started.

Written correspondence:
Claims Correspondence
P.O. Box 61599
Virginia Beach, VA 23466-1599

Encounter Data
Wellpoint maintains a system to collect member encounter data. HEDIS® outcomes are also collected through claim and encounter data submissions. All capitated providers and/or sites must report all member encounters. Failure to submit accurate and timely reports may result in delayed capitation payment and corrective action up to an including termination of the participating provider agreement.

Electronic Data Interchange (EDI)
Availity Essentials is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Advantages of Electronic Data Interchange (EDI)

- Process claims faster by submitting coordination of benefits electronically and fixing errors early with in-system notification and correction
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)
-

Availity's EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **www.availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions(work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, work with them to ensure you are receiving all reports. It's important to review rejections on the response reports. Rejections will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse, billing vendor, or Availity Customer Care if you submit directly using your practice management software at **800-AVAILITY (800-282-4548)**.

Availity EDI Payer ID's
Payer IDs ensure your EDI submissions are routed correctly when received by Availity.
Availity's comprehensive Payer ID listing https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/
Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

- Log onto https://apps.availity.com/availity/web/public.elegant.login
- Select My Providers
- Select Enrollment Center and select Transaction Enrollment

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a fast and secure way to receive payment while reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
Use EnrollSafe (**https://enrollsafe.payeehub.org/**) to register and manage EFT account changes.

EDI Submission for Corrected Claims

For corrected electronic claims use one the following frequency codes:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with you vendor on how to submit corrected claims.

Useful EDI Documentation
Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
Availity EDI Companion Guide - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
Availity Registration Page - Availity register page for users new to Availity.

Washington Publishing Company - X12 code descriptions used on EDI transactions.

Availity Essentials Direct Data Submissions - Participating Providers Only
Participating providers have the option to use HIPAA-compliant web claim submission capabilities by registering at **Availity.com**. Log onto Availity.com select the Claims & Payments table. Choose either Professional or Facility Claim and complete all required fields in the online form, then Submit.

Paper Claims Submission
CMS-1500 and CMS-1450/UB-04 forms are available at **www.cms.hhs.gov**. A paper claim must be submitted on an original form with drop out red ink, computer-printed or typed, in a large, dark font in order to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied. Submit claims on original claim forms (*CMS-1450* or *CMS-1500*) to:

New Jersey Claims
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

14.2 Timely Filing

Timely filing is within 180 calendar days from the last date the service in the course of treatment, which is the date of service for outpatient treatment or the date of discharge for inpatient treatment.

COB claims must be submitted within 60 days from the primary insurer's *EOB* or 180 days from the date of service, whichever is later.

In cases where a member is retroactively enrolled with Wellpoint, the time frames for filing a claim will begin on the date Wellpoint receives notification of the member's eligibility/enrollment.

14.3 Corrected Claims

Timely filing for corrected claims is within 365 days from the date of service. Electronic submissions must have the applicable frequency code. Paper corrected claims must be clearly marked as a corrected claim.

You have the option to submit a corrected claim electronically using EDI or by entering the corrected claim on Availity Essentials using the **Professional Claim** or **Facility Claim** option under the **Claims & Payments** menu. Select **Replacement of Prior Claim** in the **Claim Information** section. Please refer to our Reimbursement Policy for more information on the submission of corrected claims.

14.4 Coordination of Benefits

If a member is covered by more than one health care plan, we'll administer Coordination of Benefits (COB). Under COB, the primary payer of benefits is identified in order to eliminate duplication of

reimbursement. COB claims must be submitted within 60 days from the date of the primary insurer's *Explanation of Benefits* (*EOB*) or 180 days from the dates of service, whichever is later.

Members are advised to show both their third-party liability and their Wellpoint ID card to the provider even if the provider does not participate with Wellpoint. The provider should submit the balance claim to Wellpoint. If the member does not show the provider their ID cards, they may be held responsible for any coinsurance payments, if applicable.

Members are protected from being billed for the balance due on a medical claim for medically necessary, covered services when the provider participates with the third-party liability plan but does not participate with Wellpoint.

After review of the *EOB*, claims are coordinated by calculating the Wellpoint allowable minus the third-party liability payment. Wellpoint cannot exceed the maximum reimbursement that it would have covered had it been the primary payer. If the Wellpoint rate is lower than the third-party liability payment, no payment will be made to the provider. This includes copays, deductibles or coinsurance amounts. If the third-party liability did not pay for a service because the member or provider did not follow the third-party payer's guidelines, the service will not be paid by Wellpoint. When a medically necessary service not covered by the third-party payer is covered by Wellpoint (e.g., dental services, hearing aids, personal care assistant services, medical day care, incontinence supplies, family planning services), Medicaid is the only payer and the member cannot be billed.

14.5 Third-Party Liability

You must use and report any other public or private third party sources of payment for services rendered to members. If you're aware of third-party coverage, you must submit a claim first to the appropriate third party before submitting a claim to us.

In the following situations, you may bill us first and then coordinate with the liable third party, unless we have received prior approval from the state to take other action:

- The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services
- The claim is for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program
- The claim is for a child who is in a DCP&P support out-of-home placement and third-party liability recovery may not be pursued for these enrollees for safety reasons
- The claim involves coverage or services mentioned above in combination with another service

If you know the third party will neither pay for nor provide the covered service and the service is medically necessary, you may bill us without having received a written denial from the third party.

Sharing of Third-Party Liability Information by a Provider

We will notify the State within 30 days after we learn that a member has health insurance coverage not reflected in the state's file or casualty insurance coverage or if there is a change in a member's health insurance coverage. In addition, we require our providers to notify us of this information.

When you become aware that a member has retained legal counsel who either may institute or has instituted a legal cause of action for damages against a third party, you must notify us in writing, including the member's name and Medicaid identification number, date of accident and/or incident, nature of injury, name and address of the member's legal representative, copies of pleadings, and any other documents related to the action in the provider's possession or control. This will include but not be limited to (for each service date on or subsequent to the date of the accident and/or incident) the member's diagnosis and the nature of the service provided to the member.

You must notify us with seven days when you become aware of a member's death.

You must notify us of the incarceration of a member within 30 days of the date you become aware of the incarceration. Incarcerated individuals are not eligible for managed Medicaid coverage pursuant to *N.J.A.C. 10:71-3.14*. When you notify us of an incarcerated member, we will promptly notify DMAHS of possible member incarcerations (involuntary physical restraint of a person who has been arrested for, or convicted of a crime), upon verification of each incarceration, as directed by the State, we will recover capitation payments made for the period of incarceration on a prorated basis after the beginning date of incarceration.

If an incarcerated member receives inpatient services, the Fee-for-Service (FFS) Medicaid Program will pay for the enrollee's inpatient claim only. MCOs do not pay any claims while the enrollee is incarcerated. MCO coverage resumes after the enrollee is released from incarceration, upon notification from DMAHS.

You must agree to cooperate with our efforts and the State's efforts to maximize the collection of third-party payments by providing us updates to the information required by this section.

14.6 Claims Adjudication

Wellpoint is dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines. Reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. Wellpoint reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on the provider website.

We will adjudicate clean claims to a paid or denied status within 30 days of receipt for electronic claims and 40 days of receipt for paper claims. For MLTSS services, we will adjudicate clean claims to a paid or denied status within 15 days of receipt for electronic claims and 30 days of receipt for paper claims. Days are calculated from receipt date to date of payment. The date of receipt is the date we receive 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. Payments and *EOP*s are issued twice a week. We may request additional information to process a claim. Upon receipt of the requested information from the provider, we must

complete processing of the clean claim within 30 days of receipt for electronic claims and 40 days of receipt for paper claims. If we do not pay the claim within the required time frames, we will pay all applicable interest as required by law. Claims from providers under investigation for fraud or abuse are not subject to prompt pay timelines.

Claim status and Explanation of Payment Remittances may be reviewed on Availity Essentials. Log onto Availity.com and select Patient Registration tab to access Eligibility and Benefits Inquiry. Complete all required fields and submit. Claim status may also be verified by calling our interactive voice response system (IVR) at **833-731-2149**. You can also use the claims status information for accepted and rejected claims submitted through a clearinghouse.

14.7 Overpayments

Once an overpayment has been identified, our Cost Containment Unit (CCU) will notify the provider of the reason for the overpayment by mailing a notification that includes instructions about how to submit the and that repayment must be made within sixty (60) days. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or legal action.

Providers are also obligated to identify overpayments and proactively submit refunds within sixty (60) days. Refunds are to be mailed to:

Wellpoint
P.O. Box 933657
Atlanta, GA 31193-3657

Providers have the option to authorize Wellpoint to offset the overpayment by submitting the *Provider Authorization form to adjust claims and create claim offsets.* The Provider Authorization form is located on our provider website **https://provider.Wellpoint.com/NJ** -> Resources -> Forms -> Claims & Billing.

For questions regarding the Refund Notification procedure, please call Provider Services at **833-731-2149** and select the appropriate prompt.

14.8 Billing Members

Providers are prohibited from billing members for the balance of a bill for Wellpoint covered services or the amount above what we paid for covered services. Providers may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Members cannot be billed for a trauma service or if the provider has received payment from either Medicaid Fee-for-Service or Wellpoint. Additional protections under federal and state law may also apply.

Members may not be billed if any of the following occurs:

- Failure to timely submit a claim, including claims we don't receive

- Failure to submit a claim to Wellpoint for initial processing within 180 days of the last date of service in the course of treatment or the date of the third-party liability *explanation of benefits* (*EOB*), if applicable
- Failure to submit a corrected claim within the 365 day filing resubmission period
- Failure to dispute a claim within the 90-day claim payment dispute period
- Failure to dispute a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the dispute process

Under limited circumstances, members may be responsible for a portion of the payment if:

- The NJ Family Care member's plan has a copay.
- The member has been paid for the service by a health insurance company or TPL payer and has failed or refused to remit to the provider that portion of the payment to which the provider is entitled by law.
- The provider does not participate with the Medicaid health plan.
- The service is determined to be medically unnecessary before it is rendered.
- The member requests a specific service or item that is not covered by Wellpoint, and the member is informed before the service is rendered and voluntarily agrees in writing to pay for all or part of the provider's specifically listed charges prior to the service being rendered.

14.9 Claim Payment Disputes

If you disagree with the adjudication or outcome of a finalized claim, you may begin the Wellpoint Claim Payment Dispute process. A claim payment dispute may be submitted for any reduced or zero-paid claim reason including: contractual payment issues, requests for additional payment for services or treatment post-service authorizations, other health insurance denial issues, claim code editing, duplicate claim denials, retroactive eligibility issues, claim data issues, or experimental/ investigational procedure denials. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

- **A Claim Payment Reconsideration** is an informal request for an investigation into the outcome of a finalized claim.
- **A Claim Payment Appeal** is a formal, written request additional review. Wellpoint appeal rights are exhausted after the Claim Payment Appeal is concluded.

Timely dispute filing
We accept reconsideration requests within 90 calendar days from the date on the *Explanation of Payment* (*EOP*). We'll send a determination letter within 30 calendar days of receiving all necessary information. If you're dissatisfied with the resolution of a reconsideration request, you may submit a Claim Payment Appeal within 30 calendar days of receipt of the notification.

A note of timely filing
Wellpoint will consider reimbursement of a claim that has been denied due to failure to meet timely filing only if you can provide documentation the claim was submitted within the timely filing requirements or demonstrate good cause exists.

How to submit Claim Payment Disputes
Claim Payment Disputes can be submitted online through Availity Essentials at **https://www.availity.com**.

Log onto Availity.com and select the Claims & Payments tab to access Claim Status.

Locate the claim you want to dispute and select the Dispute Claim button to initiate the dispute.

To locate the initiated dispute, log onto Availity.com and from the Claims & Payments tab select Appeals to, upload supporting documentation and submit.

Important Note: For Appeals, your Availity Essentials user account will need the Claim Status role. To send attachments from Claim Status, you'll need the Medical Attachments role.

Benefits of submitting online claim disputes through Availity.com include:

- Instant acknowledgement for submissions.
- Online review for open payment dispute submissions and statuses.
- Email notification of finalized submissions. (Note: Providers must log onto Availity.com to receive the outcome.)

Providers can submit payment disputes by mail, if desired, along with the optional *Health Care Provider Application to Appeal a Claim Determination Form* available from NJ DOBI at **www.state.nj.us/dobi/chap352/352implementnotice.html**, to:

For Medicaid payment disputes:
Wellpoint
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

For Medicare payment disputes:
Wellpoint
Payment Dispute Unit
P.O. Box 110
Fond du Lac, WI 54935

In addition to using Availity.com or submission through mail, reconsiderations may be completed by calling Provider Services at **833-731-2149**.

Required Documentation for Claim Payment Disputes
When submitting Claim Payment Disputes, please include as much information as you can to help us understand why you think the claim was not paid as you expected. If a Claim Payment Dispute requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint requires the following information when submitting a Claim Payment Dispute:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Wellpoint or Medicaid ID number
- A listing of disputed claims, which should include the Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

Resolution

Wellpoint will make every effort to resolve the Claims Payment Dispute within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

- A statement of the request.
- A statement of what action Wellpoint intends to take or has taken and the reason for the action.
- Support for the action including applicable statutes, regulations, policies, claims, codes or provide manual references.
- If the determination is regarding a reconsideration, an explanation of the provider's right to request a Claim Payment Appeal within 30 calendar days of the date of the *Reconsideration Determination Letter*.
- A statement about how to request a PICPA review, if desired.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Program for Independent Claim Payment Arbitration (PICPA)

If you're dissatisfied with an Wellpoint provider claim payment dispute resolution (either claim reconsideration or claim payment appeal), you may file for independent arbitration pursuant to *New Jersey P.L. 2005, c.35*. In order to file for independent arbitration, certain conditions must be met:

- The claims amount in dispute must be $1,000 or more. Claims that are aggregated to meet the $1,000 threshold must fulfill the aggregation criteria as specified by the New Jersey Department of Banking and Insurance, which includes the following:
    - All disputed claim amounts aggregated for arbitration must be from claims that have exhausted at least the Wellpoint claim payment reconsideration process.
    - All claims in the aggregation of disputed claims **must** be timely; untimely claims will be removed from the aggregation, and if the remaining claims do not meet the threshold amount, none of the claims will be considered for arbitration at that time.
    - Disputed claim amounts should be aggregated by carrier and by covered person or CPT code
- You must complete the *Health Care Provider Application to Dispute a Claims Determination* form available through the New Jersey Department of Banking and Insurance website **www.state.nj.us/dobi/chap352/352implementnotice.html**
- Although not required by law, you should strongly consider obtaining a completed *Consent to Authorization of Release of Medical Records for Arbitration of Claims* form from the member for whom the services were provided. In the absence of this authorization, no personal health information can be shared with the arbiter. The form can be obtained from the New Jersey Department of Banking and Insurance (DOBI) website at **www.state.nj.us/dobi/chap352/352implementnotice.html**;
- The claim must not be eligible for dispute under the IHCAP

- The provider must include the fee for arbitration as required by the Department of Banking and Insurance. Please check with the Department of Banking and Insurance for the most current information as to the appropriate fee.
- The request for arbitration must be made within 90 days of the most recent adverse determination regarding the claim.

14.10 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's [BRAND] benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, [BRAND] may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Wellpoint reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, [BRAND] strives to minimize these variations.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a [BRAND] business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding

The Medical Coding Department ensures that correct coding guidelines have been applied consistently through Blue Cross NJ. Those guidelines include but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes, etc.)

- Code editing rules appropriately applied and within regulatory requirements.
- Analysis of codes, code definitions and appropriate use.

Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Outlier Reimbursement Audit And Review Process

Requirements and Policies
This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products
Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges
The reimbursement of charges for specimen are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room ("OR")**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.

- **Hospital/ Technical Anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room**: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges

0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid

	warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs

	Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc.

	Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

15 FORMS

1 WIC Referral Form
2 Domestic Violence Screening Tool
3 Well Being Screening Tool
4 Specialist as PCP Request Form
5 AAP Oral Health Risk Assessment Tool (For PCP)
6 ADA Caries Risk Assessment Tool (Age 0-6) (for PCD)
7 ADA Caries Risk Assessment Form (Age >6) **(for PCD)**
8 Counsel for HIV Antibody Blood Test
9 Consent for the HIV Antibody Blood Test
10 Results of the HIV Antibody Blood Test
11 Durable Power of Attorney
12 Personal Care Assistant (CHHA) Referral Form
13 Adult and Pediatric Day Health Services Referral Form

Referral/Nutrition Assessment For Women

Please see instructions on last page

NAME OF CLIENT	TELEPHONE NUMBER	DATE OF BIRTH
ADDRESS OF CLIENT	CHECK ONE: ☐ Pregnant ☐ Breastfeeding ☐ Non-breastfeeding	☐ ☐ ☐ Non-breastfeeding

REFERRAL (To be completed by health professional, including second page)

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

First Prenatal		# Weeks	Weight	Pre-Preg	Usual Wt
Check-up:	Date: / /	Gestation	(pounds)	(pounds)	(pounds)
Current		# Weeks	Weight	Height	
Check-up:	Date: / /	Gestation	(pounds)	(inches)	
Blood Test:	Date: / /	Hb(mg/dL)	Hct	% EP(ug/dL)	Lead

Other .

MEDICAL HISTORY

Gravida Para Ab/Misc Stillbirth EDC ADC ☐ Vag ☐ C-section Past Med/Surg History

.

Current Medical Problem(s)

.

Previous Preg Complications Date Last Preg Ended / / . Physician/Clinic Phone

.

Signature of Health Professional Date: / /

Time: .

WIC APPOINTMENT: Date: / / Time: .

ASSESSMENT (To be completed by Client or Health Professional)

1) Are you taking any of the following?

Vitamins/Minerals	☐ Yes ☐ No	Amount:	Type:
Iron		.	
Over-the-counter Medicines Special Medicines			
Street Drugs			
	☐ Yes ☐ No	Amount:	Type:
		.	
	☐ Yes ☐ No	Amount:	Type:
		.	
	☐ Yes ☐ No	Amount:	Type:
		.	
	☐ Yes ☐ No	Amount:	Type:
		.	

2) How much did you smoke before you were pregnant?		Amount:	.
How much do you smoke now?		Amount:	.
3) How much beer, wine cooler or liquor do you drink per week?		Amount:	.
4) Are you on a special diet now?	☐ Yes ☐ No	Prior to pregnancy? ☐ Yes ☐ No	
5) Are you experiencing?			
Nausea	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Frequent Vomiting	☐ Yes ☐ No	Flatus (Gas)	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Dental Problems	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Bleeding Gums	☐ Yes ☐ No
6) Do you eat?			
Paint Chips	☐ Yes ☐ No	Dirt	☐ Yes ☐ No
Laundry Starch	☐ Yes ☐ No	Clay	☐ Yes ☐ No
Corn Starch	☐ Yes ☐ No	Plaster	☐ Yes ☐ No
Ice	☐ Yes ☐ No	Other Cravings	☐ Yes ☐ No
7) Do you have a working?			
Stove	☐ Yes ☐ No	Sink with water supply	☐ Yes ☐ No
Refrigerator	Yes ☐ No		
8) Are you on any program?			
WIC	☐ Yes ☐ No	**Maternity Services**	☐ Yes ☐ No
Child Support Enf	☐ Yes ☐ No	Presumptively Eligible	☐ Yes ☐ No
Food Stamps	☐ Yes ☐ No	TANF/Medicaid	☐ Yes ☐ No
9) How do you plan to or presently feed your baby?			
Breast milk	Yes ☐ No	Undecided?	☐ Yes ☐ No
10) Do you do the following daily?			
Work	☐ Yes ☐ No	Type: How Many:	
Care for Children			
Exercise	☐ Yes ☐ No	Type:	

□ Yes □
No

11) If pregnant, how much weight (pounds) do you plan to gain?
.
12) Where do you plan to or presently take your child for medical care?
.

New Jersey State Department of Health
WIC/HEALTHSTART REFERRAL/NUTRITION ASSESSMENT FOR WOMEN
INSTRUCTIONS

--- AGENCY USE ONLY ---	**Referral Section** (Complete by Health Professional) 1) Fill in client's name, address, phone number and date of birth; or use addressograph stamp. 2) Check status of woman being referred. 3) Fill in data on first prenatal check-up and current check-up, if applicable. 4) One blood test is required prior to submitting this form to WIC. Pregnant women need blood test that was done during pregnancy. Postpartum women (breastfeeding and non-breastfeeding) need blood test that was done after delivery. 5) Complete Gravida, Para, Abortions, Miscarriages. 6) Fill in EDC (Estimated Date of Confinement) for prenatal clients. 7) Fill in ADC (Actual Date of Confinement), vaginal or C-section delivery for postpartum clients 8) Complete past medical/surgical history based on client's record. 9) Fill in any pertinent current medical problems diagnosed. Information in this section should NOT include most recent pregnancy for postpartum women. 10) Complete previous pregnancy complications, referring to list below: Write approximate letter or letters on space provided. a. Hx of low birth weight infant(s) <5.5 pounds b. Hx of premature infant(s) <37 weeks gestation c. Hx of infant(s) > 10 pounds at birth d. Hx of or planned C-section e. Multiple pregnancy or recent multiple birth f. Medical problems (e.g., diabetes, hypertension, pre-eclampsia, eclampsia) g. Disability that may compromise adequacy of diet h. Social or environmental condition that may compromise adequacy of diet i. Substance use (e.g., alcohol, drugs, cigarettes, pica) j. Vitamin/mineral supplement or medicine prescription k. Special formula prescription and medical reason for its necessity l. Other pertinent health/medical data 1) Fill in physician's name or clinic and phone number. 2) Signature of referring health professional IS REQUIRED, with current date. Assessment Section/Food Frequency *(Page 1 and 2)* 1) This section may be completed by the client or a health professional. 2) If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC standards demand further clarification. 3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly. 4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure. 5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below) If materials are provided, write the

New Jersey State Department of Health

Referral/Nutrition Assessment for Women

INSTRUCTIONS

Assessment Section/Food Frequency *(Page 1 and 2)*

1) This section may be completed by the client or a health professional.

2) If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1 through 18. Any responses that do NOT meet WIC standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/ WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.

6) Listed below is continuation of nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space labeled Other.

05 — Child Nutrition
06 — Dental Health
07 — Fat in the Diet
08 — Food Budgeting/Consumer Awareness/Meal Planning
09 — Fruit and Vegetables
11 — Mealtime Psychology
12 — Nutrients in WIC Foods
15 — Salt in the Diet
16 — Smoking and Pregnancy
17 — Snacking
18 — Sugar in Diet
19 — Vitamin A in Diet
20 — Vitamin C in Diet
44 — No Show
45 — Client Refused

Wellpoint

Domestic Violence Screening Tool

Framing Statements

1. Because violence is so common in many people's lives, I have begun to ask all my members about it.
2. I'm concerned that someone hurting you may have caused your symptoms.
3. I don't know if this is a problem for you, but many of the people I see as members are dealing with abusive relationships.

Direct Verbal Questions

1. Are you in a relationship with a person who physically hurts or threatens you?
2. Did someone cause these injuries? Was it your partner or spouse?
3. Has your partner or ex-partner ever hit you or physically hurt you? Has he or she ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
6. Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

New Member

Option 1:

1. Have you ever been hurt or threatened by your friend, spouse or partner?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?
3. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner during this pregnancy?
4. Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

1. Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?

Option 3:

1. Have you ever been forced or pressured to have sex when you did not want to?
2. Have you ever been hit, kicked, slapped, pushed or shoved by your friend, spouse or partner?

Wellpoint

Well-Being Screening Tool

For Adolescents & Adults
Patient Problem Questionnaire

Patient Name: _____ Date Completed: _____

Member ID#: _____ PCP Name: _____

The purpose of this questionnaire is to identify problems your doctor may be able to help you with. Please answer all questions by checking one box per question.

During the past month generally (questions 1 – 11):	YES	NO
1. Have you been feeling tired or have low energy?		
2. Have you been having trouble sleeping? (Too much or too little)		
3. Have you been feeling sad, hopeless, or unusually happy?		
4. Have you been feeling bad about yourself that you are a failure or have let yourself or your family down?		
5. Have you been having trouble concentrating on things, such as watching TV, reading the newspaper, or reading a book?		
6. Have you been feeling on edge, nervous?		
7. Have your eating patterns or appetite changed?		
8. Have you been trying not to gain weight (making yourself vomit, taking excessive		

laxatives, or exercising more than an hour per day)?		
9. Have you felt sudden fear or panic for no obvious reason?		
10. Have you been having thoughts that you would be better off dead, or of hurting yourself?		
11. Are you troubled by being unable to control your anger or by having thoughts about hurting others?		
12. Have you: a. Ever felt you ought to cut down on your drinking or drug use?		
b. Ever felt annoyed by people who comment on your drinking or drug use?		
c. Ever felt bad or guilty about your drinking or drug use?		
d. Ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?		
13. Do you have any other concerns about your well-being? Please explain.		
14. Have you ever sought treatment for any of the above problems for which you checked yes?		
15. If you checked off yes to any of the above questions, how difficult have these problems made it for you to do your work, go to school, take care of things at home or get along with other people? Not Difficult At All Somewhat Difficult Very Difficult Extremely Difficult		

Wellpoint

Specialist as PCP Request Form

Date: _____
Member's name: _____
Member's ID #: _____
PCP's name (if applicable): _____
Specialist/specialty: _____
Member's diagnosis: _____
Describe the medical justification for selecting a specialist as the PCP for this member.

_____
_____
_____
_____
_____

The signatures below indicate agreement by the specialist, Wellpoint and the member for whom the specialist will function as this member's PCP, including providing to the member access 24 hours a day, 7 days a week.

Specialist's signature: _____ Date: _____
Medical director's signature: _____ Date: _____
Member's signature: _____ Date: _____

AAP Oral Health Risk Assessment Tool (Age < 6)

Please note that this is an image. Visit the website link to access the most current form. **https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf**. Accessed 1 December 2019.

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: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS

⚠ Mother or primary caregiver had active decay in the past 12 months
☐Yes ☐No

- Mother or primary caregiver does not have a dentist
  ☐Yes ☐No

- Continual bottle/sippy cup use with fluid other than water
  ☐Yes ☐No
- Frequent snacking
  ☐Yes ☐No
- Special health care needs
  ☐Yes ☐No
- Medicaid eligible
  ☐Yes ☐No

PROTECTIVE FACTORS

- Existing dental home
  ☐Yes ☐No
- Drinks fluoridated water or takes fluoride supplements
  ☐Yes ☐No
- Fluoride varnish in the last 6 months
  ☐Yes ☐No
- Has teeth brushed twice daily
  ☐Yes ☐No

CLINICAL FINDINGS

⚠ White spots or visible decalcifications in the past 12 months
☐Yes ☐No

⚠ Obvious decay
☐Yes ☐No

⚠ Restorations (fillings) present
☐Yes ☐No

- Visible plaque accumulation
  ☐Yes ☐No
- Gingivitis (swollen/bleeding gums)
  ☐Yes ☐No
- Teeth present
  ☐Yes ☐No
- Healthy teeth
  ☐Yes ☐No

ASSESSMENT/PLAN

Caries Risk:
☐Low ☐High

Completed:
☐Anticipatory Guidance
☐Fluoride Varnish
☐Dental Referral

Self Management Goals:

☐Regular dental visits	☐Wean off bottle	☐Healthy snacks
☐Dental treatment for parents	☐Less/No juice	☐Less/No junk food or candy
☐Brush twice daily	☐Only water in sippy cup	☐No soda
☐Use fluoride toothpaste	☐Drink tap water	☐Xylitol

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 MW, Crall 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(6):1387–1394; 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.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Bright Futures.

National Interprofessional Initiative on Oral Health

ADA Caries Risk Assessment Form (Age 0-6)

Please note that this is an image. Visit the website link to access the most current form. **http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx**. Accessed 16 February 2021.

ADA American Dental Association®
America's leading advocate for oral health

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)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	☐ No		☐ Yes
IV.	**Caries Experience of Mother, Caregiver and/or other Siblings**	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
V.	**Dental Home**: established patient of record in a dental office	☐ Yes	☐ 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)	☐ No		☐ 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 ☐		Carious lesions or restorations in last 24 months ☐
II.	**Non-cavitated** (incipient) **Carious Lesions**	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	**Teeth Missing Due to Caries**	☐ No		☐ Yes
IV.	**Visible Plaque**	☐ No	☐ Yes	
V.	**Dental/ Orthodontic Appliances Present** (fixed or removable)	☐ No	☐ Yes	
VI.	**Salivary Flow**	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

ADA Caries Risk Assessment Form (Age >6)

Please note that this is an image. Visit the website link to access the most current form. **http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx.** Accessed 1 December 2019.

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)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	☐ Yes	☐ 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)	☐ No	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	**Chemo/Radiation Therapy**	☐ No		☐ Yes
III.	**Eating Disorders**	☐ No	☐ Yes	
IV.	**Medications that Reduce Salivary Flow**	☐ No	☐ Yes	
V.	**Drug/Alcohol Abuse**	☐ No	☐ 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 ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in last 36 months ☐
II.	**Teeth Missing Due to Caries in past 36 months**	☐ No		☐ Yes
III.	**Visible Plaque**	☐ No	☐ Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐ No	☐ Yes	
V.	**Interproximal Restorations - 1 or more**	☐ No	☐ Yes	
VI.	**Exposed Root Surfaces** Present	☐ No	☐ Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins; Open Contacts** with Food Impaction	☐ No	☐ Yes	
VIII.	**Dental/ Orthodontic Appliances** (fixed or removable)	☐ No	☐ Yes	
IX.	**Severe Dry Mouth (Xerostomia)**	☐ No		☐ Yes

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

Wellpoint

Counsel for HIV Antibody Blood Test

use patient imprint

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled
(Name of physician or other provider)
and provided me with:
A. Information concerning how HIV is transmitted
B. The benefits of voluntary testing
C. The benefits of knowing if I have HIV or not
D. The treatments which are available to me and my unborn child should I test positive
E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV. ☐

I have decided not to be tested for infection with HIV. ☐

This record will be retained as a permanent part of the patient's medical record.

_____ _____
Signature of Patient Date

_____
Signature of Witness

Wellpoint

Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when they really don't — this is a false positive test. The test may also fail to show that a person has antibodies to the virus when they really do — this is a false negative test. I have also been advised that this is not a test for AIDS and that a positive test does not mean that I have AIDS. Other tests and examinations are needed to diagnose AIDS.

I have been advised that, if I have any questions about the HIV antibody test, its benefits or its risks, I may ask those questions before I decide to agree to the blood test.

I understand that the results of this blood test will only be given to those health care workers directly responsible for my care and treatment. I also understand that my results can only be given to other agencies or persons if I sign a release form.

By signing below, I agree that I have read this form or someone has read this form to me. I have had all my questions answered and have been given all the information I want about the blood test and the use of the results of my blood test. I agree to give a tube of blood for the HIV antibody tests. There is almost no risk in giving blood. I may have some pain or a bruise around the place that the blood was taken.

_____ _____

Date Patient's/Guardian's Signature

_____ _____

Witness Signature Patient's/Guardian's Printed Name

_____

Physician Signature

Wellpoint recognizes the need for strict confidentiality guidelines.

Wellpoint

Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization for use or disclosure of the results of a blood test to detect antibodies to HIV, the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you to comply with the terms of Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _____ to furnish
(Name of physician, hospital or health care provider)
to _____ the results of the blood
(Name or title of person who is to receive results)
test for antibodies to HIV.

C. USES

The requester may use the information for any purpose, subject only to the following limitation: _____.

D. DURATION

This authorization shall become effective immediately and shall remain in effect indefinitely or until _____, 20____, whichever is shorter.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: ☐ Yes ☐ No _____ Initial

Date: _____, 20_____ _____

Signature

_____

Printed Name

Note: this form must be in at least eight-point type.

Durable Power of Attorney

You can name a durable power of attorney by filling out this form. You can use another form or use the one your doctor gives you, too. If you name a durable power of attorney, give it to your PCP.

I, _____, want _____,
Name Name of person I want to carry out my wishes

_____
Person's address

to make treatment decisions for me if I cannot. This person can make decisions when I am in a coma, not mentally able to or so sick I just cannot tell anyone. If the person I named is not able to do this for me, then I name another person to do it for me. This person is _____,
Name of second person I want to

_____.
carry out my wishes and second person's address

TREATMENT I DO **NOT** WANT. I do not want (put your initials by the services you do not want):

☐ Cardiac resuscitation (start my heart pumping after it has stopped)
☐ Mechanical respiration (machine breathing for me if my lungs have stopped)
☐ Tube feeding (a tube in my nose or stomach that will feed me)
☐ Antibiotics (drugs that kill germs)
☐ Hydration (water and other fluids)
☐ Other (say what it is here)

TREATMENT I **DO** WANT. I want (put your initial by the services you do want):

☐ No medical services
☐ Pain relief

☐ All treatment to keep me alive as long as possible
☐ Other (say what it is here)

What I say here will happen, unless I decide to change it or decide not to have a durable power of attorney at all. I can change my durable power of attorney any time I wish. I just have to let my doctor know I want to change it or not have it at all.

Signature: _____
Date: _____
Address: _____
Statement of Witness
I am not related to this person by blood or marriage. I know that I would not get any part of the person's estate when he or she dies. I am not a patient in the health care facility where this person is a patient. I am not a person who has a claim against any part of this person's estate when he or she dies. Furthermore, if I am an employee of a health facility in which this person is a patient, I am not involved in providing direct patient care to him or her. I am not directly involved in the financial affairs of the health facility.

Witness: _____
Date: _____
Address: _____

Personal Care Assistant (CHHA) Referral Form

Please Complete All Areas of the Form - Type or Print Legibly

QUESTIONS? Call: 1-855-661-1996

□ New

□ Recertification
**Submit 30 days prior to the authorization end date*

□ Increase
*Include physician's prescription

□ Insurance transfer _____ *(Include the former insurance carrier's notice of eligibility with this form)*
Type or print the former insurance carrier's Name

□ Agency Transfer _____ *(Include the member's transfer letter, stating the reason(s) for the request)*
Type or print the Agency Name

MEMBER INFORMATION

Last name	First name	Middle initial	Home/Cell phone

Member ID #	SS #	DOB	Gender □ Male □ Female

Street address	Apt/Unit	City	County	Zip

The member lives: □ Independently □ With Caregiver(s) □ Boarding Home □ Assisted Living □ Nursing Home □ Group Home □ RHCF □ Other

If translation services are required, please specify the language:

Medicaid Waiver Program: □ GO □ CCW □ TBI □ CRPD □ AACAP Is this service included in the case manager's plan of care? □ No □ Yes (If yes, attach approval)

Case Manager (*Print First Name and Last Name*): Phone #:

Diagnosis (*worded and numeric 5 digits*):

Member's Alternate Contact	Relationship	Home #	Cell #

Physician Information

Name	NPI #	Fax#
Office Address:		Office #

Provider Information

Agency Name	AGP Provider ID#	Phone#	Fax#

Street Address	City	County	Contact Person

Attestation

I hereby attest that the aforementioned agency has received a physician certification indicating the member's need for PCA services. I understand that Amerigroup can request a copy of this certification 30 days after services are ordered.

_____ _____ _____

Print: First Name and Last name | Signature | Date

Fax this completed form and any supplemental documents to: 1-888-240-4716

Wellpoint

Adult and Pediatric Day Health Services Referral Form

Please Complete All Areas of the Form - Type or Print Legibly

QUESTIONS? Call: 1-855-661-1996

□ New

□ Recertification
*Submit 30 days prior to the authorization end date

□ Increase
*Include physician's prescription

□ Insurance transfer _____ *(Include the former insurance carrier's notice of eligibility with this form)*
Type or print the former insurance carrier's Name

□ Transfer from _____ *(Include the member's transfer letter, stating the reason(s) for the request)*
Type or print the Facility Name

MEMBER INFORMATION

Last name	First name	Middle initial	Home/Cell phone

Member ID #	SS #	DOB	Gender □ Male □ Female

Street address	Apt/Unit	City	County	Zip

If translation services are required, please specify the language:

PROVIDER INFORMATION

Provider Name	AGP Provider #	Phone #	Fax#

Street Address	City	County	Contact Person

PHYSICIAN INFORMATION

Physician Name:	NPI #	Office Fax #
Office Address:		Office #

MEDICAL ELIGIBILITY SCREEN

Diagnosis (*worded and numeric 5 digits*):

Prescription is attached: □ YES □ NO	Current # of days (per week):	Requested # of days (per week):	Requested Authorization Dates From _____ To _____

State reason for PDHS request (include physician's report describing the child's special medical needs to support this request):

Director of Nursing *(Print First Name and Last Name)*	***Signature***	**Date**	**Phone Number**

Fax this completed form and any supplemental documents to: 1-888-240-4717

provider.wellpoint.com/nj/

Medicaid services provided by Wellpoint New Jersey, Inc. or Wellpoint Insurance Company.

NJWP-CD-PM-036920-23