



# Healthfirst Health Plan of New Jersey, Inc.

Healthfirst Health Plan of New Jersey, Inc. is a not-for-profit health plan dedicated to providing affordable, quality care and improving the health of the communities we serve. Through our unique hospital-managed business model, our participating hospitals maintain a leading role in organizing and guiding high quality, comprehensive healthcare services.

By working in partnership with our participating hospitals in Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties, Healthfirst NJ has developed a solid and effective approach to meeting the diverse needs of New Jersey residents.

## **New Jersey Hospitals**

Bayonne Medical Center  
Children's Specialized Hospital  
Christ Hospital  
East Orange General Hospital  
Englewood Hospital and Medical Center  
Hoboken University Medical Center  
Holy Name Medical Center  
Jersey City Medical Center  
JFK Medical Center  
Palisades Medical Center  
Raritan Bay Medical Center- Old Bridge  
Raritan Bay Medical Center- Perth Amboy  
Robert Wood Johnson University Hospital Hamilton  
Saint Clare's Health System- Boonton  
Saint Clare's Health System- Denville  
Saint Clare's Health System- Dover  
Saint Clare's Health System- Sussex  
Saint Michael's Medical Center  
Saint Peter's University Hospital  
Somerset Medical Center  
St. Joseph's Wayne Hospital  
St. Joseph's Hospital & Medical Center  
St. Mary's Hospital-Passaic  
Trinitas Hospital

*Healthfirst Health Plan of New Jersey, Inc. is part of the Healthfirst NJ family of companies which includes Healthfirst, Inc., in New York and HF Management Services, LLC, which provides comprehensive management services to healthcare organizations, and Senior Health Partners (SHP), a not-for-profit managed long term care plan serving Medicaid-eligible clients.*

*Healthfirst in New York (Managed Health, Inc. and Healthfirst NJ PHSP, Inc.) and Healthfirst NJ (Healthfirst Health Plan of New Jersey, Inc.) each maintain separate provider networks. Members must see providers in their health plan's network for services to be considered in-network. Services rendered without prior authorization by providers or facilities outside of the network are considered out-of-network.*

## Table of Contents

The NJ FamilyCare/Medicaid Provider Manual and NJ FamilyCare/Medicaid Provider Manual Appendices  
are available online at [www.healthfirstnj.org](http://www.healthfirstnj.org).

<b>1. Introduction.....</b>	<b>8</b>
1.1 Introduction to the Provider Manual.....	8
1.2 About Healthfirst .....	8
Provider Participation .....	8
1.3 Network Management and Provider Services .....	9
Online Services .....	9
Translation Services.....	9
Other Healthfirst NJ Departments .....	10
<b>2. Healthfirst NJ Programs and Benefits .....</b>	<b>12</b>
2.1 Healthfirst NJ Medicaid and NJ FamilyCare Programs .....	12
2.2 Benefits/Covered Services .....	12
Consent to Receive Noncovered Services .....	12
<b>3. Healthfirst NJ Provider Networks .....</b>	<b>13</b>
3.1 Description of the Networks.....	13
Hospital Responsibilities.....	13
Primary Care .....	13
Primary Care for HIV Positive Members.....	14
Treatment Adherence.....	14
Harm Reduction Services.....	14
Specialist Physicians .....	14
Tertiary Care.....	15
Behavioral Healthcare .....	15
Ancillary Services .....	15
Federally Qualified Health Centers (FQHCs) .....	15
Credentialing of Providers .....	15
Partnering with Healthfirst NJ - Mutual Expectations.....	15
Quality Improvement and Commitment to Providers .....	16
3.2 Provider Rights and Responsibilities .....	16
Provider Rights.....	16
Provider Responsibilities .....	16
Non-Discrimination .....	16
Cultural Competence.....	17
Program Participation and Compliance .....	17
Release of Member Information .....	17
Billing.....	18
Fraud, Waste & Abuse Procedures .....	18
Reporting Fraud, Waste & Abuse .....	19
Provider Information .....	19
3.3 Appointment Availability and Twenty-four (24) Hour Access Standards .....	19
Office Hours.....	19
Twenty-four (24) Hour Coverage.....	20
Appointment Time Standards .....	20
Specialist Appointment Time Standards.....	21
Prenatal Care Appointment Time Standards .....	21
Initial Appointment Time Standards.....	21
Lab and Radiology Services Appointment Time Standards .....	21
Dental Appointment Time Standards.....	21
Mental Health/Substance Abuse Appointment Time Standards.....	21
Appointment Standards for Elderly and Disabled Members .....	21

Waiting Time Standards .....	21
Missed Appointments .....	22
3.4 Provider Application Process .....	22
3.5 Credentialing and Recredentialing Requirements .....	22
The Credentialing Subcommittee .....	22
3.6 Termination of Provider Agreements .....	23
Termination by Mutual Consent .....	23
Non-renewal by Healthfirst NJ or a Provider .....	23
Termination by Healthfirst NJ .....	23
Continuity of Care .....	24
Reporting .....	24
Appeal Hearings Regarding Provider Termination .....	24
Reporting Suspected Fraudulent Conduct .....	25
3.7 Provider Profiling .....	25
<b>4. Eligibility and Membership .....</b>	<b>27</b>
4.1 Scope of Benefits .....	27
Healthfirst NJ Medicaid .....	27
NJ FamilyCare (A through D) .....	27
4.2 Marketing .....	28
4.3 Enrollment and Disenrollment .....	29
Mandatory Medicaid Managed Care .....	29
Member Enrollment Rosters .....	29
Newborns .....	29
PCP Selection .....	30
Involuntary Change of PCP (Requesting Member Transfer) .....	30
Continuity of Care for New Members .....	30
New Members – existing plans of care .....	31
Contacting Members .....	31
Disenrollment .....	31
Voluntary Disenrollment .....	31
Involuntary Disenrollment .....	31
4.4 Eligibility Verification .....	32
4.5 Member Rights and Responsibilities .....	33
4.6 Member Services and Education .....	34
New Member Outreach and Orientation .....	34
Special Outreach and Care Management Programs .....	35
Translation Services .....	35
<b>5. Regulatory and Reporting Requirements .....</b>	<b>36</b>
5.1 Reporting Requirements .....	36
5.2 Fraud, Waste and Abuse Hotline .....	36
5.3 Medical Record Reviews and Documentation Standards .....	47
Transfer of Medical Records .....	48
5.4 Confidentiality .....	48
5.5 Advance Directives/Healthcare Proxy .....	48
Advance Directive for Mental Healthcare .....	49
<b>6. Primary Care .....</b>	<b>50</b>
6.1 Definition of Primary Care .....	50
PCP Responsibilities .....	50
Access .....	50
Clinical Care .....	50
Preventive Care .....	50
Behavioral Healthcare Screening .....	51

Coordination of Care and Services.....	51
Referrals .....	51
Administrative Responsibilities .....	51
6.2 Primary Care Panels and Member Enrollment Rosters.....	51
6.3 Preventive Care Standards .....	51
Vaccines for Children (VFC) .....	52
EPSDT Services.....	52
Lead Screening .....	54
WIC Program.....	54
Mental Health/Substance Abuse .....	55
6.4 Genetic Testing and Counseling .....	55
6.5 Services considered to be Medical or Dental .....	55
<b>7. Obstetrics and Gynecology.....</b>	<b>56</b>
7.1 Definition of Services.....	56
Guidelines for Differentiating Gynecological Care from Primary Care.....	56
Access to Family Planning and Reproductive Health Services .....	57
7.2 Diagnostic Testing.....	58
7.3 Consent Requirements for Hysterectomy.....	58
7.4 Family Planning and Reproductive Health.....	59
Scope of Services.....	59
Consent Requirements for Sterilization.....	59
General Requirements .....	60
Specific Disclosures .....	61
<b>8. Specialty Care.....</b>	<b>62</b>
8.1 Definition of Specialty Care .....	62
Specialists as PCPs .....	62
Specialty Care Centers.....	63
<b>9. Behavioral Healthcare and Chemical Dependency .....</b>	<b>64</b>
9.1 Description of the Network .....	64
9.2 Benefits and Access to Care .....	64
Benefits Overview.....	64
Access to Care for Healthfirst NJ DDD Members.....	64
Access to Care for Healthfirst NJ non-DDD Members.....	65
9.3 Utilization and Medical Management Guidelines.....	65
Authorization of Services.....	65
Authorization of Services When Care is Managed by Healthfirst NJ.....	65
Continued Extended Services Review.....	66
Healthfirst NJ Treatment Principles .....	66
<b>10. Ancillary and Other Special Services .....</b>	<b>67</b>
10.1 Overview of Services and the Provider Network .....	67
Ancillary Services Provider Responsibilities .....	67
10.2 Laboratory .....	67
10.3 Pharmacy .....	67
Programs and Covered Services.....	67
Prescription Formulary .....	68
Generic Drugs .....	68
Specialty Medications.....	68
10.4 Durable Medical Equipment, Orthotics and Prosthetics, and Medical Supplies .....	69
10.5 Home Healthcare.....	69
Services and Eligibility.....	69
Responsibilities of Certified Home Health Agencies.....	70
Prior Authorization Process: General Guidelines .....	70
10.6 Dental .....	70

10.7 Routine Vision .....	71
10.8 Hospice.....	71
10.9 Transportation .....	71
Emergency Transportation .....	71
<b>11. Emergency and Urgent Care .....</b>	<b>72</b>
11.1 Overview.....	72
Definition of an Emergency Medical/Dental Conditions.....	72
Emergency Dental Services .....	72
Definition of Urgent Medical Condition .....	72
Definition of Urgently Needed Services .....	72
Emergency and Urgent Care Guidelines.....	72
Emergency Inpatient Admissions .....	72
<b>12. Medical Management .....</b>	<b>74</b>
12.1 Program Overview.....	74
12.2 PCP-Directed Care.....	74
General Guidelines.....	74
Ancillary Services .....	74
Behavioral Health and Chemical Dependency Services .....	75
Obstetrical Services.....	75
12.3 Authorization of Services.....	75
General Requirements .....	75
Standard Time Frames for Prior Authorization Determinations .....	75
Authorization of Inpatient Admissions: Elective Admissions.....	76
Emergency Admissions .....	76
12.4 Out-of-Network Services .....	77
12.5 Out-of-Area Services.....	77
12.6 Continuity of Care.....	77
Standing Authorizations.....	77
Transition from Nonparticipating to Participating Providers.....	77
Medical Records.....	78
Continuity of Care Guidelines.....	78
12.7 Continued Extended Services Review.....	79
12.8 Retrospective Review.....	79
<b>13. Medical Management and Care Management Programs .....</b>	<b>80</b>
13.1 Overview.....	80
Asthma .....	80
Congestive Heart Failure.....	81
Chronic Obstructive Pulmonary Disease (COPD) .....	81
Diabetes .....	81
HIV/AIDS .....	81
Hypertension .....	81
Lead.....	81
Behavioral Health/Domestic Violence .....	81
Care Management for Special Needs .....	81
Healthy Mom/Healthy Baby .....	82
High Risk Codes.....	82
<b>14. Quality Improvement Program .....</b>	<b>84</b>
14.1 Overview Philosophy of the Program .....	84
Program Scope.....	84
14.2 Reporting Requirements and Quality Programs .....	85
Encounter Data (DMAHS) .....	85

CMS Coding Requirements .....	85
Healthcare Effectiveness Data and Information Set (HEDIS).....	85
HEDIS Follow-up After Hospitalization for Mental Illness Measure .....	86
HEDIS Antidepressant Medication Management Measure .....	87
Provider Network Reports .....	87
Reporting Requirements for the New Jersey State Cancer Registry (NJSCR) .....	87
Additional Information Regarding Public Health Reporting.....	87
HIV/AIDS .....	88
STD .....	88
Child Abuse and Domestic Violence .....	88
Smoking Cessation.....	89
14.3 Programs and Registries .....	89
Immuni-Kids Program .....	89
Adolescent Registry and Healthy Teen Program .....	89
Diabetes Control for Life.....	89
Heartwise .....	90
Healthfirst NJ Advantage Program .....	90
14.4 Clinical Practice Guidelines .....	90
14.5 Quality Improvement Projects, Surveys and Investigations.....	90
Continuous Quality Improvement (CQI) Projects.....	90
Member Satisfaction Surveys.....	90
Quality of Care Investigations.....	90
<b>15. Appeals and Grievances.....</b>	<b>92</b>
15.1 Action Denial Notice .....	92
15.2 Action Appeals.....	92
Internal Appeal Process (Stage 1).....	92
Formal Internal Utilization Management Appeal Process (Stage 2) .....	92
External Appeal Process (Stage 3) .....	93
15.3 Expedited Resolution Appeals .....	93
Action Following Denial of a Request for Expedited Resolution .....	93
15.4 Notice of an Action Appeals Determination .....	93
15.5 Member Rights to a Fair Hearing.....	94
15.6 Member Complaints .....	94
<b>16. Provider Compensation .....</b>	<b>95</b>
16.1 Primary Care Services/Primary Care Providers .....	95
16.2 Obstetrical Care.....	96
16.3 Family Planning Services .....	96
16.4 Healthfirst NJ Payment in Full/Member Hold Harmless.....	96
<b>17. Billing &amp; Claims Processing.....</b>	<b>97</b>
17.1 Overview.....	97
17.2 General Billing Requirements.....	98
Facilities.....	99
Facilities Billing on Behalf of Employed Providers.....	99
Present on Admission (POA) .....	99
17.3 Reimbursement .....	99
Hospital Reimbursement .....	99
Provider Reimbursement.....	99
Obstetrical Care.....	99
17.4 Use of Provider Numbers for Billing.....	100
17.5 Coordination of Benefits (COB) .....	100
17.6 Billing Instructions .....	100
Electronic Billing Instructions.....	100
Paper Claim Submission .....	101



Claim Inquiries.....	101
17.7 Provider Complaints, Appeals and Dispute Resolution .....	101
17.8 Explanation of Payment (EOP).....	103
17.9 Electronic Funds Transfer/Electronic Remittance Advice.....	104
17.10 Overpayments .....	104
Overpayment Recovery Procedures .....	104
Repayment Options Offered to Providers.....	105
<b>18. Glossary of Terms .....</b>	<b>106</b>

**Appendices**

The Appendices to this Provider Manual is a separate document. Please refer to the *Healthfirst Health Plan of New Jersey, Inc. NJ FamilyCare/Medicaid Provider Manual Appendices*. The NJ FamilyCare/Medicaid Provider Manual and NJ FamilyCare/Medicaid Provider Manual Appendices are available online at [www.healthfirstnj.org](http://www.healthfirstnj.org).

## 1. Introduction

### 1.1 Introduction to the Provider Manual

Healthfirst Health Plan of New Jersey, Inc. (Healthfirst NJ) is committed to ensuring that its members receive easily accessible, high-quality, comprehensive healthcare services. The Healthfirst NJ provider network is a key partner in achieving this goal. This manual has been developed to assist our participating providers in understanding the administrative policies and procedures that govern the management of Healthfirst NJ. It is designed to provide you with easy access to information that will enable you and your office staff to care for NJ FamilyCare/Medicaid members within administrative guidelines. All of the information in this manual applies to all NJ FamilyCare/Medicaid members, unless specifically indicated. This manual is incorporated into your provider agreement with Healthfirst NJ and its provisions enforced as part of the provider agreement.

#### Updates to the Manual

Healthfirst NJ will update the Provider Manual and Appendices periodically and will make electronic versions available that may be downloaded from our website at [www.healthfirstnj.org](http://www.healthfirstnj.org). Information related to these updates may appear on the Healthfirst NJ website and in other mailings. These mediums provide the most current information on the Healthfirst NJ programs and your responsibilities under these programs.

#### Keep us Informed

Please take the time to read through the Provider Manual and let us know if there are any sections that are unclear or if there are other topics about which you would like more information. Our goal is to provide you with material that is timely, accurate and easy to understand. We welcome your comments.

### 1.2 About Healthfirst

Healthfirst operates not-for-profit managed care organizations dedicated to providing affordable, high-quality care and improving the effectiveness of healthcare delivery.

We work in partnership with area hospitals and medical centers to develop effective and efficient programs that maximize safe clinical practices and enhance service delivery. This partnership has resulted in an innovative hands-on approach to coordinating health and disease management programs that serve the complex medical needs of our members.

These same values are the guiding force behind our hospital-managed business model and explain why we return the financial savings of our operational efficiencies to our participating hospitals for the benefit of the public healthcare system—improving the quality of care for our members and the health of our communities.

Our strong relationships with community-based organizations, schools, advocacy groups, local politicians, hospitals, governmental agencies and businesses enable us to stay abreast of healthcare needs within the communities we serve and develop programs to meet them.

The Healthfirst family of companies has over 14 years of success delivering quality government-sponsored healthcare. These companies include Healthfirst Inc. in New York, Healthfirst Health Plan of New Jersey, Inc., and HF Management Services, LLC, which provides comprehensive management services to healthcare organizations, and Senior Health Partners (SHP), a not-for-profit managed long term care plan serving Medicaid-eligible clients.

#### Provider Participation

Healthfirst NJ hospitals and their affiliated providers may be contracted to participate in one Healthfirst NJ program or in a combination of programs (see Section 2). Because contracting differs among the programs, it is important to note that a provider who is contracted to provide services for one program is considered to be out-of-network for all of the other programs. Additionally, participation is office site specific. While a contract may cover multiple locations, if an application has not been submitted or approved for a particular office, services rendered there are considered out-of-network. To confirm the programs that you participate in, contact Provider Services.

### 1.3 Network Management and Provider Services

#### Network Management

All participating hospitals, their affiliated providers and individual participating providers have a designated Healthfirst NJ representative who serves as the liaison between the facility, its affiliated providers, participating providers and Healthfirst NJ. These representatives provide information, solve problems and respond, as needed, to provider issues.

#### Provider Services

Healthfirst NJ also has a dedicated phone unit available to assist providers with questions regarding Healthfirst NJ policies and procedures, member care, reimbursement, claim information or general information about Healthfirst NJ and its products. If you have any questions or need more information about Healthfirst NJ and its products, please call Provider Services at **1-866-889-2523**, Monday through Friday from 9:00 am to 5:00 pm.

#### Online Services

Hospitals, providers and their office staff can access information 24 hours a day, 7 days a week on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org).

Quick and easy online registration provides immediate access to tools that enable you to:

- Check claim status;
- Verify member eligibility;
- View the status of authorizations;
- Submit questions to Healthfirst NJ;
- Access Healthfirst NJ Policies and Procedures;
- Download Member Enrollment rosters and other reports;
- Review the latest Clinical Guidelines, newsletters, reference materials and more.

For questions or more information about our website, send an e-mail to [webmaster@healthfirst.org](mailto:webmaster@healthfirst.org).

#### Translation Services

Healthfirst NJ has staff that speaks English, Spanish, Russian, Mandarin and Cantonese to help improve communication with our members. Additionally, Healthfirst NJ has contracted with a 24 hr / 7day phone relay service (TTY service) to assist Healthfirst NJ employees in communicating with hearing impaired members in both English and Spanish. Those numbers are **1-800-852-7897** (English) and **1-866-658-7714** (Spanish).

This same staff and relay service are available to our providers as needed. If a provider does not have translation service or language capabilities, they should call Member Services who will connect them with the appropriate translator.

#### Other Healthfirst NJ Departments

In addition to Provider Services, there are other departments at Healthfirst NJ that you may contact or work with on a regular basis. The following table highlights these areas and outlines their key functions. Staff from these departments is available to assist you in providing care to NJ FamilyCare/Medicaid members.

Department	Key Functions and Responsibilities
<p><b>Appeals and Grievances Unit</b>  P.O. Box 12102  Newark, NJ 07101-3402  <b>1-866-889-2527</b>  Fax: <b>1-866-505-7041</b></p>	<ul style="list-style-type: none"> <li>■ Member appeals and grievances</li> </ul>
<p><b>Medical Claims</b>  P.O. Box 12101  Newark, NJ 07101-3401  Monday through Friday, 8:00 am to 6:00 pm  <b>1-866-889-2523</b>  Fax: <b>1-866-889-2526</b></p>	<ul style="list-style-type: none"> <li>■ Claims payment/status inquiries</li> <li>■ Claim review and reconsideration</li> </ul>
<p><b>Network Management</b>  P.O. Box 12108  Newark, NJ 07101-3408  <b>1-866-889-2523</b>  Fax: <b>1-866-697-2378</b></p>	<ul style="list-style-type: none"> <li>■ Provider Communications</li> </ul>
<p><b>Davis Vision Claims</b>  Attn: Vision Care Processing Unit  P.O. Box 1525  Latham, NY 12110  Monday through Friday, 8:00am to 8:00pm  Saturday, 9:00am to 4:00pm  <b>1-800-753-3311</b></p>	<ul style="list-style-type: none"> <li>■ Claims payment/status inquiries regarding vision/eye-care benefits</li> </ul>
<p><b>DentaQuest Dental Claims</b>  Attn: Claims Department  12121 N. Corporate Parkway  Mequon, WI 53092  Monday through Friday, 8:00am to 5:00pm  <b>1-800-341-8478</b></p>	<ul style="list-style-type: none"> <li>■ Claims payments/status inquiries regarding dental benefits.</li> </ul>
<p><b>Medical Management, Authorizations and Behavioral Health Unit</b>  P.O. Box 12103  Newark, NJ 07101-3403  24 hours a day, 7 days a week  <b>1-866-467-7178</b>  Fax: <b>1-866-506-7060</b></p>	<ul style="list-style-type: none"> <li>■ Authorization of services</li> <li>■ Transitional care</li> <li>■ Care management/disease management</li> <li>■ Assistance in finding appropriate specialists or accessing in-network or out-of-network providers</li> <li>■ Utilization review</li> <li>■ Service authorizations for initial and continuing care</li> </ul>
<p><b>Member Services</b>  P.O. Box 12105  Newark, NJ 07101-3405  Monday through Friday 8:00am to 6:00pm  Phone: <b>1-888-GO-4-HFNJ (1-888-464-4365) English</b>  TTY: <b>1-800-852-7897</b>  <b>Spanish TTY: 1-866-658-7714</b></p>	<ul style="list-style-type: none"> <li>■ Eligibility verification</li> <li>■ Member benefits</li> <li>■ Distribution of member handbooks and provider directories to members</li> <li>■ New member orientations</li> <li>■ PCP selection</li> </ul>

<p><b>Quality Improvement</b>  P.O. Box 12104  Newark, NJ 07101-3404  Health Promotions Program  <b>1-866-889-2524</b>  Fax: <b>1-888-478-3606</b></p>	<ul style="list-style-type: none"> <li>■ Quality of care investigations</li> <li>■ HEDIS Reporting</li> <li>■ Quality Improvement Committee</li> <li>■ Quality improvement projects / focused studies</li> <li>■ Health Promotion Programs</li> <li>■ Member satisfaction surveys</li> <li>■ Public health reporting</li> <li>■ New Jersey QAPI Standards and QAPI requirements</li> <li>■ Clinical practice guidelines</li> </ul>
<p><b>Fraud, Waste and Abuse Hotline</b>  <b>1-877-879-9137</b></p>	
<p><b>Express Scripts Inc. Pharmacy (ESI)</b>  <b>Mail Stop:</b> BL0470-B7P  P.O. Box 390873  Bloomington, MN 55439  <b>Claims Address:</b>  Attn: MED-D Accounts  P.O. Box 390007  Bloomington, MN 55439</p> <p>24 hours a day, 7 days a week  Customer Service: <b>1-877-266-1484</b>  Pharmacy Help Desk: <b>1-800-824-0898</b></p>	<ul style="list-style-type: none"> <li>■ Filling a prescription</li> <li>■ Rx Formulary Listing</li> <li>■ Rx Prior Authorizations</li> </ul>
<p><b>CuraScript</b>  <b>Specialty Pharmacy</b>  Monday through Friday 8:00am to 9:00pm  Saturday, 9:00am to 1:00pm  <b>1-866-848-9870</b></p>	
<p><b>American Specialty Health</b>  <b>Chiropractor Services</b>  Monday through Friday 5:00am to 6:00pm (PST)  <b>1-800-678-9133</b></p>	

## 2. Healthfirst NJ Programs and Benefits

### 2.1 Healthfirst NJ Medicaid and NJ FamilyCare Programs

#### Healthfirst NJ Medicaid

Medicaid is the joint Federal/State program covering comprehensive health services with specific limits for income and resources available only to pregnant women, the aged (65+), blind, or permanently disabled (ABD) receiving Social Security benefits, very low income households with dependent children or single adults/childless couples receiving cash assistance, and children whose family income meets the NJ FamilyCare Plan A income limits.

In addition to services covered by Healthfirst NJ, Medicaid members may access certain other services that are paid by New Jersey's fee-for-service program.

#### NJ FamilyCare

NJ FamilyCare is a federal- and state-funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians obtain affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have access to affordable employer-provided health insurance, or cannot afford to pay the high cost of private health insurance. Eligibility is based on family size and monthly income and is determined by the number of children and adults living in the household. Family size includes children under age twenty-one (21), natural and adoptive parents, and their spouses. If a child is living in a household with a grandparent, guardian, or caretaker, that person is not included in the family size, and their income is not taken into consideration when calculating eligibility for NJ FamilyCare/Medicaid, unless the guardian is also requesting coverage. The member's monthly income will determine if their coverage under NJ FamilyCare is free or if they will have to pay a low monthly premium and small copayment for some services.

### 2.2 Benefits/Covered Services

Members who participate under a government-sponsored program are entitled to receive all services covered by that program. NJ FamilyCare/Medicaid members are entitled to receive all of the services covered under the NJ FamilyCare/Medicaid program, but some services, such as prescription drugs for ABD population, are covered directly by Medicaid Fee-for-Service.

To view a detailed summary of the services covered by NJ FamilyCare/Medicaid, see *Appendix XXII* and *Appendix XXIII*.

Any changes to a particular benefit package will be noted on our website or in other mailings. Copies of these materials are located on our web site, [www.healthfirstnj.org](http://www.healthfirstnj.org).

#### Consent to Receive Noncovered Services

Whenever it is determined that a given service is not covered by Healthfirst NJ, providers must:

- Inform the patient that while you believe that their Healthfirst NJ program does not cover the service, they should contact Member Services directly in order to determine whether the service is covered.
- Further advise the member that if they disagree, they may file a grievance or an appeal if dissatisfied. Information on the process for filing grievances and appeals may be obtained by calling Member Services.
- Advise the member of the cost for the service that they will be billed directly for the cost of non-covered services, and that Healthfirst NJ will not be in any way financially responsible; and
- Make a notation in the patient's chart that this information was clearly communicated to the patient who elected either to seek further review, or to proceed with or decline the services.

## 3. Healthfirst NJ Provider Networks

### 3.1 Description of the Networks

Healthfirst NJ serves the healthcare needs of its members through comprehensive provider networks for each of its programs. There are separate, but overlapping, provider networks in place for the Healthfirst NJ programs. They each include the clinical practitioners necessary to offer healthcare services covered by Healthfirst. The networks are organized into hospital systems around each Healthfirst NJ hospital or designated group of hospitals. A hospital system includes all inpatient and outpatient facilities linked with the institution as well as the participating primary and specialty care physicians and other healthcare personnel affiliated with the hospital's delivery system.

Medical services are generally rendered by hospital and community-based physicians within each hospital system. However, members may receive services from any participating provider or hospital, subject to any of Healthfirst NJ's utilization review policies. Members are not required to receive services from a particular participating hospital or group of participating providers. Additional services such as behavioral healthcare, home care, dental services and other ancillary services are provided and managed by Healthfirst NJ, by selected hospitals, or by other organizations specializing in these areas.

#### Hospital Responsibilities

Healthfirst NJ has contracted with hospitals to provide inpatient care, outpatient services and diagnostic testing to its member population. The hospitals and their associated delivery systems of providers, allied and ancillary health personnel, therapists and other affiliated providers comprise the Healthfirst NJ provider network. A list of participating Healthfirst NJ hospitals can be found in the Provider Directory. You can find the Provider Directory online at [www.healthfirstnj.org](http://www.healthfirstnj.org) after logging into the secure provider portal, or you may ask your Network Management Representative to provide you with a printed Provider Directory.

The following is an overview of responsibilities for hospitals participating with Healthfirst NJ:

1. Provide all contracted services within the scope of the hospital's operating certificate.
2. Verify member eligibility for all services.
3. Obtain prior authorization for all elective admissions from the Healthfirst NJ Medical Management Department.
4. Report all emergency admissions to Healthfirst NJ within twenty-four (24) hours or on the next business day. However, authorization by Healthfirst NJ is not required for emergency treatment
5. Refer members back to their PCPs for coordination of specialty care following an emergency room visit.
6. Ensure continuity of care by coordinating discharge arrangements with the member's PCP, specialty care provider (as appropriate), other post-discharge providers such as certified home health agencies, and the Healthfirst NJ Medical Management Department.
7. Ascertain whether the member has executed an Advance Directive, include an executed Advance Directive in the member's medical record, and honor the member's wishes as documented in the Advance Directive.
8. Implement operating procedures required to comply with Healthfirst NJ's policies and procedures.

#### Primary Care

Healthfirst NJ primary and specialty care physicians practice in a variety of settings including hospital outpatient departments, hospital-sponsored, independent community-based practices and private physicians' offices located either on participating hospital campuses or within the community. In addition, there are community-based primary care providers who care for NJ FamilyCare/Medicaid members even though they are not formally affiliated with a participating hospital. These physicians participate with Healthfirst NJ through special arrangements.

Primary Care Providers (PCPs) are providers that specialize in Family Practice, Internal Medicine, General Practice, Geriatrics, and Pediatrics. Other healthcare professionals qualified as PCPs include:

- Nurse Providers/Clinical Nurse Specialists certified by the State Board of Nursing that specialize in Family Practice, Internal Medicine, General Practice, Geriatrics or Pediatrics.
- Physician Assistants licensed by the NJ Board of Medical Examiners and Certified Nurse Midwives registered by the NJ Board of Medical Examiners.

All members enrolling in Healthfirst NJ select or are assigned a participating PCP. Generally, members choose geographically convenient providers and hospitals. Members may change PCPs at any time and select a new provider from the Healthfirst NJ network.

PCPs are responsible for coordinating all of the care a member receives, and are expected to refer members to specialists in the Healthfirst NJ network for care that is outside of the scope of primary care. Written referrals are not required for NJ FamilyCare/Medicaid members to receive care from in-network specialists. However, PCPs are responsible for monitoring all member care and promoting the return of the member to primary care for services and management. PCPs are also responsible for requesting authorizations from Medical Management. Authorizations, when required, are essential for prompt claims payment. Please refer to *Section 12* for more details on our authorization processes.

Because the PCP is the member's first contact with Healthfirst NJ, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions using appropriate diagnostic procedures and recommending them to Care Management for intensive review and follow-up. If the case meets Care Management criteria, the PCP, along with the Healthfirst NJ Care Manager, formulates and implements a time specific treatment plan, taking into consideration the member's input. The PCP should also refer members to appropriate specialists to accommodate the treatment plan, and update treatment plans periodically. Please refer to *Section 13* for more information.

All Healthfirst NJ members can access participating Obstetricians and Gynecologists directly for ambulatory services including preventive health care.

### **Primary Care for HIV Positive Members**

All HIV Specialist PCPs must meet additional credentialing requirements to serve this population. *See Appendix IIA*. These multi-disciplinary providers coordinate care throughout the service delivery system.

### **Treatment Adherence**

At every visit, the HIV Specialist PCP should discuss and document in the medical record the member's adherence to their treatment plan. For members who are non-adherent, the provider should either provide directly, or ensure access to, additional treatment adherence support services. To arrange for community-based treatment adherence support services contact the Healthfirst NJ Medical Management Department at **1-866-467-7178**.

Healthfirst NJ has established policies and procedures to assist its providers to assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and the medical community.

### **Harm Reduction Services**

Providers must ensure harm reduction services are provided to HIV positive members. These services include:

- Education and counseling regarding reduction of perinatal transmission;
- Individual and group HIV prevention and risk reduction education and counseling;
- Harm reduction education; and
- Counseling and supportive services for partner/spousal notification.

If you are not sure where to refer a member, the Healthfirst NJ Medical Management Department can assist you in securing these services. Call **1-866-467-7178** for more information.

### **Specialist Physicians (excluding Behavioral Health Providers)**

Healthfirst NJ has contracted with specialist physicians and other specialty healthcare professionals to provide care and services to its members that fall outside the scope of the PCP's training. The member is able to access these services without a referral from the PCP or authorization by Healthfirst NJ.

Specialist physicians also have the responsibility of identifying individuals with complex or serious medical conditions. Once identified, the condition should be assessed and monitored using appropriate diagnostic procedures. These cases should be referred to Care Management for intensive review and follow-up. The specialist, along with Care Management, should establish and implement a time-specific treatment plan that takes into consideration the member's input, and should coordinate this plan with the member's PCP.



Specialty care services are provided by clinicians practicing within the Healthfirst NJ Network. Healthfirst NJ makes special arrangements to accommodate requests to specialists affiliated with non-network institutions when appropriate.

### **Tertiary Care**

Healthfirst NJ negotiates system-wide arrangements for the provision of selected tertiary care services.

### **Behavioral Healthcare**

Healthfirst NJ has contracted with physicians, community agencies and other licensed professionals to provide Behavioral Healthcare and services outside the scope of the PCP's training. Healthfirst NJ negotiates arrangements for the provision of behavioral care services (mental health and chemical dependency services). See *Section 9* for more information.

### **Ancillary Services**

Healthfirst NJ's Ancillary Department manages network-wide arrangements that provide members with enhanced or specialized services beyond hospital and physician-based care. Such managed services include vendor partnerships to manage routine vision, dental, chiropractic and pharmacy benefits, as well as contracted ancillary providers who provide specialized healthcare services such as behavioral health, skilled nursing facilities, home health and infusion, laboratory, diagnostic testing, hearing aids, therapies, DME, orthotics/prosthetics and transportation services. Please refer to *Section 10* for a detailed description of all Ancillary services policies and procedures.

### **Federally Qualified Health Centers (FQHCs)**

Healthfirst NJ has contracted with FQHCs to provide primary care, specialty care and outpatient services and other designated services to its member population.

### **Credentialing of Providers**

All participating providers are credentialed in accordance with the Healthfirst NJ Policies and Procedures for Credentialing and Recredentialing based upon the specialty of the provider. In some cases Healthfirst NJ has delegated the responsibility for some of the credentialing functions to other organizations such as hospitals and organized delivery systems (ODS). Whether or not credentialing functions are delegated, each participating provider is subject to all requirements based upon NJAC 11:24C and Standard IX of the NJ Quality Assurance Performance Improvement Standards (QAPI). Healthfirst NJ retains the accountability for making all final credentialing and recredentialing decisions through its Credentialing Subcommittee under the oversight of the Quality Improvement Committee (QIC).

### **Partnering with Healthfirst NJ - Mutual Expectations**

Healthfirst NJ is committed to working with its participating providers to ensure that high-quality services are provided in an atmosphere of collaboration and respect. Mutual expectations are as follows:

#### **From Healthfirst NJ**

- Open, respectful, receptive communication
- Knowledgeable and helpful staff
- Timely response to questions and concerns
- Timely communication of policy changes
- Timely, comprehensive orientation, training and educational programs
- Timely processing of provider applications
- Timely payment for covered services rendered
- Responsive appeals and grievance processes
- Assistance with complex member issues
- Feedback on performance and utilization

#### **From Participating Providers**

- Professional, respectful and responsible healthcare for members
- Timely response to inquiries
- Assistance with problem-solving and other issues
- Maintenance of all contractual credentialing standards and licensing obligations
- Adherence to access and scheduling standards
- Compliance with medical management protocols
- Timely and accurate claims submission

- Cooperative office and administrative staff
- Compliance with quality improvement protocols and requests

### Quality Improvement and Commitment to Providers

Healthfirst NJ has implemented a uniform Quality Improvement Program throughout the network with oversight maintained by the Healthfirst NJ Chief Medical Officer and Healthfirst NJ Quality Improvement staff. This program supports processes designed to improve the quality and safety of clinical care and the quality of service provided to members to ensure members receive the highest quality of care. This includes clinical and service quality indicators, public health reporting, quality investigations, focused clinical studies, quality programs and member satisfaction surveys. All Healthfirst NJ providers are required to participate in quality improvement efforts.

In addition, the Quality Improvement plans developed by participating providers must adhere to the Healthfirst NJ program standards. Healthfirst NJ offers provider education and training programs regarding quality improvement initiatives conducted by the Quality Improvement and Provider Services departments. Healthfirst NJ works closely with participating facilities to build consensus and support for critical network policies and procedures and to find solutions to operational issues.

## 3.2 Provider Rights and Responsibilities

### Provider Rights

Healthfirst NJ will not discriminate against any healthcare professional acting within the scope of his/her license or certification under state law regarding participation in the network, reimbursement or indemnification, solely on the basis of the practitioner's license or certification. Nor will Healthfirst NJ discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions. Consistent with this policy, Healthfirst NJ nevertheless may differentiate among providers based on the following:

- Healthfirst NJ may refuse to grant participation status to healthcare professionals in excess of the number in any given category that Healthfirst NJ deems necessary to meet the needs of its members.
- Healthfirst NJ may use different reimbursement methodologies for different clinical specialties or for different hospital affiliations.
- Healthfirst NJ may implement measures designed to maintain quality and control costs consistent with its responsibilities.

Healthfirst NJ providers will be given written notice of material changes in participation rules and requirements at least 30 days before the changes are implemented. These communications will generally be circulated in newsletters or special mailings, or will be posted online to the secure provider portal at [www.healthfirstnj.org](http://www.healthfirstnj.org). Healthfirst NJ will not prohibit or otherwise restrict a healthcare professional, acting within the lawful scope of practice, from advising or advocating on behalf of a NJ FamilyCare/Medicaid member regarding the following:

- The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered). This includes providing sufficient information to the individual so that there is an opportunity to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

### Provider Responsibilities

Healthfirst NJ maintains provider agreements that incorporate provider and health plan responsibilities consistent with industry standards in compliance with applicable federal and New Jersey State laws and regulations, as well as requirements for individuals and organizations receiving federal funds. The requirements on the following page are applicable to Healthfirst NJ participating providers.

### Non-Discrimination

Providers must provide care to all NJ FamilyCare/Medicaid members. Providers must not discriminate on the basis of the following:

- Age
- National origin
- Claims experience
- Race
- Disability
- Sex

- Economic, social or religious background
- Sexual orientation
- Health status
- Source of payment
- Legally defined handicap
- Veteran status
- Marital status

In addition, providers are required to be in compliance with Title VI of the Civil Rights Act of 1975, the Age Discrimination Act

of 1975, the Americans with Disabilities Act (ADA) and other laws applicable to recipients of federal funds. Healthfirst NJ has developed a plan for achieving full compliance with these regulations, and may request information from your practice as part of this program. The scope of the guidelines includes ensuring appropriate access to services through physical access to the site of care (wheelchair accessibility), access within the site (exam rooms, tables and medical equipment) and access to appropriate assessment and communications tools that enable disabled individuals to receive needed services and to understand and participate in their care. Visit [www.healthfirstnj.org](http://www.healthfirstnj.org) for more information on ADA compliance and guidelines.

### **Cultural Competence**

Providers must ensure that services and information about treatment are provided in a manner consistent with the patient's ability to understand what is being communicated. Members of different racial, ethnic and religious backgrounds, as well as individuals with disabilities, should receive information in an understandable manner that is responsive to their specific needs. If there are foreign language issues, a family member, friend or healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator. In addition, the Healthfirst NJ Member Services and Medical Management Departments can provide assistance for members who do not speak English, either through their multi-lingual staff or by facilitating a connection with a telephone based language bank that will provide operators for translation. It is essential that all efforts be made to ensure that the member understands diagnostic information and treatment options and that language, cultural differences or disabilities do not pose a barrier to communication.

### **Program Participation and Compliance**

Healthfirst NJ has developed Quality Improvement, Medical Management and other programs to identify opportunities for improving the delivery of health services and their related outcomes. In addition, Healthfirst NJ has operating agreements with federal Centers for Medicare and Medicaid Services that govern the terms of its participation in the Medicaid Programs. Regulatory authorities periodically review Healthfirst NJ operations and data reporting (i.e. complaints, enrollment and financial information). Providers are expected to cooperate with Healthfirst NJ to meet its regulatory responsibilities and to comply with its internal programs to ensure compliance with contractual obligations. This applies to the policies set forth in this Provider Manual, as well as to any new programs developed by Healthfirst NJ.

Healthfirst NJ invites its providers to participate on committees that address medical management and quality improvement issues. Providers may sit on the Quality Improvement Committee and its subcommittees or they may provide expertise as physician consultants for peer review and specialty utilization management review. Please refer to *Section 14* for additional information.

In addition, Healthfirst NJ providers are responsible for supporting the patient care components of the Member Rights and Responsibilities found in *Section 4* of this Provider Manual. It outlines member rights related to access to care and to complete treatment information; privacy and confidentiality; non-discrimination; refusal of medical treatment and other fundamental elements of the member's relationship with Healthfirst NJ. It is expected that providers will inform members under their care about specific healthcare needs requiring follow up and will teach members appropriate self-care and other measures to promote their own health. Further, providers must discuss potential treatment options, side effects and management of symptoms (without regard to plan coverage).

*Please note: The member has the final say in the course of action they will take about their health.*

### **Release of Member Information**

Medical information about NJ FamilyCare/Medicaid members must be released to Healthfirst NJ upon request and in compliance with the Confidentiality Policy found in *Section 5* of this Provider Manual. Healthfirst NJ will only release

medical information to persons authorized by Healthfirst NJ to receive such information for medical management, claims processing, or quality and regulatory reviews.

### **Billing**

Providers must submit claims for reimbursement of services provided. Claims must be accurate and submitted according to the guidelines described in *Section 16*. Providers may never bill NJ FamilyCare/Medicaid members for covered services. See *Section 2* for information on non-covered services. Failure to comply with Healthfirst NJ policies in this regard may result in nonpayment for services or termination from the Healthfirst NJ provider network.

### **Fraud, Waste and Abuse Procedures**

Healthfirst NJ maintains a “zero tolerance” policy towards any type of fraud or abuse whether committed by providers or members. Accordingly, Healthfirst NJ has developed a comprehensive fraud and abuse plan for the detection, investigation, and prevention of fraudulent activities. Healthfirst NJ’s fraud and abuse plan includes a dedicated Special Investigations Unit, as well as the retention of a third party vendor, to detect suspicious billing patterns and investigate suspected fraud and/or abuse of Healthfirst NJ providers or members.

**Fraud** is broadly defined as the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in an unauthorized benefit.

**Abuse** is broadly defined as provider practices that are inconsistent with sound, fiscal, business or medical practices and result in an unnecessary cost to the NJ FamilyCare/Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Also includes member practices that result in unnecessary cost to the NJ FamilyCare/Medicaid program.

**Waste** is broadly defined as the extravagant, careless or needless expenditure of funds that results from deficient practices, systems, controls or decisions.

Examples of fraudulent, abusive and wasteful activities monitored by Healthfirst NJ include, but are not limited to, the following:

- Billing for services not provided;
- Routinely billing for a higher level of service than was actually provided (i.e. upcoding; miscoding);
- Over utilization of services;
- Misrepresenting the services rendered (e.g. improper use of procedure codes for the item or service rendered) ;
- Altering claim forms to obtain a higher payment amount or submitting inaccurate claims;
- Deliberately submitting a claim twice in order to receive duplicate payments;
- The failure to maintain or provide medical records or other documentation to Healthfirst NJ, as may be requested pursuant to an audit or investigation, concerning health care services or supplies provided to members;
- Ordering or furnishing improper, unnecessary, or excessive health care services or supplies which are not medically necessary;
- Practicing outside the scope of one’s license or providing care after one’s license has been suspended or revoked;
- Accepting inducements to utilize or refrain from utilizing a service;
- Balance billing members in violation of Healthfirst NJ provider agreements or denying services based upon a member’s inability to pay a copayment;
- The sharing of a NJ FamilyCare/Medicaid member identification card amongst multiple individuals to obtain medical care; and
- Collusion between a provider and member to obtain reimbursement for non-covered services.

Improper billing practices or suspected fraudulent and/or abusive activity committed by a provider will be first reviewed by Healthfirst NJ’s Fraud and Abuse Review Committee. The Fraud and Abuse Review Committee, which meets on a regular basis, is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers; and has the authority to make recommendations to the Healthfirst NJ Credentialing Subcommittee regarding the allegation including, but not limited to, termination of the provider agreement according to the guidelines

described in *Section 3.6*; referral of the Provider to applicable regulatory or law enforcement agencies; and recovery of overpayments.

Upon referral by the Fraud and Abuse Review Committee, the Credentialing Subcommittee of the Quality Improvement Committee will conduct a separate review of allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. If the Credentialing Subcommittee recommends the formal termination of a provider, the Subcommittee will make its recommendations to the Quality Improvement Committee in this regard, and the Quality Improvement Committee will render the final decision as to whether a provider should be terminated. If termination is recommended, a *Notice of Proposed Adverse Action* will be issued to the provider and the provider will have the opportunity to appeal the decision as further outlined in *Section 3.5*.

### **Reporting Fraud, Waste and Abuse**

Healthfirst NJ asks that you please report all suspected fraudulent or abusive activity whether committed by another provider or member to our Fraud, Waste and Abuse Hotline at **1-877-879-9137**

Any information that you provide to Healthfirst NJ will be treated as confidential. You may either report suspected fraudulent or abusive activity anonymously or you can opt to provide your contact information, and Healthfirst NJ will maintain your confidentiality to the extent legally possible.

### **Provider Information**

Providers are responsible for contacting Healthfirst NJ to report any changes in their practice. It is essential that Healthfirst NJ maintain an accurate provider database in order to ensure proper payment of claims to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Any changes to the following list of items must be reported in writing to Healthfirst NJ as soon as possible, but at least two weeks prior to the effective date:

- Provider's name and Tax ID number(s)
- Provider's address, zip code, telephone or fax number
- Provider's billing address
- Languages spoken in the provider's office
- Wheelchair accessibility
- Covering provider
- Age limits for the practice (if applicable)
- Provider's NJ license (e.g., revocation, suspension)
- NJ Medicaid Number (if applicable)
- National Provider Identification Number (if applicable)
- Office hours
- Provider's board eligibility/board certification status
- Participation status
- Provider specialty change
- Provider panel modification
- Provider malpractice insurance coverage
- Change of status/loss/non-renewal of hospital privileges
- Provider DEA status
- Provider New Jersey Controlled Dangerous Substance Status

## **3.3 Appointment Availability and Twenty-four (24)-Hour Access Standards**

Healthfirst NJ maintains provider access, visit scheduling and waiting time standards that comply with CMS regulations. Healthfirst NJ actively monitors adherence to these standards (*Appendix I*). Healthfirst NJ conducts audits of provider

appointment availability, office waiting times and twenty-four (24)-hour access and coverage. All participating providers are expected to provide care for their NJ FamilyCare/Medicaid members within these access guidelines.

### **Office Hours**

NJ FamilyCare/Medicaid participating providers **must practice at least two (2) days per week and maintain a minimum of twenty (20) office hours per week** at each primary care site. HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement.

### **Twenty-four (24)-Hour Coverage**

Participating providers must be accessible twenty-four (24)-hours-a-day, seven (7)-days-a-week throughout the year either directly or through back-up coverage arrangements with other Healthfirst NJ participating providers. The telephone response time will not exceed two (2) hours, except for emergencies which require immediate response from the PCP.

Each provider must have an on-call coverage plan acceptable to Healthfirst NJ that outlines the following:

- Regular office hours including days, times and locations.
- Twenty- four (24) hours per day, seven (7) days per week toll-free telephone answering system that will respond in person (not voicemail) and will include Telecommunication Device for the Deaf (TDD) or Tech Telephone (IT) systems.
- Providers who will be taking after-hours calls.
- Answering the NJ FamilyCare/Medicaid member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a NJ FamilyCare/Medicaid member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special NJ FamilyCare/Medicaid member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs.
- Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.
- Response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues - within thirty (30) to forty-five (45) minutes;
  - Same day for non-symptomatic concerns;
  - Fifteen (15) minutes for crisis situations.

**Providers who have a non-participating provider covering for them for any services should refer to Section 12 of this manual for authorization requirements prior to rendering services.**

Facilities, as well as individual practitioners, must conform to the following requirements:

- Members will be provided with a telephone number to use for contacting providers after regular business hours. Telephone operators receiving after-hours calls will be familiar with Healthfirst NJ and its emergency care policies and procedures, and will have key Healthfirst NJ telephone numbers available at all times.
- The Healthfirst NJ provider will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member according to the above time frames.
- It is expected that Healthfirst NJ providers will be familiar with Healthfirst NJ and will be able to act in accordance with Healthfirst NJ emergency policies and procedures such as notifying Medical Management of emergency care or admissions. These policies are further discussed in *Section 12*. Please be aware that hospital-based physicians may have their own particular on-call group relationships.
- If the covering provider is not located at the usual site of care for the member, the covering provider must provide clinical information to the member's PCP by the close of business that day, or if on a weekend, by the next business day so that it can be entered into the member's medical record.

**NJ FamilyCare/Medicaid members must be able to locate a Healthfirst NJ participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs**

members to the emergency room in lieu of appropriate contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

### Appointment Time Standards

Healthfirst NJ providers are expected to adhere to appointment time standards. They are as follows:

- **Emergency Services:** Immediately upon presentation at a service delivery site.
- **Urgent Care:** Within twenty-four (24) hours. (An urgent, symptomatic visit is an encounter with a healthcare provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening).
- **Symptomatic Acute Care:** Within seventy-two (72) hours. (A non-urgent, symptomatic office visit is an encounter with a healthcare provider associated with the presentation of medical signs, but not requiring immediate attention.)
- **Routine Care (non-symptomatic):** Within twenty-eight (28) days.
- **Routine Physicals:** Within four (4) weeks for routine physicals needed for school, camp, work
- **Non-symptomatic office visits** will include but will not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

### Specialist Appointment Time Standards

- **Specialist Requests:** Within four (4) weeks or shorter as medically indicated. A specialty request visit is an encounter with a medical specialist that is required by the NJ FamilyCare/Medicaid member's medical condition as determined by the NJ FamilyCare/Medicaid member's Primary Care Provider (PCP).
- **Emergency appointments:** Must be provided within twenty-four (24) hours of request.
- **Urgent Specialty Care:** Within twenty-four (24) hours of request.

### Prenatal Care Appointment Time Standards

Members will be seen within the following timeframes:

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

### Initial Appointment Time Standards

- **Baseline Physicals for New Adult NJ FamilyCare/Medicaid members:** Within one hundred-eighty (180) calendar days of initial enrollment.
- **Baseline Physicals for New Children NJ FamilyCare/Medicaid members and Adult Clients of DDD:** Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines.

### Lab and Radiology Services Appointment Time Standards

- Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care.

### Dental Appointment Time Standards

- Emergency dental treatment no later than forty-eight (48) hours or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider.
- Urgent care appointments within three (3) days of request.
- Routine non-symptomatic appointments within thirty (30) days of request.

#### **Mental Health/Substance Abuse Appointment Time Standards**

- **Emergency services:** Immediately upon presentation at a service delivery site.
- **Urgent care appointments:** Within twenty-four (24) hours of the request.
- **Routine care appointments:** Within ten (10) days of the request.

#### **Appointment Standards – Elderly and Disabled Members**

Healthfirst will ensure that each new member or, as appropriate, authorized person is contacted to offer an initial visit to the member's selected PCP. Each new member will be contacted within forty-five (45) days of enrollment and offered an appointment date according to his/her needs, except for members identified through the enrollment process as having special needs will be contacted within ten (10) business days of enrollment and offered an expedited appointment.

#### **Waiting Time Standards**

In addition to access and scheduling standards, Healthfirst NJ providers are expected to adhere to site-of-care waiting time standards. They are as follows:

- **Emergency Visits:** Members are to be seen immediately upon presentation at the service delivery site.
- **Urgent Care and Urgent Walk-In Visits:** Members should be seen within one (1) hour of arrival.  
*Please note: Prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment with prescribed pharmaceuticals.*
- **Scheduled Appointments:** Members should not be kept waiting for longer than forty-five (45) minutes.
- **Non-Urgent Walk-In Visits:** Members with non-urgent care needs should be seen within two (2) hours of arrival or scheduled for an appointment in a time frame consistent with the Healthfirst NJ scheduling guidelines.
- **Patient Encounters:** Four (4) per hour for adults and four (4) per hour for children.

#### **Missed Appointments**

Healthfirst NJ expects providers to follow up with members who miss scheduled appointments. When there is a missed appointment, providers should follow these guidelines to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained.

- At the time an appointment is scheduled, confirm a contact telephone number with the member. If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone.
- To encourage member compliance and minimize the occurrence of "no shows," provide a return appointment card to each member for the next scheduled appointment.

### **3.4 Provider Application Process**

Participating hospitals, hospital-sponsored practices, treatment centers, and community-based groups and individual providers should call **1-866-889-2523** or their assigned Network Management Representative to notify Healthfirst NJ about new providers joining existing practices or to inquire about how to become a participating provider. Providers who wish to join the network must complete an application package and submit the appropriate credentialing documents/information.

### **3.5 Credentialing and Recredentialing Requirements**

Healthfirst NJ is committed to providing healthcare services to its members through a high quality provider network that meets the licensing requirements of the New Jersey Board of Medical Examiners, New Jersey State Board of Nursing, or other professional board as well as Healthfirst NJ's credentialing criteria listed in *Appendix II*. Providers are initially

credentialed and bi-annually recredentialed through approved delegation agreements with sponsoring hospitals, or every three years through a rigorous credentialing review conducted by Healthfirst NJ. Providers have the right to review their Healthfirst NJ credentialing file (with the exception of peer review references or recommendations) and may contact Healthfirst NJ if they wish to make arrangements to do so.

### **The Credentialing Subcommittee**

The Credentialing Subcommittee is a multidisciplinary committee of clinical practitioners from Healthfirst NJ participating hospitals, as well as the Healthfirst NJ Medical Director, Vice President of Quality Improvement and Director of Credentialing (without vote).

The Subcommittee is charged with the credentialing and recredentialing function and, through the review of credentialing and recredentialing materials, has the authority to make recommendations and decisions regarding credentialing, recredentialing and termination of providers. The Subcommittee meets quarterly and is responsible, through a peer review process, for the following functions:

- The HFNJ Credentialing Committee has the authority to review all credentialing/reccredentialing materials and make recommendations /decisions regarding the credentialing, recredentialing, and termination of providers.
- Revise Credentialing policies and procedures and implementation of Credentialing policies and procedures,
- Submit the Credentialing policies and procedures
- Review of practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about the practitioner's ability to deliver care. At a minimum, the Credentialing Committee reviews the credentials of practitioners who do not meet the HFNJ credentialing criteria.
- Review and approve the Standards for Delegated Credentialing.
- Review practitioner sanctions and make recommendations as to practitioners' ability to deliver care and remain in the Healthfirst NJ network.
- Review and approve the Delegated Credentialing File Audit Results
- Review and approve minutes of Credentials Committee Meetings.
- Review recommendations made by the Fraud and Abuse Review Committee concerning alleged improper billing practices and suspected fraud and/or abuse committed by a provider. If the Credentialing Subcommittee determines that formal termination of a provider is warranted, the Subcommittee will submit its recommendations to the Quality Improvement Committee in this regard for final determination.
- Review of Practitioner Quality of Care issues and make recommendations to the Quality Improvement Committee in this regard. The recommendations may include termination from the HFNJ Network and is dependent upon the severity of the Quality Management issue and the practitioner's ability to deliver care.
- Review and approve facilities and vendors that meet the HFNJ credentialing criteria.
- Provide a summary report of findings and submit to Healthfirst NJ Quality Improvement Committee (QIC) on a quarterly basis or more frequently as required.

Please refer to *Appendix II* for a complete list of credentialing requirements.

## **3.6 Termination of Provider Agreements**

Healthfirst NJ or its participating providers may decide to terminate or elect not to renew a provider agreement. Termination procedures are subject to the provisions of the provider agreement, modified by certain limitations as outlined in this section.

In the event of a conflict between the Provider Manual and the terms of your provider agreement, the terms of your provider agreement will prevail.

### **Termination by Mutual Consent**

A participating provider and Healthfirst NJ may discontinue a provider's participation with Healthfirst NJ and terminate the applicable provider agreement at any time on mutual consent. Providers should contact their Network Management Representative or the Director of Network Management if they wish to end their participation. Any hospital choosing to end their participation should contact the President of Healthfirst NJ.

### **Non-renewal by Healthfirst NJ or a Provider**

Either Healthfirst NJ or a participating provider may also decline to renew a provider agreement prior to the annual renewal date. Providers who choose not to renew their participation with Healthfirst NJ must give Healthfirst NJ written notice of their intent not to renew their provider agreement at least sixty (60) days prior to the renewal date. Verbal notification is not sufficient for providers to initiate the nonrenewal process. If Healthfirst NJ decides not to renew a provider agreement, Healthfirst NJ will also give at least sixty (60) days notice prior to the renewal date.

The decision not to renew a contract is not considered a termination of a provider agreement under New Jersey regulations (specifically NJAC 11:24-3.5). Therefore, providers are not afforded the opportunity to appeal Healthfirst NJ's decision not to renew.

### **Termination by Healthfirst NJ**

In certain cases, Healthfirst NJ may decide to terminate a provider's participation prior to the annual renewal date in the provider agreement. In these cases, Healthfirst NJ will give ninety (90) days written notice to the provider. That notice will include the reason for the termination and the provider's right, if any, to appeal the decision.

In certain instances, Healthfirst NJ may terminate a provider's participation for cause on thirty (30) days notice. Grounds for termination for cause on thirty (30) days notice includes, but is not limited to, the following:

- The provider's failure to provide services in accordance with the provider agreement and this provider manual.
- The provider's failure to comply with Healthfirst NJ's policies and procedures including those relating to quality assurance, peer review, utilization management and credentialing.
- The provider's failure to provide encounter data.
- Discrimination by the provider against NJ FamilyCare/Medicaid members.

Healthfirst NJ will give a provider thirty (30) days prior written notice of its intent to terminate for cause as set forth above and explain the reason for its decision. Providers are given the opportunity to correct the problem within that thirty (30)-day period. If the provider does not correct the problem, their provider agreement will be deemed terminated based on the provider's breach of the agreement. In such cases, the provider is not permitted an appeal or hearing.

Healthfirst NJ may also terminate a provider's participation immediately under the following circumstances:

- Failure to maintain required professional licensure or a final disciplinary action is taken by a government regulatory agency that impairs the provider's ability to practice.
- Failure to maintain adequate malpractice insurance.
- Failure to maintain DEA and CDS certificates, if applicable, to the provider's practice.
- The provider's conviction of any crime, whether a felony or misdemeanor.
- There is a determination of fraud on the part of the provider.
- Continuation of the provider's participation may cause imminent harm to patients.

Providers whose participation is terminated immediately for these reasons will be contacted as soon as possible to inform them of our decision, but will not receive advance written notice or the right to appeal our decision.

Under no circumstances will Healthfirst NJ initiate termination or non-renewal actions against a provider solely because he/she has:

- Advocated on behalf of a member.
- Filed a complaint against Healthfirst NJ with State or Federal regulatory bodies.
- Appealed a decision made by Healthfirst NJ.
- Provided information, filed a report or requested a hearing or review.

### **Continuity of Care**

In the event of termination or non-renewal of a provider's participation agreement for any reason, both the provider and Healthfirst NJ are required under New Jersey regulations to continue providing services to NJ FamilyCare/Medicaid members under active treatment with the provider for a period from one hundred-twenty (120) days to one year, depending



on the members' diagnosis and condition. All treatment and reimbursement for such members will continue under the terms and conditions of the expiring or terminated provider agreement. Additional information on continuity of care is found in *Section 12*.

### **Reporting**

When a PCP leaves the network, Healthfirst NJ reassigns the provider's patients to another PCP. Members are notified of this change via letter from Healthfirst NJ thirty (30) business days prior to termination. Members have the option to change the new provider assignment by calling Member Services and selecting a provider of their choice. Healthfirst NJ also provides notice to members who are receiving a course treatment from providers who are not PCPs when those providers leave the network.

Healthfirst NJ is required to report to relevant regulatory agencies, including the New Jersey State Board of Medical Examiners and/or the National Practitioner Data Bank, the termination of a participating provider from the network under the following circumstances:

- Alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare.
- Voluntary or involuntary termination of contract or employment to avoid disciplinary action.
- A determination of fraud or of imminent harm to a patient's health.

If a provider is terminated from the network, suspended from the network because of deficiencies in the quality of patient care, or there is a determination of fraud, written notice of the action must be given to the applicable licensing entity, or disciplinary bodies or other appropriate authorities.

### **Appeal Hearings Regarding Provider Termination**

Providers will receive a notice from Healthfirst NJ terminating their participation. In those cases where the provider has the right to appeal the termination decision, the notice will explain the reason for the termination; explain how the Provider may request a hearing regarding the termination and any exceptions to the Provider's hearing rights, set forth the procedure for requesting a hearing, and state that the Provider participation in the hearing process shall not be deemed to be an abrogation of the Provider's legal rights.

Providers are not entitled to a hearing if their provider contract is not-renewed or if it terminated based on (a) a determination of fraud; (b) provider or affiliated providers breach of this Agreement; or (c) if, in the opinion of the Healthfirst NJ medical director, provider or an affiliated provider represents an imminent danger to a patient or the public health, safety and welfare.

To request a hearing, providers must, within ten (10) business days of receiving the termination notice, the provider must submit a written request for a hearing to: Healthfirst NJ Provider Services, PO Box 12108, Newark, NJ 07101-3408.

Providers are encouraged to submit any additional documentation about the case together with the request for a hearing.

**A provider's failure to submit a request for a hearing within 10 days will be deemed a waiver of any appeal rights. The proposed termination will become final and the provider will not be afforded additional appeal rights.**

Healthfirst NJ will schedule and hold a hearing within thirty (30) days of the provider's written request for a hearing. The provider will be further apprised, in writing, of the date, time and place of the hearing, and a list of witnesses, if applicable, that are expected to testify at the hearing on behalf of Healthfirst NJ. Healthfirst NJ will consider any reasonable requests for to reschedule a hearing other than the date originally scheduled; however, unreasonable or excessive requests (as determined by Healthfirst NJ) to reschedule a hearing will lead to a waiver of appeal rights. In addition, Healthfirst NJ reserves the right to be represented by outside counsel at the hearing.

The hearing panel will consist of three (3) individuals appointed by Healthfirst NJ. Specifically, the hearing panel will include the Healthfirst NJ Medical Director, a provider in the same or similar medical specialty as the provider under review ("clinical peer"),

and a third individual selected by Healthfirst NJ. If Healthfirst NJ selects a hearing panel that is larger than three (3) individuals, at least one-third (1/3) of the panel's membership will be clinical peers. In addition, if the provider participates in Healthfirst NJ's NJ FamilyCare/Medicaid program, the majority of the hearing panel members will be clinical peers.

At least ten (10) days prior to the scheduled hearing, a provider shall submit to Healthfirst NJ a written summary of his/her position and a copy of any exhibits or additional evidence that will be presented at the hearing.

At the hearing, a provider will be afforded the following rights:

- To be present at the hearing and represented by legal counsel;
- To present any additional evidence that is relevant to the provider's case without regard to its admissibility in a court of law;
- To call, examine, or cross-examine any witnesses, all of whom will testify under oath;
- To submit a written statement at the close of the hearing; and
- A copy of the record of the proceedings and at the provider's expense.

The hearing panel will render a written decision within thirty (30) business days of the hearing. The hearing panel may postpone its decision provided to give the provider and Healthfirst NJ notice of the postponed decision before the decision is due.

The hearing panel may uphold or reverse the underlying determination made by the Healthfirst NJ Quality Improvement Committee, or may conditionally reinstate the provider subject to certain conditions determined by the hearing panel. The hearing panel's decision will set forth the contract provisions and facts in which the provider and Healthfirst NJ relied at the hearing, the reasons for the Panel's decision, any conditions for reinstatement, if applicable, along with the duration of the conditions and consequences of failing to adhere to those conditions

### **Reporting Suspected Fraudulent Conduct**

Healthfirst NJ will report suspected healthcare insurance fraud to the New Jersey Office of the Insurance Fraud Prosecutor and/or the Office of the State Comptroller, Medicaid Fraud Division, whether or not Healthfirst NJ elects to terminate a Provider Agreement.

## **3.7 Provider Profiling**

Healthfirst NJ monitors the performance of its provider network to ensure the quality and appropriate use of health care services; and to identify opportunities for provider improvement and managing medical costs. Healthfirst NJ has developed criteria and methodologies to collect and analyze profiling data to evaluate a provider's practice patterns and performance. Areas evaluated include but are not limited to billing/coding patterns; inpatient, outpatient, ancillary, pharmacy utilization trends; and specialty costs.

All providers are measured against an appropriate group of health care providers using similar treatment modalities and servicing a comparable patient population. On a periodic basis, and upon the request by a provider, Healthfirst NJ will provide a copy of the provider profile, data and analysis used to evaluate a provider's performance. Providers will be afforded the opportunity to meet with Healthfirst NJ to discuss the information reported in the provider profile and the unique nature of the provider's patient population which may have a bearing on the provider's profile, and to work cooperatively with Healthfirst NJ to improve performance.



## 4. Eligibility and Membership

### 4.1 Scope of Benefits

The Healthfirst NJ service area includes Bergen, Essex, Hudson, Mercer, Middlesex, Passaic, Somerset, Sussex, and Union counties only.

#### Healthfirst NJ Medicaid

Medicaid is the joint federal/state program covering comprehensive health services for very low income children, parents, pregnant women and people who are aged, blind, and disabled (ABD) and meet Medicaid criteria.

In addition to services covered by Healthfirst NJ, Medicaid members may access certain other services that are paid by New Jersey's fee-for-service program.

#### NJ FamilyCare

NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage; it is not a welfare program. NJ FamilyCare is for families who do not have health insurance available such as affordable employer insurance or cannot afford to pay the high cost of private health insurance. Eligibility is based on family size and monthly income. This is determined by the number of children and adults living in the household. Family size includes children under age twenty-one (21), natural and adoptive parents, and their spouses. If a child is living in a household with a grandparent, guardian, or caretaker, that person is not included in the family size, and their income is not taken into consideration when calculating eligibility for NJ FamilyCare/Medicaid, unless the guardian is also requesting coverage. The family's monthly income will determine if their coverage under NJ FamilyCare is free or if they will have to pay a low monthly premium and small co-payment for some services.

#### NJ FamilyCare A

NJ FamilyCare A means the State-operated program which provides comprehensive managed care to:

- Uninsured children below the age of nineteen (19) years, parents and caretaker relatives with family incomes at or below 133% of the federal poverty level.
- TANF (Temporary Assistance for Needy Families -formerly AFDC) who are in work-related extensions.
- Children under the age of one (1) year and pregnant women eligible under the New Jersey Care Special Medicaid Program.
- Pregnant women up to 200% of the federal poverty level.
- Other individuals who qualify for NJ Special Medicaid Programs.

In addition to services covered by NJ FamilyCare A members may access certain other services that are paid by New Jersey's fee-for-service program. NJ FamilyCare A members pay no premiums and no co-payments.

#### NJ FamilyCare B

NJ FamilyCare B is New Jersey's program for uninsured children below the age of nineteen (19) years with family incomes above 133% and up to and including 150% of the federal poverty level. NJ FamilyCare B members pay no premiums and no co-payments.

In addition to services covered by NJ FamilyCare B members may access certain other services that are paid by New Jersey's fee-for-service program.

#### NJ FamilyCare C

NJ FamilyCare C is New Jersey's program for uninsured children below the age of nineteen (19) years with family incomes above 150% and up to and including 200% of the federal poverty level.

Income-based premium payment contributions are not required for any NJ FamilyCare C members. With the exception of Eskimo and Native Americans, NJ FamilyCare C members are responsible for co-payments. In addition to services covered by NJ FamilyCare C members may access certain other services that are paid by New Jersey's fee-for-service program.

### **NJ FamilyCare D**

NJ FamilyCare D is New Jersey's program for parents/caretakers and children under age nineteen (19) who meet the following criteria:

- Parents/caretakers with children below the age of 19 who do not qualify for AFDC-related Medicaid with family incomes up to and including 133 percent of the federal poverty level; and
- Children below the age of 19 with family incomes between 201 percent and up to and including 350 percent of the federal poverty level.

NJ FamilyCare D has income-based premiums and co-payments. In addition to services covered by NJ FamilyCare D members may access certain other services that are paid by New Jersey's fee-for-service program.

Enrollment in a Medicaid Managed Care Plan is now **mandatory** for the NJ FamilyCare/Medicaid-eligible population living in New Jersey.

Those individuals who do not voluntarily select a plan will be assigned to a participating managed care plan by ACS, Inc, the Health Benefits Coordinator under contract with New Jersey to manage the mandatory enrollment process. However, there are certain categories of NJ FamilyCare/Medicaid eligible's that are either excluded from the NJ FamilyCare/Medicaid managed care program or exempted from mandatory enrollment. If you are treating patients who qualify for exemption, you may be required to complete an exemption form. This form must be submitted to the Health Benefits Coordinator for approval of the exemption. Exempt individuals have the option of choosing to join a managed care plan. Please contact Healthfirst NJ if you have questions regarding managed care exemptions. See *Appendix III* for a complete list of the Medicaid Managed Care excluded and exempt population groups. To obtain exemption forms, please call the Health Benefits Coordinator at **1-800-701-0710 (TTY: 1-800-701-0720)**.

## **4.2 Marketing**

Marketing guidelines and policies have been implemented to govern marketing by healthcare providers. The goal of these guidelines is to ensure that marketing activities by all parties involved in Healthfirst NJ programs are conducted in a responsible manner so that potential members receive the most accurate and complete information possible. Providers may advise their patients of managed care plans with which they participate, but they must list all plans, and cannot promote one plan over another.

Under its contract with the Division of Medical Assistance & Health Services (DMAHS), Healthfirst NJ is held responsible for marketing activities undertaken by any individual or entity involved in marketing for, or on behalf of, Healthfirst NJ. This applies regardless of whether Healthfirst NJ directly employs the involved party or if that party is affiliated with Healthfirst NJ by subcontract or through a participating provider agreement. Hospitals, clinics, physicians and other providers belonging to the provider network are considered subcontractors and are subject to the marketing guidelines. Violations of the marketing guidelines may lead to a suspension of marketing activities at Healthfirst NJ facilities, regulatory sanctions affecting the provider or Healthfirst NJ. All Healthfirst NJ marketing activities are conducted in strict compliance with DMAHS marketing guidelines (see *Appendix IV*). These policies are followed throughout the Healthfirst NJ service area.

Healthfirst NJ does not discriminate against prospective members based on age, gender, race, national origin, sexual orientation or medical/mental condition. Written marketing materials developed by Healthfirst NJ, as well as those produced independently by Healthfirst NJ providers, must be approved by CMS and DMAHS prior to use. Healthfirst NJ providers who wish to develop materials prepared by Healthfirst NJ providers that advertise Healthfirst NJ must be submitted to regulators for pre-approval through Healthfirst NJ.

*Please note: Marketing correspondence should not be sent to patients who are in an exclusion category for Medicaid and cannot join a managed care plan (see Appendix III).*

If you have patients in your practice who are interested in or eligible for one of the Healthfirst NJ programs, you may refer them to Healthfirst NJ Member Services. Healthfirst NJ representatives will assist these individuals with the applicable enrollment or application process, and will function as the liaison with the Health Benefits Coordinator for potential NJ FamilyCare/Medicaid members.

**For providers interested in on-site marketing, Healthfirst NJ will schedule time for a representative to be available at your office or facility for the convenience of your patients. Please call 1-866-889-2523 for more information.**

Healthfirst NJ participating providers will comply with marketing guidelines for medical service providers as outlined in the MCO Marketing Guidelines. All providers participating in NJ FamilyCare/Medicaid are bound by the requirements of government contracts with the managed care plan, which include the MCO Marketing Guidelines (see *Appendix IV*).

### **4.3 Enrollment and Disenrollment**

#### **Mandatory Medicaid Managed Care**

NJ FamilyCare/Medicaid recipients will have sixty (60) days from notification that they must select a managed care plan of their choice. Family members may be enrolled into different plans and are no longer required to have one (1) plan per family. Medicaid eligible's who do not select a managed care plan within the allotted time period will be "auto-assigned" to a plan by ACS, Inc., the enrollment broker charged with managing all mandatory Medicaid managed care enrollments and disenrollments.

With the exception of Aged Blind and Disabled (ABD) members, Clients of the Division of Developmental Disabilities (DDD) and Children under the Division of Youth and Family Services (DYFS), members may be subjected to a twelve (12) month enrollment Lock-In period once enrolled. Medicaid and NJ FamilyCare A members are subjected to the Lock-In period after ninety (90) days. Members may initiate Disenrollment for good cause at any time.

Healthfirst NJ will assign a maximum of two thousand (2,000) members to a primary care provider based on a twenty (20) hour FTE. Additionally, we will abide by the contractual requirement that no PCP will be assigned more than three thousand (3,000) members across all plans that he/she is a participating provider. Lastly, we will assign no more than one thousand (1,000) Developmentally Disabled members to any one (1) provider's panel and no more than fifteen hundred (1,500) members across all plans that he/she is a participating provider.

For a Certified Nurse Practitioner, who can also serve as a PCP, we will assign no more than one thousand (1,000) members to a CNP and no more than fifteen hundred (1,500) across all plans that he/she is a participating provider.

#### **Member Enrollment Rosters**

Members are enrolled monthly into the Healthfirst NJ programs. Each month, Healthfirst NJ will provide PCPs with an enrollment roster for each program that identifies new members in the provider's panel as well as those members who have left the practice. Providers may use these rosters to verify eligibility. However, if a member is not listed on the roster and says that he/she belongs to the provider's panel, the provider should verify eligibility by accessing the Member Eligibility section of our web site or by calling Member Services. Member Enrollment Rosters are available on our web site, [www.healthfirstnj.org](http://www.healthfirstnj.org).

#### **Newborns**

When a NJ FamilyCare/Medicaid member is pregnant, the PCP should notify Member Services and Medical Management as soon as the pregnancy is confirmed. The mother's name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided at this time. Hospitals must notify Medical Management of all deliveries



within one (1) business day of the child's birth. Hospitals must also provide Healthfirst NJ with the newborn's Client Identification Number (CIN).

All newborns of Medicaid-eligible mothers are automatically assigned to the mother's managed care plan at birth. Healthfirst NJ Providers are required to accept a mother's Healthfirst NJ enrollment as sufficient proof of the newborn's enrollment in the mother's plan. The mother does not have to produce a Medicaid or Healthfirst NJ ID for the infant.

Early notification of the pregnancy enables Healthfirst NJ staff to ensure that a PCP is selected for the infant before the actual delivery takes place and that the member is offered Care Management in the pre-natal and post partum periods. The only exceptions to this policy are newborns that meet the exclusion criteria listed in the Medicaid Managed Care Exclusions table (see *Appendix III*). These infants are excluded from enrollment in any Medicaid managed care plan.

### **PCP Selection**

NJ FamilyCare/Medicaid members select a PCP upon enrollment. If no PCP is indicated on the enrollment form, Healthfirst NJ will assign a PCP and issue notice to the member. Healthfirst NJ Member Services staff provides assistance with PCP selection and changes. PCP changes are effective immediately.

### **Involuntary Change of PCP (Requesting Member Transfer)**

PCPs may wish to arrange the transfer of a member to another provider. The physician may request a transfer of a member when the following situations exist:

- When a member has taken legal action against the provider;
- Member is persistently noncompliant with a therapeutic regime;
- Member is verbally abusive to physician or staff; or
- Member makes medically inappropriate demands or unreasonably refuses the physicians recommendations.

Providers should initially speak with the member to try to resolve the issues. If that cannot be done or is not successful, the following steps should be followed:

- The member must receive a letter informing him/her that the PCP cannot remain his/her provider and the reason for this change.
- The letter must indicate that the member will have thirty (30) days from receipt of the letter to select another PCP and must inform the member that he/she should contact Healthfirst NJ Member Services for assistance, if necessary.
- The member must be informed that the PCP will provide any needed care, medical services and/or prescriptions during the thirty (30) day period.
- The member must be informed that the PCP will provide the member's medical records to the new PCP if requested.
- The letter to the member should be sent certified mail, return receipt requested in order to ensure that the member receives the letter.
- A copy of the letter must be placed in the member's medical record.
- A copy of the letter must be sent to the Provider Services Department.
- The Provider should contact Healthfirst NJ Member Services, provide the member's name and Healthfirst NJ ID number and inform them that the member requires assistance in selecting a new PCP.

Healthfirst NJ approves any reassignments and all of the above situations should be clearly documented in the medical record. For more information, please call **1-866-889-2523**.

### **Continuity of Care for New Members**

In some situations, members enrolling with Healthfirst NJ may continue care with their existing healthcare provider for a transitional period when there is a need for the member to complete a course of treatment or it is in the interest of the member to receive ongoing services. New members who are pregnant will be allowed to continue with their existing provider through the post-partum care associated with the delivery. Services received during this period must be consistent with the scope of benefits available to Medicaid recipients.

Nonparticipating providers who care for NJ FamilyCare/Medicaid members during a transition period must adhere to the Healthfirst NJ quality assurance protocols, policies and procedures and must accept Healthfirst NJ reimbursement rates. Further, the practitioner will provide Healthfirst NJ and the member's new Healthfirst NJ provider with medical information relevant to the member's care.

New members may have preexisting appointments arranged for specialty care that were scheduled before their NJ FamilyCare/Medicaid membership became active. If a new NJ FamilyCare/Medicaid member presents in your office under these circumstances, please call Medical Management for assistance.

### **New Members—Existing Plans of Care**

Healthfirst NJ will honor and pay for plans of care for new members initiated prior to enrollment with Healthfirst NJ.

Services will be continued until the member is evaluated by his/her primary care provider and a new plan of care is established with Healthfirst NJ. Services include:

- Prescriptions;
- Durable medical equipment;
- Medical supplies;
- Prosthetic and orthotic appliances; and
- Any other on-going services members initiated prior to enrollment with Healthfirst NJ.

### **Contacting Members**

Healthfirst NJ will use its best efforts to contact the new member or, where applicable, authorized person and/or contractor care manager. However, if after documented, reasonable outreach (i.e., mailers, certified mail, use of MEDM system provided by the State, contact with the Medical Assistance Customer Center (MACC), DDD, or DYFS/DCF to confirm addresses and/or to request assistance in locating the member) the member fails to respond within twenty (20) working days of certified mail, Healthfirst NJ may cease paying for the pre-existing service until the member or, where applicable, authorized person, contacts Healthfirst NJ for re-evaluation.

### **Disenrollment**

There are two (2) types of disenrollment processes: voluntary and involuntary. Members may elect to disenroll from Healthfirst NJ or Healthfirst NJ may disenroll members for a variety of reasons.

#### **Voluntary Disenrollment**

All NJ FamilyCare/Medicaid A members may disenroll or transfer from Healthfirst NJ after the ninety (90)-day grace period or for a "good cause" reason during the twelve (12)-month lock-in period. To disenroll from a Healthfirst NJ program, members may contact the Member Services Department. For NJ FamilyCare/Medicaid, members should contact the Health Benefits Coordinator at **1-800-701-0710** or TTY **1-800-852-7897**. The Health Benefits Coordinator processes all plan disenrollments.

#### **Involuntary Disenrollment**

Healthfirst NJ will not, either verbally or in writing, or by any action or inaction, request or encourage a member to disenroll from a Healthfirst NJ program. However, there may be circumstances that require Healthfirst NJ to involuntarily disenroll a member. These are as follows:

- The member moves out of the Healthfirst NJ service area.
- The member loses Medicaid eligibility.
- A member supplies fraudulent information or makes misrepresentations on the enrollment application that materially affects his or her eligibility to enroll in Healthfirst NJ.
- A member's behavior is disruptive, unruly, abusive or uncooperative to the extent that the Healthfirst NJ practitioner's ability to provide services is impaired (except where such behavior is related to an underlying physical and/or mental condition such as Tourette Syndrome).
- A member knowingly permits abuse or misuse of the NJ FamilyCare/Medicaid membership card.

- If a member who is enrolled in a Healthfirst NJ plan with premium obligations fails to pay premiums, reasonable efforts will be made to secure receipt of delinquent premiums. Healthfirst NJ will provide a thirty (30) day written notice to the member as well as one (1) written and one (1) verbal warning prior to requesting that DMAHS disenroll the member. Included in those notices will be the reason(s) for disenrollment and a statement on the member's right to file a disenrollment grievance.
- Healthfirst NJ members participating in a waiver (except the Division of Developmental Disabilities Community Care Waiver) or demonstration program or admitted for excluded long term institutionalized care shall be disenrolled from the applicable Healthfirst NJ plan on the date of admission to institutionalized care. These institutional services are paid by the Medicaid Fee-For-Service Program and do not require coordination by Healthfirst NJ. Exception: For Nursing Facility Care, Healthfirst NJ remains financially responsible for services in this setting for thirty (30) days. Thereafter, if the member continues to receive services in this setting, he or she will be disenrolled. This thirty (30) day exception does not apply for NJ FamilyCare B and C members, except for rehabilitation services, which may be provided in this setting, when appropriate.

*Providers should notify Healthfirst NJ of any difficulties they encounter. Refer to Involuntary Change of PCP (Requesting Member Transfer) in this section.*

#### 4.4 Eligibility Verification

Verifying a member's eligibility prior to rendering healthcare services ensures accurate and prompt processing of claims. Please take the following steps below to verify NJ FamilyCare/Medicaid member eligibility: However, verification of eligibility is not a guarantee of payment by Healthfirst. Healthfirst may deny payment for services if claims submission requirements are not followed, prior authorization or utilization review policies are not followed or if the member is subsequently retroactively disenrolled from Healthfirst NJ:

#### View the Member ID Card

Each NJ FamilyCare/Medicaid member is issued an identification card which includes the member's PCP, affiliated hospital, mental health and substance abuse benefits manager as well as other identification and informational items. If a NJ FamilyCare/Medicaid member is eligible for dental coverage, the dental phone number will be printed on the member ID card. NJ FamilyCare/Medicaid members should keep their Healthfirst NJ identification cards together since some benefits can only be accessed through the card. Go to [www.healthfirstnj.org](http://www.healthfirstnj.org) to view a sample of member ID cards for all products.

<small>RdBN 003858 RdPCN A4 RdGRP B7PA</small>			
<b>JANE DOE</b> <b>Member ID: 000000000</b> Provider Name: <b>Dr. John Doe</b>		Group: <b>XXXX</b> DOB: <b>00/00/0000</b>	
Provider Phone: <b>201-123-4567</b> Dental: <b>800-896-2373</b> Mental Health: <b>866-467-7178</b> Issue Date: <b>00-00-0000</b>	<b>Benefits</b> PCP Office Visit Specialists Emergency Room Prescription	<b>Copay</b> \$0 \$0 \$0 \$0	<b>Member Information</b> This card does not guarantee coverage. • If an emergency exists, go to the nearest emergency room or call 911. You do not need approval from Healthfirst NJ or your doctor to go to the emergency room in an emergency. • Benefit Questions? Call Member Services: <b>888-464-4365</b> TTY/ID: <b>800-852-7897</b> <hr/> <b>Provider Information</b> <b>866-889-2523</b> • Member Eligibility? Call: <b>866-889-2523</b> • Pre authorization is needed for hospital admission, surgical procedures, and certain other services. Call Medical Management: <b>866-467-7178</b> • For Electronic Claims: <b>Submit to Payer ID 80141</b> • For Paper Claims, send to: Healthfirst NJ Claims Dept. P.O. Box 12101 Newark, NJ 07101-3401 <a href="http://www.healthfirstnj.com">www.healthfirstnj.com</a>

Healthfirst NJ FamilyCare (A) ID Card

<small>RdBN 003858 RdPCN A4 RdGRP B7PA</small>			
<b>JANE DOE</b> <b>Member ID: 00000000000</b> Provider Name: <b>Dr. John Doe</b>		Group: <b>XXXX</b> DOB: <b>00/00/0000</b>	
Provider Phone: <b>201-123-4567</b> Dental: <b>800-896-2373</b> Mental Health: <b>866-467-7178</b> Issue Date: <b>00-00-0000</b>	<b>Benefits</b> PCP Office Visit Specialists Emergency Room Prescription	<b>Copay</b> \$0 \$0 \$0 \$0	<b>Member Information</b> This card does not guarantee coverage. • If an emergency exists, go to the nearest emergency room or call 911. You do not need approval from Healthfirst NJ or your doctor to go to the emergency room in an emergency. • Benefit Questions? Call Member Services: <b>888-464-4365</b> TTY/ID: <b>800-852-7897</b> <hr/> <b>Provider Information</b> <b>866-889-2523</b> • Member Eligibility? Call: <b>866-889-2523</b> • Pre authorization is needed for hospital admission, surgical procedures, and certain other services. Call Medical Management: <b>866-467-7178</b> • For Electronic Claims: <b>Submit to Payer ID 80141</b> • For Paper Claims, send to: Healthfirst NJ Claims Dept. P.O. Box 12101 Newark, NJ 07101-3401 <a href="http://www.healthfirstnj.com">www.healthfirstnj.com</a>

Healthfirst NJ FamilyCare (B) ID Card

<small>RdBN 003858 RdPCN A4 RdGRP B7PA</small>			
<b>JANE DOE</b> <b>Member ID: 00000000000</b> Provider Name: <b>Dr. John Doe</b>		Group: <b>XXXX</b> DOB: <b>00/00/0000</b>	
Provider Phone: <b>201-123-4567</b> Dental: <b>800-896-2373</b> Mental Health: <b>866-467-7178</b> Issue Date: <b>00-00-0000</b>	<b>Benefits</b> PCP Office Visit Specialists Emergency Room Prescription: <b>Generic \$1</b> <b>Brand Name \$5</b>	<b>Copay</b> \$5 \$5 \$10 \$5	<b>Member Information</b> This card does not guarantee coverage. • If an emergency exists, go to the nearest emergency room or call 911. You do not need approval from Healthfirst NJ or your doctor to go to the emergency room in an emergency. • Benefit Questions? Call Member Services: <b>888-464-4365</b> TTY/ID: <b>800-852-7897</b> <hr/> <b>Provider Information</b> <b>866-889-2523</b> • Member Eligibility? Call: <b>866-889-2523</b> • Pre authorization is needed for hospital admission, surgical procedures, and certain other services. Call Medical Management: <b>866-467-7178</b> • For Electronic Claims: <b>Submit to Payer ID 80141</b> • For Paper Claims, send to: Healthfirst NJ Claims Dept. P.O. Box 12101 Newark, NJ 07101-3401 <a href="http://www.healthfirstnj.com">www.healthfirstnj.com</a>

Healthfirst NJ FamilyCare (C) ID Card

<small>RdBN 003858 RdPCN A4 RdGRP B7PA</small>			
<b>JANE DOE</b> <b>Member ID: 00000000000</b> Provider Name: <b>Dr. John Doe</b>		Group: <b>XXXX</b> DOB: <b>00/00/0000</b>	
Provider Phone: <b>201-123-4567</b> Dental: <b>800-896-2373</b> Mental Health: <b>866-467-7178</b> Issue Date: <b>00-00-0000</b>	<b>Benefits</b> PCP Office Visit Specialists Emergency Room Prescription	<b>Copay</b> \$5 \$5 \$35 \$5	<b>Member Information</b> This card does not guarantee coverage. • If an emergency exists, go to the nearest emergency room or call 911. You do not need approval from Healthfirst NJ or your doctor to go to the emergency room in an emergency. • Benefit Questions? Call Member Services: <b>888-464-4365</b> TTY/ID: <b>800-852-7897</b> <hr/> <b>Provider Information</b> <b>866-889-2523</b> • Member Eligibility? Call: <b>866-889-2523</b> • Pre authorization is needed for hospital admission, surgical procedures, and certain other services. Call Medical Management: <b>866-467-7178</b> • For Electronic Claims: <b>Submit to Payer ID 80141</b> • For Paper Claims, send to: Healthfirst NJ Claims Dept. P.O. Box 12101 Newark, NJ 07101-3401 <a href="http://www.healthfirstnj.com">www.healthfirstnj.com</a>

Healthfirst NJ FamilyCare (D) ID Card

Verify Online ([www.healthfirstnj.org](http://www.healthfirstnj.org))



Providers may access eligibility information on our web site using the member's Healthfirst NJ ID number. Providers may verify eligibility for up to ten members at one time, or view individual information and demographics.

#### **Call the Automated System (1-866-889-2523)**

Callers will be prompted to enter a Member's ID number to verify eligibility.

#### **Check the Member Enrollment Roster**

Members are enrolled monthly into the Healthfirst NJ programs. Members select a PCP at the time of enrollment. Healthfirst NJ provides PCPs a monthly enrollment roster that identifies new members in the provider's panel as well as those members who have left the practice. The enrollment roster contains demographic information for each member by Healthfirst NJ program. Providers may use these rosters to verify eligibility. However, if a member is not listed on the roster and says that he/she belongs to the provider's panel, the provider should verify eligibility through the Member Eligibility section of our web site or by calling Member Services. Member Enrollment Rosters are available on our web site, [www.healthfirstnj.org](http://www.healthfirstnj.org).

### **4.5 Member Rights and Responsibilities**

A member's relationship with Healthfirst NJ guarantees a number of basic rights including entitlement to high quality, accessible, responsive and responsible healthcare; respectful and confidential treatment; and avenues to express dissatisfaction or receive assistance. In return, members are responsible for taking charge of their healthcare needs, using services appropriately, complying with member policies and procedures, and requesting assistance from Healthfirst NJ to ensure that they are utilizing and receiving services appropriately.

NJ FamilyCare/Medicaid member rights and responsibilities are outlined below. This information is provided to all new members as part of their orientation package. Providers participating in Healthfirst NJ are expected to make every effort to support member rights.

#### **Members have the right to:**

- The right to be treated with respect, dignity and need for privacy.
- The right to be provided with information about Healthfirst NJ, its services, the practitioners providing care and members rights and responsibilities and be able to communicate and be understood with the assistance of a translator if needed.
- The right to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.
- The right to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence.
- The right to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the member's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers. Healthfirst NJ will make no attempt to disenroll a member for filing a complaint or grievance/appeal against Healthfirst NJ.
- The right to formulate Advance Directives.
- The right to have access to his/her medical records in accordance with applicable Federal and State laws.
- The right to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect.
- The right to be free of hazardous procedures.
- The right to receive information on available treatment options or alternative courses of care.
- The right to refuse treatment and be informed of the consequences of such refusal.
- The right to have services provided that promote a meaningful quality of life and autonomy for members, independent living in members' homes and other community settings as long as medically and socially feasible, and preservation and support of members' natural support systems.

- The right to treatment without discrimination as to race, color, religion, sex, age, marital status or national origin.
- The right to be informed where, when and how to get the services needed from Healthfirst NJ.
- The right to request a copy of personal health information maintained by Healthfirst NJ and to receive an accounting of certain disclosures of personal health information made.
- The right to obtain a current directory of providers.
- The right to a second opinion about your care.
- The right to a free medical screening exam in the emergency room to determine if an emergency exists.
- The right to call 911 for emergency without prior authorization.
- The right to appoint a Health Care Proxy, who is someone who you can trust to make health care decisions on their behalf. The Health Care Proxy uses Advance Directives as a guideline to implement your wishes.
- The right to voice complaints about concerns or problems members are having related to coverage or care and recommended changes in policies and services with Healthfirst NJ or with the Division of Medical Assistance and Health Services, or the Department of Banking and Insurance and to receive an answer in a reasonable amount of time.
- The right to information about health care coverage and costs.
- The right to receive communication in the language understood by the member, or provided a translator if needed.
- To be free from balance billing.

**Minors specific rights in addition to the above rights and responsibilities**

- Minors are defined as those under age nineteen (19).
- Minors will have the right to approve their own health care in certain situations, for example, if they are pregnant.
- In the case of an emergency where a minor's condition requires prompt attention for the preservation of life and limb, such attention should be given immediately regardless of whether the consent has been received.
- Minors will be informed of their rights as a part of the Grievance and Action Appeals process and as part of the yearly distribution of the Member Handbook.

**Members have the responsibility to:**

- Work with their PCP to guard and improve their health.
- Find out how their health care system works.
- Listen to their PCP's advice and ask questions when they are in doubt.
- Call or go back to their PCP if they do not get better, or ask for a second opinion.
- Treat all Healthfirst NJ staff with the respect that they expect themselves.
- Tell us if they have problems with any health care staff by calling the Member Services Department.
- Keep their appointments.
- Use the emergency room only for real emergencies.
- Call their PCP when they need medical care, even if it is after-hours.
- Provide their doctors, hospitals and other medical professionals, information they may need in order to render care.

## 4.6 Member Services and Education

The Member Services Department provides members with an extensive array of customer service, outreach, orientation and educational programs, including translation services to assist members who do not understand English.

### **New Member Outreach and Orientation**

All new NJ FamilyCare/Medicaid members are contacted to schedule a one-on-one orientation visit in the comfort of their home. The orientation focuses on explaining the enrollment process, benefits, and rights and responsibilities to new members. Member orientations include presentations on covered benefits and services, the role of the PCP, free access services and access to “carved out” services.

All members receive a new member enrollment kit that contains a member handbook, and a Provider Directory that lists primary care, Ob-Gyn, specialists and ancillary service providers. Members also receive copies of our member newsletter and health education materials.

As part of the mandatory Medicaid managed care program, ACS, Inc., the enrollment broker issues health risk assessment questionnaires to newly enrolled individuals and families as part of the enrollment process. Healthfirst NJ also sends health risk assessment forms to new members. Healthfirst NJ uses these self-reported health assessment tools to contact members with healthcare problems or specific service needs. Healthfirst NJ encourages these members to visit their PCP as soon as possible to obtain services. In addition, Healthfirst NJ Care Managers call members with complex medical needs to ensure that they receive appropriate attention and care.

### **Special Outreach and Care Management Programs**

Healthfirst NJ sponsors special outreach programs to encourage appropriate preventive care and to provide care management services for selected conditions. Outreach programs include Quality Improvement initiatives that remind members to seek preventive care services such as well-child care, immunizations, screening tests such as prostate cancer screenings, mammograms and regular Pap Smears.

Healthfirst NJ also has the following programs: Asthma, Congestive Heart Failure, HIV/AIDS, “Healthy Mom/Healthy Baby”, Behavioral Health Care/Domestic Violence, Chronic Obstructive Pulmonary Disease, Hypertension and Diabetes Care Management Programs. Additional health promotion programs include Advantage for senior members, Diabetes Registry and Heartwise. These programs are further discussed in *Section 13*.

### **Translation Services**

Healthfirst NJ has staff that speaks English, Spanish, Russian, Mandarin and Cantonese to help improve communication with our members. Additionally, Healthfirst NJ contracts with a 24 hr/7 day phone interpreter service (TTY Service) to assist Healthfirst NJ employees in communicating with members in both English and Spanish. Those numbers are **1-800-852-7897** (English) and **1-866-658-7714** (Spanish).

Healthfirst NJ also contracts with a certified translator to ensure that all member materials and advertisements are appropriately and accurately translated.

## 5. Regulatory and Reporting Requirements

### 5.1 Reporting Requirements

Healthfirst NJ is required to report to Federal and State regulatory agencies, including DMAHS, on a variety of data elements including financial, clinical and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst NJ relies upon its provider network to supply it with comprehensive, accurate and timely information. Healthfirst NJ also expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, lead screening, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets. Please refer to *Section 14* for more information.

Please note that there are special reporting requirement for FQHCs as designated by DMAHS relating to the reporting of encounter data. Please refer to *Section 16* for more information.

#### Fraud, Waste and Abuse Hotline

If you suspect fraud, abuse or waste by a NJ FamilyCare/Medicaid member or by another provider, please call our anonymous and confidential Fraud and Abuse Hotline at **1-877-879-9137**. Fraud is intentional deception or misrepresentation an individual knows to be false or does not believe to be true and makes regardless, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. Examples of fraud, abuse and waste can include:

- Submitting inaccurate claims.
- Billing for services that were not provided.
- Accepting inducements to utilize or refrain from utilizing a service.
- Using another person's Healthfirst NJ Identification Card.
- Failing to comply with Healthfirst NJ policies.

### 5.2 Fraud, Waste and Abuse (FWA)

It is the policy of Healthfirst NJ to comply with all federal and state laws regarding fraud, waste and abuse, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal and state healthcare programs, and to provide protections for those who report in good faith actual or suspected wrongdoing.

Healthfirst NJ also is required to refer potential fraud or misconduct related to the Medicare program to the HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the NJ state funded programs are reported to the Office of the Medicaid Inspector General (OMIG).

#### The Compliance Policy

Healthfirst NJ maintains a strict policy of **zero tolerance** toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, Healthfirst NJ provides this information to vendors to achieve the following goals:

- Demonstrate to vendors its commitment to responsible corporate conduct.
- Maintain an environment that encourages employees and vendors to report potential problems.
- Ensure appropriate investigation of possible misconduct by the company and its vendors.

In general, Healthfirst NJ has adopted various fraud prevention and detection programs whose purpose is to protect the member, the government, and/or Healthfirst NJ from paying more for a service than it is obligated to pay. Therefore,



Healthfirst NJ established a Special Investigations Unit (SIU), who ensures that Healthfirst NJ is in compliance with all applicable state and federal regulations.

The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if fraud or abuse has occurred. Therefore, Healthfirst NJ employees and contracted entities have a responsibility to report any inappropriate activities to the SIU, the Regulatory Affairs Department of their immediate supervisor, if applicable.

For further information on our compliance program, please visit our provider web page at [www.healthfirstnj.org](http://www.healthfirstnj.org) and select "A Guide to the Compliance Program"

### Definitions

**Abuse** - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

**Fraud** - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or State law.

**Waste** - The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

### Relevant Statutes and Regulations

#### I. THE DEFICIT REDUCTION ACT OF 2005

As a participant in the Medicaid Program, we must comply with the terms of the Deficit Reduction Act of 2005 (the "DRA"). The DRA, specifically Section 6033, entitled "Employee Education About False Claim Recovery", which was effective January 1, 2007, requires any organization that receives \$5 million or more in Federal Medicaid funds annually (including payments from managed care companies such as Healthfirst) to adopt a compliance program in accordance with Federal law and to inform its employees and any contractor or agent of the terms of the False Claims Act. Any organization that does not comply with the requirements may be denied Medicaid reimbursement. *You should carefully consult with your attorney to determine if you are subject to this requirement.*

Healthfirst is required to provide our contractors and/or vendors with information regarding our policies and procedures for preventing and detecting fraud, waste, and abuse in government sponsored health programs as well as the provisions associated with the False Claims Act. In turn, we require our contractors and vendors to disseminate and make this information available to employees and managers within the organization.

#### False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (but the act does not cover tax fraud).

The State of New Jersey also enacted a state law regarding the reporting of false claims, which is very similar to the federal law. The primary difference between the New Jersey False Claims Act (NJFCA) and the federal FCA, is that the NJFCA applies to false claims **made to the state**, or to "any contractor, grantee, or other recipient of State funds," as opposed to the federal government. In addition, NJFCA actions may be brought in **either state or federal court**, whereas federal FCA matters may be brought only in federal court.

For New Jersey, false claims investigations are the responsibility of the state's Attorney General's Office.

For the purposes of this policy, “knowing and/or knowingly” means that a person, with respect to the information has actual knowledge of the information; acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment,
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government,
- Conspires with others to get a false or fraudulent claim paid by the Federal Government,
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government.

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Healthfirst NJ;
- Knowingly failing to provide members with access to services for which Healthfirst NJ has received premium payments; and
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports.

### ***What Money Can Be Recovered?***

Those that defraud the government can end up paying triple the damages done to the government, a fine (between \$5,500 and \$11,000) for every false claim, and the claimant's costs and attorneys' fees.

If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

### **Protections for Whistle Blowers**

Whistle blower protection is provided by Federal acts and related State and Federal laws that shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates anyway, whistle blower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

To report information about fraud, waste or abuse involving Medicare or any other healthcare program involving only federal funds you can call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is **1-800-HHS-TIPS (1-800-447-8477)**. For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to <http://oig.hhs.gov/hotline.html>.

**The following are the applicable false claim act regulations for further reference:**

### **Federal Program Fraud Civil Remedies Act**

31 U.S.C. 3801-3812

For a copy of this citation, please visit:

<http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=950781435289+0+2+0&WAIAction=retrieve>

Provides federal administrative remedies for false claims and statements, including those made to federally funded healthcare programs. Current civil penalties are \$5,500 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.

For a copy of the New Jersey Statutory citations listed below, visit <http://www.njleg.state.nj.us/>

### **New Jersey Medical Assistance and Health Services Act**

Criminal Penalties, N.J.S.A. 30:4D-17(a)-(d)

This act provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to \$10,000, imprisonment for up to three (3) years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to

\$10,000, imprisonment for up to three (3) years, or both; (c) kickbacks, rebates and bribes: fine of up to \$10,000, imprisonment for up to three (3) years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to \$3,000, or imprisonment for up to one (1) year, or both. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

#### Civil Remedies

N.J.S.A. 30:4D-7.h., N.J.S.A. 30:4D-17(e)-(i); N.J.S.A. 30:4D-17.1.a.:

In addition to the criminal sanctions discussed in the section above, violations of N.J.S.30:4D(a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation: recovery of overpayments, interest, up to triple damages, from \$2,000 to \$5,500 to \$11,000 for each false claim. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

#### Health Care Claims Fraud Act

N.J.S.A. 2C:21-4.2 & 4.3; N.J.S.A. 2C:51-5

Provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

- A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to five (5) times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;
- A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to five (5) times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to one (1) year;
- A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits five (5) or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to five (5) times the monetary benefit obtained or sought to be obtained;
- A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to five (5) times the monetary benefit obtained or sought to be obtained.

#### Conscientious Employee Protection Act

"Whistleblower Act", N.J.S.A. 34:19-4

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
- Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is

a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or

- Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
- Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employee or any governmental entity.
- Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
  - i. Is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
  - ii. Is fraudulent or criminal; or
  - iii. Is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one (1) or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergent in nature.

### **NJ 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.

A person or a practitioner violates this act if he:

1. Presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (C.39:6-61 et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or
2. Prepares or makes any written or oral statement that is intended to be presented to any insurance company, the Unsatisfied Claim and Judgment Fund or any claimant thereof in connection with, or in support of or opposition to any claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (C.39:6-61 et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or
3. Conceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to (a) any insurance benefit or payment or (b) the amount of any benefit or payment to which the person is entitled;
4. Prepares or makes any written or oral statement, intended to be presented to any insurance company or producer for the purpose of obtaining:
  - a. a motor vehicle insurance policy, that the person to be insured maintains a principal residence in this State when, in fact, that person's principal residence is in a state other than this State; or
  - b. an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract; or
5. Conceals or knowingly fails to disclose any evidence, written or oral, which:
  - a. Has or has not occurred.
  - b. A person or practitioner violates this act if he knowingly assists, conspires with, or urges any person or practitioner to violate any of the provisions of this act.

- c. A person or practitioner violates this act if, due to the assistance, conspiracy or urging of any person or practitioner, he knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this act.
- d. A person or practitioner who is the owner, administrator or employee of any hospital violates this act if he knowingly allows the use of the facilities of the hospital by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this act.
- e. A person or practitioner violates this act if, for pecuniary gain, for himself or another, he directly or indirectly solicits any person or practitioner to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action, against any person, for damages for negligence, or, for pecuniary gain, for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, or for pecuniary gain, for himself or another, directly or indirectly solicits other persons to make a claim for personal injury protection benefits pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.); provided, however, that this subsection shall not apply to any conduct otherwise permitted by law or by rule of the Supreme Court.

#### § 17:33A-5. Remedies; penalties; fund established

a. Whenever the commissioner determines that a person has violated any provision of P.L.1983, c.320 (C.17:33A-1 et seq.), the commissioner may either:

1. Bring a civil action in accordance with subsection b. of this section; or
2. Levy a civil administrative penalty and order restitution in accordance with subsection c. of this section.

In addition to or as an alternative to the remedies provided in this section, the commissioner may request the Attorney General to bring a criminal action under applicable criminal statutes. Additionally, nothing in this section shall be construed to preclude the commissioner from referring the matter to appropriate state licensing authorities, including the insurance producer licensing section in the Department of Banking and Insurance, for consideration of licensing actions, including license suspension or revocation.

### **Responsible Parties – Health Care Fraud**

#### **Special Investigations Unit**

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud awareness, detection, investigation and reporting. The Special Investigations Unit will also ensure that Healthfirst NJ is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention and reporting.

#### **Healthfirst NJ Contracted Vendor**

Healthfirst NJ contracts with a vendor to assist in the identification of potential fraud, waste and abusive billing practices as mandated by federal and state regulations. Through the use of state-of-the-art detection software, this vendor identifies billing patterns that are not within industry norms. Providers selected for review will be asked to submit a sample of randomly selected medical records for examination. Please note that it is important to provide the Healthfirst NJ contracted vendor with all supporting documentation. This will minimize any future disputes regarding any identified issues.

If, after a complete review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Healthfirst NJ will utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. In addition, education will be provided to ensure further billings are submitted according to established guidelines. The results of these reviews are presented to the Healthfirst NJ Fraud, Waste, and Abuse Committee.

Failure to cooperate may result in the non-renewal of your contract with Healthfirst NJ and/or additional reporting to state and/or federal authorities.

#### **Fraud, Waste and Abuse Committee**

The Fraud, Waste and Abuse Review Committee is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers; and has the authority to make recommendations to the Healthfirst NJ Credentialing Subcommittee regarding the allegation including, but not limited to, termination of the provider

agreement according to the guidelines described in Section 3.6; referral of the provider to applicable regulatory or law enforcement agencies; and recovery of overpayments.

Upon referral by the Fraud and Abuse Review Committee, the Credentialing Subcommittee will conduct a separate review of allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. If the Credentialing Subcommittee recommends the formal termination of a provider, the Subcommittee will make its recommendations to the Health Care Quality Council in this regard, and the Health Care Quality Council will render the final decision as to whether a provider should be terminated. If termination is recommended, a *Notice of Proposed Adverse Action* will be issued to the provider and the provider shall have the opportunity to appeal the decision as outlined in Section 3.6.

The Fraud, Waste and Abuse Committee meets approximately once a month and is comprised of the following Healthfirst staff members:

- Terrance Byrd, VP and President Healthfirst New Jersey
- Deborah Hammond, VP – Medical Director
- Stephanie Gillette, VP Claims
- Susan Kwon, VP Network Management
- Christine Helzner, Vice President Regulatory Affairs
- Sonya Henderson, Vice President Compliance and Audit
- Nahum Kianovsky, Associate General Counsel

#### **Prescription FWA Committee**

In addition to the Fraud, Waste, and Abuse Committee discussed above, Healthfirst NJ also maintains a Prescription FWA Committee. This committee is concerned with fraud, waste and abuse and potentially hazardous Prescription use within the Prescription Drug Program. The committee meets on a quarterly basis to review reports prepared by Express Scripts, Inc. (ESI), the plan's contracted Pharmacy Benefit Manager. The committee is responsible for directing all further investigative activities and reporting of suspect questionable activities to the plan's Fraud, Waste and Abuse Committee for further direction.

The committee is composed of the following Healthfirst NJ staff members:

- Vice President Regulatory Affairs
- Pharmacy Director
- Director Special Investigations Unit
- Vice President Medical Director
- Finance Department Representative

#### **Common Methods of Fraud and Abuse**

In order to assist you with understanding and/or identifying what may constitute fraud, waste and/or abuse, we have provided some typical examples for your reference.

**Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered.
- A provider who, using existing information on his or her patients creates claims for office visits or services that never took place.
- A provider who, in the course of billing for actual patient treatments, adds charges for x-rays or laboratory tests that were never performed.
- A Durable Medical Equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up.

**Falsification of Claims:** In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one (1) or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so.
- A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery.
- A provider falsifies the dates on which services were provided, so that they fall within a given eligibility period of the member.
- A provider falsifies the identity of the provider of services, so as to obtain payment for services rendered by a non-covered and/or non-licensed provider.
  - For example, submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy.
- A provider upcodes the services rendered to obtain greater reimbursement.
- Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision making than was actually rendered; encounters that required straightforward decision making are reported as having required highly complex decision making.
- Reporting more intensive surgical procedures than were actually performed.
- Anesthesiologist bill for more intensive surgical procedures than reported by the surgeon.

**Unbundling:** Provider submits a claim reporting comprehensive procedure code (Resection of small intestine) along with multiple incidental procedure codes (Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

**Fragmentation:** Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antipartum care, Vaginal delivery and Obstetric care) which includes the three (3) components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

**Duplicate claim submissions:** Submitting claims under two (2) Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

**Fictitious Providers:** Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

**Examples of FWA within the Prescription Drug Program**

Plan Sponsor

- Failure to provide medically necessary services
- Marketing schemes
- Offering beneficiaries inducement to enroll
- Unsolicited marketing
- Misrepresenting prescription drug products
- Payment for excluded drugs
- Multiple billing
- Inaccurate data submission

Pharmacy Benefit Manager (PBM)

- Prescription drug switching
- Steering a beneficiary to a certain plan or drug
- Inappropriate formulary decisions
- Failure to offer negotiated prices

Pharmacy

- Inappropriate billing practices
- Prescription drug shorting
- Bait and switch pricing
- Prescription drug forging or altering
- Dispensing expired or adulterated drugs

- Prescription refill errors
- Failure to offer negotiated prices

#### Prescriber

- Prescription drug switching
- “Script” mills
- Provision of false information
- Theft of DEA number or prescription pad

#### Wholesaler

- Counterfeit or adulterated drugs through black markets
- Drug diversions
- Inappropriate/false documentation of pricing information

#### Manufacturer

- Lack of data integrity to establish payment or determine reimbursement
- Kickbacks, inducement, or other illegal remuneration
- Inappropriate relations with formulary committee members
- Inappropriate relations with physicians
- Illegal “off-label” promotion
- Illegal use of free samples

#### Beneficiary

- Misrepresentation of enrollment status
- Identity theft
- Prescription forging or altering
- Drug diversion or inappropriate use
- Prescription stockpiling
- Doctor “shopping” for drugs

### Reporting of fraudulent, wasteful and abusive activities

Healthfirst NJ maintains a strict policy of **zero tolerance** toward fraud and abuse and other inappropriate activities. As part of our commitment to this “zero-tolerance” policy, Healthfirst NJ wants to ensure that our providers understand that we expect vendors to bring any alleged inappropriate activity which involves Healthfirst to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

Corporate Compliance Officer at:  
25 Broadway – 9<sup>th</sup> Floor  
By phone – **212-453-4495**  
E-Mail – [compliance@healthfirst.org](mailto:compliance@healthfirst.org)

Special Investigations Unit (SIU) at:  
123 William Street – 10<sup>th</sup> Floor  
By phone – **212-801-3292**  
E-mail – [wokeefe@healthfirst.org](mailto:wokeefe@healthfirst.org)

Regulatory Affairs  
25 Broadway – 9<sup>th</sup> Floor  
By phone – **646-313-8967**  
E-mail – [chelzner@healthfirst.org](mailto:chelzner@healthfirst.org)

**Anonymously** - using the Healthfirst Hotline at **1-877-879-9137** or website at [hfcompliance.ethicspoint.com](http://hfcompliance.ethicspoint.com).

### 5.3 Medical Record Reviews and Documentation Standards

Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between providers.

All providers rendering healthcare services to NJ FamilyCare/Medicaid members must maintain a member health record in accordance with standards adopted by Healthfirst NJ and in compliance with CMS and NCQA Guidelines for Medical Record Review (*Appendix V*). Providers should also be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network providers.

Healthfirst NJ periodically requests medical records and conducts reviews to evaluate practice patterns, identify opportunities for improvement and to ensure compliance with quality standards. All Healthfirst NJ medical record reviews are conducted by clinical professionals; all information contained in the records is kept strictly confidential. Member's authorization to allow Healthfirst NJ to review records is obtained at the time of the member's enrollment; therefore providers must make medical records available upon request by Healthfirst NJ.

Healthfirst NJ reviews medical records as part of the following activities:

- Credentialing and recredentialing.
- Clinical quality of care investigations.
- Monitoring utilization to validate prospective and continued extended services review processes, identify trends, assess level of care determinations and review billing issues.
- Monitoring for accuracy and completeness of coding.
- Monitoring for compliance with approved Clinical Practice Guidelines and Standards of Care.
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS®/QARR compliance.
- Monitoring of provider compliance with public health regulation on reporting requirements.
- Monitoring for compliance with Healthfirst NJ Medical Record Documentation Standards

In addition, Peer Review Organizations on behalf of CMS also audit medical records as part of their respective quality review processes. If deficiencies are found after internal medical record reviews or reviews conducted by regulatory agencies, providers will be required to participate in a corrective action plan.

Medical records of a NJ FamilyCare/Medicaid member must be protected against loss, destruction or unauthorized use and retained for at least ten years from the last date of service or until the member reaches age twenty-three (23), whichever is longer.

#### Transfer of Medical Records

When transferring medical records from one participating PCP to another, a release of information form is not required. However, a release form must be signed when the member requests records to be sent to other entities outside of Healthfirst NJ such as other insurance companies. When a member transfers PCPs, providers must facilitate the transfer of medical records in a timely manner without cost to the member.

### 5.3 Confidentiality

A member's Protected Health Information (PHI) is protected in the contractual relationships between Healthfirst NJ and the member and between Healthfirst NJ and the provider. PHI includes enrollment with Healthfirst NJ, medical records and/or the payment for the provision of health services that is derived in whole or in part using personally identifiable information which is not otherwise publicly available. Such PHI must be safeguarded and held in strict confidence, so as to comply with applicable privacy provisions of State and Federal law, including the Health Insurance Portability and Accountability Act (HIPAA).

NJ FamilyCare/Medicaid members sign an authorization at the time of enrollment that allows Healthfirst NJ to review, release and use their respective PHI. All providers should take all reasonable measures to protect the privacy and confidentiality of members' nonpublic personal information at all times and to prevent the use or disclosure to any non-affiliated third party.

**During the initial encounter with a NJ FamilyCare/Medicaid member, the provider must obtain the member's written consent to disclose PHI to Healthfirst NJ. This consent should be maintained in the member's file and is subject to audit by Healthfirst NJ.**

All providers should remain aware that PHI about the provision of substance abuse services, and those that identify the presence of HIV-related illness, are governed by a special set of confidentiality rules. Release of these records requires a special authorization. They should not be released to anyone other than the patient except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of NJ FamilyCare/Medicaid members' information, please call **1-866-889-2523**.

#### **5.4 Advance Directives/Healthcare Proxy**

All NJ FamilyCare/Medicaid members have the right to make decisions about the amount and type of care that they receive. Through the use of written Advance Directives, a NJ FamilyCare/Medicaid member can indicate and define his/her wishes regarding the type and amount of care that will be provided in the event they are unable to make decisions themselves. Examples of the types of care that may be addressed in an Advance Directive include the use of ventilators, intubation and other life-saving procedures as well as the areas of nutrition and hydration therapy.

NJ FamilyCare/Medicaid members also have the right to appoint a healthcare agent through a "Proxy Directive" or "Healthcare Proxy". This allows someone other than the member to make decisions about the member's care should the member lose the ability to make decisions on his/her own. A Healthcare Proxy is not a living will. It is a formal document that enables a member to designate a trusted individual to make healthcare decisions on his/her behalf if the need arises. All competent adults can appoint a healthcare agent by signing a Healthcare Proxy form. A lawyer is not required, but two (2) witnesses must be present and must also sign the form. Members who have questions or would like additional information on these issues should be directed to the Member Services Department. Members may also make their wishes known through a Living Will or "Instruction Directive." This is written directions regarding the medical treatment a member wishes to accept or refuse and the circumstances in which those wishes are implemented.

Finally, members may also combine both the written instructions and the proxy in a "Combined Directive." This is a single document in which a member chooses a health care proxy to make decisions for them when they are unable to and provides written instructions on their health care preferences.

See *Appendix VI* for copies of the Instruction Directive, Proxy Directive and Combined Directive.

Inpatient facilities must determine if a member has executed an advance medical directive or that the member is aware of the possibility of doing so. If the member has completed a Healthcare Proxy, a copy should be kept in the member's inpatient chart or medical record or the name, address and phone number of the healthcare agent should be documented in the member's inpatient medical records. It must be clearly documented in the inpatient medical record that the member has executed an Advance Directive.

If the facility feels that it is unable to adhere to the member's wishes, the hospital should notify the member of this fact and recommend that they contact the NJ FamilyCare/Medicaid member Services Department. Otherwise, Healthfirst NJ expects the facility to adhere to the member's wishes as determined by the chosen healthcare agent.

#### **Advance Directives for Mental Healthcare**

The New Jersey Advance Directives for Mental Health Care Act (N.J.S.A. 26:2H-53) permits a member with mental illness to execute an Advance Directive that specifies preferences for mental health services in the event that he/she lacks decision-making capacity. The Advance Directive may be supplemented by a video or audio tape recording.

A member may execute, reaffirm, modify, revoke or suspend an Advance Directive for mental healthcare at any time and it should be signed and dated by, or at the direction of, the member in the presence of at least one (1) adult witness, who will attest that the member is of sound mind and free of duress and undue influence. A member may also include a Proxy Directive designating a competent adult to act as his/her mental health care representative.

## 6. Primary Care

### 6.1 Definition of Primary Care

All members enrolled in Healthfirst NJ select a PCP at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to members, including primary and specialty care, hospital care, diagnostic testing and therapeutic care. Healthfirst NJ defines the following clinical specialty areas and practitioners as primary care providers.

Providers	Nurse Practitioners
<ul style="list-style-type: none"> <li>• Family Practice</li> <li>• General Practice</li> <li>• Infectious Disease (HIV Specialist PCP)</li> <li>• Internal Medicine</li> <li>• Pediatrics</li> <li>• Geriatrics</li> </ul>	<ul style="list-style-type: none"> <li>• Adult Health</li> <li>• Family Health</li> <li>• Pediatrics</li> <li>• Gerontology</li> </ul>

### PCP Responsibilities

PCPs are the first points of entry into the Healthfirst NJ delivery system. PCPs play essential clinical and oversight roles in managing the care of NJ FamilyCare/Medicaid members. Healthfirst NJ has identified the following scope of activities and responsibilities as key expectations for participating PCPs.

### Access

- For participation in the NJ FamilyCare/Medicaid program, the PCP must maintain a minimum of twenty (20) office hours per week at each primary care office site within a county.
- Maintain twenty-four (24)-hour-a-day, seven (7) days a week access either directly or through arrangements with other Healthfirst NJ providers for back-up coverage. See *Section 3* for additional information on access and coverage requirements.

### Obstetricians and Gynecology

All Healthfirst NJ members can access our participating Obstetrician and Gynecologists directly for ambulatory services including preventive health care.

### Clinical Care

- Provide first-line primary, preventive, inpatient and urgent care or arrange for care, as appropriate, to manage conditions outside of the scope of primary care.
- Identify NJ FamilyCare/Medicaid members with complex or serious medical conditions, assessing those conditions through appropriate diagnostic procedures and contacting the Healthfirst NJ Care Management staff to collaborate on treatment plans and follow-up.
- Provide NJ FamilyCare/Medicaid members with education on the appropriate use of healthcare services, personal health behavior, health risks, preventing STDs, including HIV/AIDS, and achieving and maintaining optimal physical and mental health.

### Preventive Care

- Provide or arrange for all appropriate screenings and preventive care including immunizations and well child visits; tuberculosis screening, diagnosis and treatment; lead screening for children, HIV testing and counseling, mammography screening, prostate cancer screening, colorectal cancer screening, cervical cancer screening and glycohemoglobin testing for members being treated with insulin or oral hypoglycemic agents (*Appendix VII*).
- Maintain compliance with established preventive care standards (*Appendix VII*) and clinical practice guidelines (*Appendix XXIV*) adopted by Healthfirst NJ.
- Participate in the Healthfirst NJ Quality Improvement programs designed to improve preventive care for members.

### Behavioral Healthcare Screening

Healthfirst NJ has adopted the State of New Jersey's approved *Well-Being Screening Tool for Adolescents & Adults Patient*

*Problem Questionnaire (Appendix VIIC)* to assist its PCPs in identifying NJ FamilyCare/Medicaid members with symptoms of depression who are appropriate candidates for referral to the Healthfirst NJ Behavioral Care Unit. The tool should be used at the base-line appointment, at the annual preventive care visit and at any point where the member's condition indicates that a behavioral health issue may be present. A copy of the tool should be kept in the member's medical record. This tool is not intended to replace a complete mental health evaluation and assessment.

PCPs must obtain consent from a member before contacting a Healthfirst NJ representative or behavioral health provider requesting that they attempt to contact the member to arrange for an evaluation of their needs regarding mental health or alcohol/substance abuse services.

Providers are required to notify a member's mental health/substance abuse provider of the findings of his/her physical examination within 24 hours of receipt for urgent cases and within 5 business days in non-urgent cases.

### Coordination of Care and Services

- Coordinate primary and specialty care, ancillary services and other covered healthcare services.
- Arrange for behavioral health and substance abuse services through the Healthfirst NJ Behavioral Care Unit.
- Arrange for transportation services, as needed, to ensure that members are able to access healthcare services.

### Referrals

Healthfirst NJ affords access for its NJ FamilyCare/Medicaid members to network specialists without a written referral.

**The Primary Care Provider (PCP) is expected to refer the member for specialist care with written instructions to guide both the member and the specialist.** Written instructions must include the specialist's name and address, and what the referral is for. It remains the PCP's responsibility to monitor and promote the return of the member to primary care for services and management.

### Administrative Responsibilities

- Verify member eligibility at every visit on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org), on the member enrollment roster, or by calling **1-866-889-2523**. You may also call Member Services at **1-888-GO-4-HFNJ (1-888-464-4365)** to ensure that members are still actively enrolled in Healthfirst NJ.
- Provide comprehensive, accurate and reliable encounter data in the form of a CMS 1500 or UB-04 to Healthfirst NJ on a timely basis.
- Verify provider participation by visiting our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org), or by calling **1-866-889-2523**.

Administrative responsibilities must be adhered to as it may result into an erroneous referral. Under no circumstances will a member bear the cost of services when referred to an out of network provider by the PCP. Healthfirst bears responsibility for referral errors occurred by providers. Healthfirst provides routine updates on our provider network and member eligibility via the website or by calling Provider Services Department.

## 6.2 Primary Care Panels and Member Enrollment Rosters

NJ FamilyCare/Medicaid members select a PCP at the time of enrollment. PCPs may receive monthly enrollment/eligibility rosters indicating the NJ FamilyCare/Medicaid members enrolled in the PCP's panel for that month or they may access the enrollment rosters on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org). The enrollment roster contains demographic information for each member in the provider's panel. Each time a NJ FamilyCare/Medicaid member goes for a visit to the PCP, the eligibility verification steps outlined in *Section 4* should be followed.

## 6.3 Preventive Care Standards

Healthfirst NJ provides its members with routine and preventive healthcare services. These services are provided and coordinated by the PCP. Direct access to a women's health specialist is provided within the network for routine and preventive women's healthcare services. Pediatric and adult routine physicals and screenings are recommended according to age and risk factors (Appendix VIIA & B).

Healthfirst NJ expects participating PCPs to adhere to established preventive care standards and schedules in effect in New Jersey. These include EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Program, WIC (Women, Infant and Children) Program the New Jersey Department of Health and Senior Services Vaccines for Children Program.

### **Vaccines for Children (VFC)**

Healthfirst NJ providers receive vaccines for immunizations free of charge through the New Jersey Department of Health and Senior Services' Vaccines for Children (VFC) Program. Provider must be enrolled in the New Jersey VFC Program and have a provider identification number (PIN) to order. To enroll, contact the New Jersey Department of Health and Senior Services at **1-609-588-7512** and you will be sent an enrollment packet. Upon enrollment, you will need to analyze the number of VFC-eligible children in your practice so VFC can determine the funding needed to purchase vaccines. Once enrolled, providers are notified of their PIN (provider identification number) and other information by mail. To the extent possible, and as permitted by New Jersey statutes and regulations, providers will participate in the statewide immunization registry database, when it becomes fully operational and will provide immunizations recommended by local health departments based on local epidemiological conditions.

Providers enrolled in New Jersey VFC Program may order vaccines using one of the following methods:

- **Toll-free Telephone Number: 1-800-589-7516**

This is the most expedient way to order vaccines. You will receive your shipment sooner than if you order by fax or mail. The Customer Service Staff can answer questions about availability, special order vaccines, brand preference, back-orders and other VFC order processing concerns.

- **Fax: 1-609-588-7575**

If you order by fax, the order will not be processed until the Customer Service Representative confirms the order by telephone with your office. Three attempts will be made to confirm (two by phone and one by fax).

- **Mail:**

New Jersey Vaccines for Children (NJVFC) Program  
PO Box 369  
Trenton, NJ 08625-0369

If you order by mail, the order will not be processed until the Customer Service Representative confirms the order by telephone with your office. Three (3) attempts will be made to confirm (two (2) by phone and one (1) by fax).

- **Internet:** Internet orders can be sent via e-mail to [njvfc@ahsi.org](mailto:njvfc@ahsi.org) or [VFC@doh.state.nj.us](mailto:VFC@doh.state.nj.us)

### **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services**

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated comprehensive health program for NJ FamilyCare/Medicaid recipients from birth through twenty (20) years of age as required under section 1905 of the Social Security act (42 U.S.C 1396(d)) and federal regulation 42 CFR 441.50. Healthfirst NJ providers will comply with EPSDT program requirements and performance standards which include the following:

#### **Health Services**

1. 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.
2. A comprehensive unclothed physical examination including:
  - Vision and hearing screening;
  - Dental inspection; and
  - Nutritional assessment.

3. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines and immunizations recommended by local health departments based on local epidemiological conditions. Providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits and necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented. Updated Immunization Recommendation Schedule is available in Appendix XIX.
4. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by Healthfirst NJ. The following list of screening tests is not all inclusive:
  - Hemoglobin/hematocrit/EP
  - Urinalysis
  - Tuberculin test – intradermal, administered annually and when medically indicated
  - Lead screening using blood lead level determinations must be done for every Healthfirst member:
    - i. between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age
    - ii. at eighteen to twenty-six (18-26) months, preferably at twenty-four (24) months of age
    - iii. test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested
  - Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and will be obtained as necessary.
5. Health education/anticipatory guidance.
6. 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.)

EPSDT screening services will reflect the age of the child and be provided periodically according to the following schedule:

- Neonatal exam
- Under six (6) weeks
- Two (2) months
- Four (4) months
- Six (6) months
- Nine (9) months
- Twelve (12) months
- Fifteen (15) months
- Eighteen (18) months
- Twenty-four (24) months
- Annually through age twenty (20)

The Primary Care Provider must provide the following screenings and services from birth through age twenty (20) in accordance with the EPSDT screening schedule

### **Vision Services**

At a minimum, include 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 (3).

### **Dental Services**

Dental services may 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. A referral to a dentist at or after age one (1) is mandatory, and at age three (3) and annually thereafter through age twenty (20).

### **Hearing Services**

At a minimum, 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 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 three (3) years of age and older. Speech and hearing assessment will be a part of each preventive visit for an older child.

### **Mental Health/Substance Abuse**

Providers are required to include a mental health/substance abuse assessment documenting pertinent findings. When there is an indication of possible MH/SA issues, a mental health/substance abuse screening tool(s) found in *Appendix VIIC* – approved equivalent will be used to evaluate the member.

Providers are required to notify a member's mental health/substance abuse provider of the findings of his/her physical examination within 24 hours of receipt for urgent cases and within 5 business days in non-urgent cases.

### **Other Considerations**

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.

Providers should use the *EPSDT Medical Record Tools* available in *Appendix XX* or on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org) and retain in the patient's medical record. If a member misses an EPSDT appointment, or needs a referral for problems identified through EPSDT examinations, the PCP must document the missed appointment or appropriate referral needed in the medical record, contact the member and try to reschedule. Periodically, Healthfirst will send PCP's a list of their members who have not received an encounter for EPSDT services within the recommended timeframes. The PCP's office must contact the members on this list to set up an appointment. Efforts to contact the members must also be documented in the medical record.

### **Lead Screening**

Healthfirst NJ providers shall perform screening for the presence of lead toxicity in children pursuant to N.J.S.A. 26:2-137.2 et seq. (P.L. 1995, c 328) which consist of the following components:

**Verbal Risk Assessment** - The provider will perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of six (6) and seventy-two (72) months as indicated on the schedule to determine child's risk for lead toxicity.

**Blood Lead Testing** - Regardless of risk, each child must be tested;

- Between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age,
- At eighteen to twenty-six (18-26) months, preferably at two (2) years, and
- Any child between twenty-seven (27) and seventy-two (72) months of age not previously tested

Providers must report all blood lead screening results, both positive and negative, to the County Lead Poisoning Center at the local health department. If a screening identifies a child with blood lead levels equal to or greater than ten (10) micrograms per deciliter, providers must immediately report the findings to the County Lead Poisoning Center. Providers are also encouraged to complete and return the *Lead Level Notification Form* (Appendix VIIF) for children with blood lead level equal to or greater than ten (10) micrograms per deciliter to enroll in Healthfirst NJ Lead Case Management Program (see Section 13).

The lead screening guideline and procedures can be found in *Appendix XVI*.

### **Women, Infants and Children (WIC) Program**

New Jersey WIC Services provides supplemental nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to the age of five. WIC services include nutrition education and counseling, breastfeeding promotion and support, immunization screening and health care referrals. Providers are required to refer potentially eligible women (pregnant, breast-

feeding and postpartum), infants and children up to age five (5) to established WIC programs. A New Jersey WIC form is located in *Appendix XV* and includes information needed by the WIC program to provide appropriate services. A copy of this completed form should be kept in the member's medical record.

Members may apply WIC services at their local WIC agency. To find the appropriate local agency, call the WIC agency toll free at **1-866-44-NJWIC (1-866-446-5942)**.

### **Mental Health and Substance Abuse**

Prevention is a key in quality clinical care provided for our members. It is extremely important to help our members receive evaluations and get help as soon as possible if they have any symptoms of depression or substance abuse. The Quality Improvement Department works with all Healthfirst NJ providers to assess members using the *Well-Being Screening Tool for Adolescents & Adults Patient Problem Questionnaire* as a screening tool (*Appendix VIIC*). It is a requirement for Healthfirst NJ providers to include this information in the member's chart and to refer the member to an appropriate mental health professional, if necessary.

## **6.4 Genetic Testing and Counseling**

Healthfirst NJ provides a full range of genetic testing lab services for adults, children and infants, and relies on its provider network to identify members who might benefit from genetic testing and counseling

NJ FamilyCare/Medicaid members who may consider genetic counseling and testing are:

- Those who have or are concerned that they might have an inherited disorder or birth defect.
- Women who are pregnant or planning to be after age thirty (30).
- Couples who already have a child with mental retardation, an inherited disorder or a birth defect.
- Couples whose infant has a genetic disease diagnosed by routine newborn screening.
- Women who have had two or more miscarriages or babies who died in infancy.
- People concerned that their jobs, lifestyles or medical history may pose a risk to pregnancy, including exposure to radiation, medications, chemicals, infection or drugs.
- Couples who would like testing or more information about genetic defects that occur frequently in their ethnic group.
- Couples who are first cousins or close blood relatives.
- Pregnant women who, based on ultrasound tests or blood tests for alpha-fetoprotein, have been told their pregnancy may be at increased risk for complications or birth defects.

NJ FamilyCare/Medicaid members can self-refer to a network provider for genetic testing and counseling and/or receive assistance through the Medical Management or Member Services departments. If a request involves a non-network provider, the service requires pre-authorization from Medical Management.

Healthfirst NJ also identifies members who might benefit from genetic testing through its Care Management Program and complex needs assessment.

## **6.5 Services considered to be Medical or Dental**

Healthfirst NJ recognizes that there are services that may be provided by either a medical or dental provider. The following medical services may be performed by either a physician (M.D. or D.O.) or a doctor of dental medicine or surgery within the scope of the provider's license:

- Fractured jaw
- Removal of cysts
- Removal of impacted teeth
- Repair of cleft palate
- Other oral surgical anomalies

Impacted teeth surgeries should always be treated under the dental benefit and will be managed directly by the dental vendor. Surgeries related to fractured jaw, repair of cleft palate, removal of cysts should be handled under the medical benefit particularly as significant medical treatment follow up may be involved.

## 7. Obstetrics and Gynecology

### 7.1 Definition of Services

All female NJ FamilyCare/Medicaid members twelve (12) years and older have direct or free access to a Obstetrician/Gynecologist (Ob-Gyn) who will be responsible for providing and managing medical care for obstetrical and gynecological conditions. NJ FamilyCare/Medicaid members have free access to Family Planning Services at any in-network or out-of-network provider accepting Medicaid for these services. NJ FamilyCare D members, except those with a specific program status code (PSC), that is PSC 380, may only obtain family planning services in-network.

Healthfirst NJ includes the following seven (7) specialty areas in its definition of Obstetrics and Gynecology. Practitioners in the specialties will be referred to as Ob-Gyn providers in this Provider Manual, unless otherwise indicated.

1. Gynecology
2. Gynecology (Nurse Practitioner)
3. Midwifery
4. Obstetrics
5. Obstetrics and Gynecology
6. Obstetrics and Gynecology (Nurse Practitioner)
7. Women's Health (Nurse Practitioner)
8. Maternal and Fetal Medicine
9. Obstetrics and Gynecology – High Risk

In certain circumstances, a member may choose the same provider to serve as both her PCP and Ob-Gyn. This might occur if a member selects a family practitioner as her PCP or HIV Specialist PCP who also provides routine Ob-Gyn services.

NJ FamilyCare/Medicaid members may access Ob-Gyn services directly, without a referral from a PCP for routine care. The PCP, however, may refer a member to an Ob-Gyn for consultation. Reports of all diagnostic tests must be forwarded to the PCP for inclusion in the member's medical record. See *Section 7* for additional details.

In addition, NJ FamilyCare/Medicaid members may choose to receive this care from a nonparticipating provider who accepts Medicaid for these services. NJ FamilyCare/Medicaid members should present their NJ FamilyCare/Medicaid cards when accessing services in this way.

Ob-Gyn providers should notify NJ FamilyCare/Medicaid member Services as soon as a member's pregnancy is confirmed. The mother's name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided. Please refer all pregnant women to the Healthfirst NJ Obstetrical Care Management Program by calling **1-866-467-7178**. Additional information on this program is found in Section 13.

*Please note: OB services for pregnant HIV positive members must be available twenty-four (24) hours a day.*

#### **Guidelines for Differentiating Gynecological Care from Primary Care**

The following table identifies several examples of clinical situations and defines whether they should be managed by the Ob-Gyn or referred back to the PCP for clinical follow up. Healthfirst NJ acknowledges that in all cases, the provider's best medical judgment should prevail; these examples provide guidance, not requirements.

Clinical Example	Provider
<ul style="list-style-type: none"> <li>■ Amenorrhea</li> <li>■ Vaginal bleeding/discharge</li> <li>■ Diagnosing infertility</li> </ul>	Ob-Gyn may address these conditions without a PCP referral.
<ul style="list-style-type: none"> <li>■ Hematuria</li> <li>■ Breast mass/breast discharge</li> <li>■ Sexual dysfunction</li> <li>■ Osteoporosis</li> <li>■ Skin conditions in the genital area</li> </ul>	These might be handled initially by the PCP, but Healthfirst NJ will allow a direct visit to the Ob-Gyn for these conditions.
<ul style="list-style-type: none"> <li>■ Abdominal pain</li> <li>■ Back pain</li> </ul>	These conditions require an initial PCP visit with subsequent Ob-Gyn consultation at the PCP's discretion.
<ul style="list-style-type: none"> <li>■ Upper respiratory infection</li> <li>■ Pharyngitis</li> <li>■ Other skin conditions</li> </ul>	These conditions should be treated exclusively by the PCP (with consultation from appropriate specialists, if required).

### Access to Family Planning and Reproductive Health Services

Healthfirst NJ Medicaid and NJ FamilyCare A, B, C, members may obtain family planning and reproductive health services without a PCP referral from either in-network or out-of-network Medicaid providers including:

- Birth control: pills, condoms, diaphragms, IUDs, Depo-Provera, Norplant and contraceptive foams.
- Emergency test.
- Sterilization (tubal ligations, vasectomies).
- Testing and treatment for STDs
- Pap smears, testing for cervical cancer, pelvic problems, breast disease, anemia and high blood pressure.

NJ FamilyCare D members, except those with program status code (PSC) 380 are required to obtain family planning services from a Healthfirst NJ provider. Family planning services outside the HFNJ provider network is not a covered benefit for these members.

Family Planning Services, including medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biological medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling are covered for NJ FamilyCare D members. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the NJ FamilyCare program.

All termination of pregnancy services are covered under Medicaid fee-for-service. **Exception:** spontaneous abortions/miscarriage such as those included under ICD-9 diagnosis codes 632, 634.0-634.99, 637.0-637.99 are not elective/induced abortions services are covered by Healthfirst NJ. The following services are provided by the New Jersey Medicaid program under the State fee-for-service program but require medical orders from Healthfirst NJ PCPs/providers. These services will not be included in Healthfirst's capitation schedule for elective and or induced abortions:

- History and physical examination on day of surgery
- Related surgical services and procedure
- Cervical dilation and insertion of cervical dilator
- Anesthesia including para cervical block,
- Lab tests including PT, PTT, OB Panel (includes hemogram, platelet count, hepatitis B surface antigen, rubella antibody, VDRL, blood typing ABO and Rh, CBC and differential)
- Pregnancy test
- Urinalysis and urine drug screen
- Glucose and electrolytes
- Routine venipuncture
- Ultrasound, pathological examination of aborted fetus
- Rhogam and its administration.

## 7.2 Diagnostic Testing

All testing, procedures and consultations related to pregnancy and Ob-Gyn conditions may be performed or ordered directly by the participating Ob-Gyn without consulting the PCP including:

- Sonograms performed during pregnancy.
- Cervical biopsy.
- Cesarean section.
- Referral to a cardiologist for evaluation of heart murmur/dyspnea during pregnancy.
- Referral to an endocrinologist for evaluation of galactorrhea.

If an Ob-Gyn orders or performs certain diagnostic tests, he/she must communicate the members test results to the PCP.

Ob-Gyn providers should not order tests or consultations for the evaluation of any condition that is not obstetric or gynecological. For example, if a member expresses concern about knee pain during a routine exam and requests referral to an orthopedist, the Ob-Gyn may not provide such a referral. The member must be referred back to her PCP for follow up on this condition.

## 7.3 Consent Requirements for Hysterectomy

Hysterectomy and other sterilization procedures are subject to special informed consent guidelines for patients receiving Medicaid benefits. Medical necessity and informed consent for hysterectomy are discussed in this section; information on family planning and sterilization procedures follows.

Before a hysterectomy is performed on a NJ FamilyCare/Medicaid member, an adequately documented informed consent procedure must be completed. In addition, the hysterectomy will only be authorized if it is not being performed solely for the purpose of rendering the member incapable of reproduction and there are clinical indications for performing the hysterectomy - these cannot include rendering the individual permanently incapable of reproducing.

Informed consent policies and procedures for hysterectomy are strictly regulated. Providers must ensure that they are in full compliance with appropriate documentation standards to be reimbursed for performing these procedures. Providers must comply with the Informed Consent Procedures for Hysterectomy and Sterilization specified in 42CFR, Part 441, sub-part F.

All women undergoing hysterectomies must be informed, verbally and in writing, prior to surgery that the procedure will render them permanently incapable of reproducing. Patients or authorized representatives must sign the FD-189 *Acknowledgment of Receipt of Hysterectomy Information Form (Appendix XIV)*. This documents that the patient received all pertinent information or certifies that there are reasons to waive the receipt of information. It also contains the surgeon's statement that the hysterectomy is not being performed for the purpose of sterilization. Patients or authorized representatives must sign the *Sterilization Consent Form 7473-MED (Appendix XIV)*. This documents that the patient received all pertinent information or certifies that there are reasons to waive the receipt of information. It also contains the surgeon's statement that the hysterectomy is not being performed for the purpose of sterilization.

Copies of the FD-189 and 7473-MED and associated instructions may also be obtained by contacting: the Division of Medical Assistance & Health Services, Quakerbridge Plaza , P.O. Box 712, Trenton, N.J. 08625-0712

The requirement that the patient sign Part 1 of the form may be waived under certain circumstances, such as evidence that the woman was sterile prior to the hysterectomy and the hysterectomy was performed in a life-threatening emergency situation in which prior receipt of hysterectomy information was not possible.

In either of these situations, the surgeon performing the hysterectomy must certify in writing on a 7473-MED form that one of these two conditions existed. He/she must attest to the reason for the patient's sterility or indicate the nature of the emergency that precluded transmittal of the *Sterilization Consent Form*. For example, the patient may already be post-menopausal at the time of the hysterectomy, or she may have been admitted to the hospital via the emergency room requiring immediate surgery.

In certain situations, a member may not have been a Medicaid recipient at the time of her hysterectomy, but if she subsequently applied for Medicaid and was determined to qualify for retroactive eligibility, the surgeon might receive payment from Medicaid for this procedure. He/she must certify in writing that the woman received information prior to surgery indicating that the hysterectomy would make her permanently incapable of reproducing, or that there was one of the extenuating circumstances allowing waiver of Part 1 of 7473-MED. **Providers must submit the 7473-MED form with the claim in order for the procedure to be reimbursed.**

## 7.4 Family Planning and Reproductive Health

### Scope of Services

Family planning and reproductive health services are comprised of the diagnostic, educational, counseling and medically necessary treatments, medication, and supplies furnished or prescribed by, or under the supervision of a physician or nurse practitioner for the purpose of:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant and injection procedures involving pharmaceuticals such as Depo-Provera;
- Screening and treatment for STDs;
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy and pelvic abnormality/pathology; and
- Termination of pregnancy services (provider must document duration of pregnancy).

HIV testing and pre and post-test counseling (when performed within the context of a family planning encounter) is considered a free access service. HIV blood testing and counseling may also be obtained from Healthfirst NJ PCPs, or by anonymous counseling and testing programs operated by New Jersey Department of Health and Senior Services Division of HIV/AIDS Services (DHAS) will comply with all applicable requirements of New Jersey's laws relating to informed consent and confidentiality.

All pregnant women must receive HIV education, counseling and testing with their consent as part of their regular prenatal care. A refusal of testing must be documented in the patient's medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (the use of Zidovudine [AZT] or most current treatment accepted by the medical community for treating this disease) for the mother and newborn infant should be made available during pregnancy and/or to the infant within the first months of life.

### Consent Requirements for Sterilization

Family planning and reproductive health services include sterilization. Sterilization is defined as any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing, or performed for other reasons, but which renders the individual permanently incapable of reproducing. Medicaid reimbursement is available for sterilization only if informed consent guidelines are met. The consent requirements for voluntary sterilization are described in this section. General requirements are summarized below, followed by specific disclosures that must be made to the patient prior to the procedure.

## General Requirements

### Minimum Age

Members undergoing sterilization must be at least twenty-one (21) years of age at the time of giving voluntary, informed consent to sterilization.

### Restrictions:

- The member undergoing sterilization must not be a mentally incompetent individual. For the purpose of this restriction, the term “mentally incompetent individual” refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- The member undergoing a sterilization procedure must not be an institutionalized person. For the purposes of this restriction, “institutionalized individual” refers to an individual who is (a) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or (b) confined under a voluntary commitment, in a mental hospital or other facility for the cure and treatment of mental illness.
- Informed consent to sterilization may not be obtained while the member is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the member’s state of awareness.

### Translation Services

An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

### Disabled Persons

Suitable arrangements must be made to ensure that the sterilization consent information is effectively communicated to deaf, blind or otherwise disabled individuals.

### Presence of Witnesses

The presence of a witness is optional when informed consent is obtained.

### Waiting Period

Voluntary informed consent to sterilization must be given no less than thirty (30) days or not more than one-hundred eighty (180) days prior to the sterilization procedure. When computing the number of days in this waiting period, the day the recipient signs the form is not included.

### Waiver of Waiting Period

Waiver of the thirty (30)-day waiting period may only occur in cases of premature delivery, when the sterilization was scheduled for the expected delivery date or when there is emergency abdominal surgery. Since premature deliveries and emergency abdominal surgeries are unexpected, medically necessary procedures, sterilization may be performed during the same hospitalization, as long as seventy-two (72) hours have passed between the original signing of the informed consent document and the sterilization procedure.

### Consent Form

A copy of the *Sterilization Consent Form (7473-MED)* must be given to the member undergoing the procedure. Completed copies of the form must be submitted to Medical Management before prior authorization for the procedure is given.

To obtain the *Sterilization Consent Form (7473-MED)* and the associated instructions in English and Spanish, contact: the Division of Medical Assistance & Health Services, Quakerbridge Plaza, P.O. Box 712, Trenton, N.J. 08625-0712

### **Specific Disclosures**

The individual obtaining informed consent for a sterilization procedure must offer to answer any questions concerning the procedure and must verbally provide all of the following information or advice to the individual electing to undergo the procedure. In addition, the physician who performs the sterilization procedure must discuss the following points with the member at least thirty (30) days before the procedure, usually during the preparation examination:

- Advice that the member is free to withhold or withdraw consent to the procedure at any time before the 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 procedure is considered to be 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 performance of 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 thirty (30) days except under the circumstances specified under the "Waiver of 30-Day Waiting Period."

## 8. Specialty Care

### 8.1 Definition of Specialty Care

Healthfirst NJ has contracted with specialist physicians and other specialty care professionals to provide healthcare services beyond the scope of primary care. Members access these services in accordance with the Healthfirst NJ prior authorization policies.

Specialty care practitioners provide medically necessary care within the scope of their practice. They are responsible for the following four activities:

1. Identifying individuals with complex or serious medical conditions, assessing and diagnosing those conditions and working with the member, the PCP and Medical Management to provide effective, coordinated medical care.
2. Collaborating with PCPs to provide coordinated clinical care and to enhance continuity of care for NJ FamilyCare/Medicaid members. Members are responsible for contacting the PCP to request information, where needed.
3. Following up with PCPs in writing to apprise them of consultation results, diagnostic testing results and treatment plans.
4. Assisting members in accessing required services such as diagnostic tests, acute rehabilitation, home care, DME and transportation.

A complete listing of participating specialty providers can be found on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org).

#### Specialists as PCPs

Under certain circumstances, Healthfirst NJ may authorize a specialist to function as a member's PCP. This may occur when a member has a life threatening, degenerative or disabling condition or disease that requires prolonged specialized medical care through a specialty provider or at a specialty care center. In these situations, Healthfirst NJ arranges for the specialist to take on primary care responsibilities in caring for the member. The member's PCP must be part of this decision process, and the Healthfirst NJ Medical Management Department must authorize the transfer of primary care responsibilities to the specialist. The specialist will then be accountable for coordinating care, referring the member to sub-specialty providers as appropriate, managing health education and preventive care activities, and complying with all guidelines, reporting requirements, medical and Care Management policies.

Specialists who take responsibility for coordinating the member's primary and specialty care must adhere to all PCP appointment and access standards. Section 3.3 contains more specific provider availability information.

The following situations illustrate examples of cases when it would be acceptable and beneficial for a specialty care physician or specialty care center to take on the primary management of care for a NJ FamilyCare/Medicaid member.

- HIV-positive members may select an HIV Specialist to serve as their PCP.
- Members with multiple traumas who require prolonged complex rehabilitative management.
- Members with cancer who require a complex, ongoing course of treatment.

The following procedures are applicable under these circumstances. Additional information on this subject also appears in *Section 12* of this Provider Manual.

- If the PCP or specialist believes that it is in the member's best interest to assign primary care responsibilities to the specialist, or if the member requests this arrangement, the PCP will discuss the option with the member.
- The PCP or specialist will contact Medical Management with information about the member's condition, course of treatment and the name of the treating specialist. If all parties agree, the PCP, the specialist and Medical Management will coordinate a plan to transfer care.
- If a member has requested the transfer, and the PCP or the specialist disagrees with the request, the member may contact Medical management directly. In these cases, the Medical Director will make a final determination.

### **Specialty Care Centers**

In some situations, a member may be best served by receiving care for a complex condition through a team of providers affiliated with an accredited or designated Specialty Care Center with experience in treating their life-threatening or degenerative and disabling disease or condition. For example, an HIV infected mother with an HIV-infected and/or HIV-exposed child may be appropriately served by a Maternal/Pediatric HIV Specialized Care Center.

The member, his/her PCP, or a specialty provider may initiate a request for this service. When a member makes the request, the PCP and Medical Management will evaluate the situation. The following procedures will be followed:

- The member, or the PCP on behalf of a member, should contact Medical Management to request care at a Specialty Care Center if he or she believes that this is the most appropriate resource.
- If there is a Specialty Care Center in the Healthfirst NJ network that provides the same or substantially similar services to those requested, the member will be referred for in-network care.
- If it is determined that an out-of-network Specialty Care Center is the most appropriate provider of care for an individual member, Medical Management will contact the out-of-network Specialty Care Center to negotiate an arrangement. Healthfirst NJ is financially responsible for all authorized out-of-network medical expenses.

## 9. Behavioral Healthcare and Chemical Dependency

### 9.1 Description of the Network

Healthfirst NJ has participation agreements with a broad network of physicians and other licensed professionals, community agencies, and inpatient and outpatient facilities to provide behavioral healthcare and chemical dependency services to NJ FamilyCare/Medicaid members.

Providers may contact the Healthfirst NJ Behavioral Care Unit at **1-866-467-7178** to determine a member's hospital affiliation, obtain information on participating providers and to facilitate access to services. Members may contact Member Services for information and/or a list of behavioral healthcare providers.

#### Behavioral Healthcare and Chemical Dependency Provider Responsibilities

Healthfirst NJ expects behavioral healthcare and chemical dependency providers to assume the following set of responsibilities.

- Contact the Healthfirst NJ Behavioral Care Unit to verify member eligibility and to receive authorization to provide services. Maintain this contact as treatment progresses to receive continuing authorization for additional services.
- Comply with the established policies and procedures of the Healthfirst NJ Medical Management and Quality Improvement Programs.
- Coordinate with the Healthfirst NJ Medical Management Department when necessary to ensure appropriate integration of services.

### 9.2 Benefits and Access to Care

#### Benefits Overview

Behavioral health care and chemical dependency benefits are different for each Healthfirst NJ program. Behavioral healthcare and chemical dependency services are covered by Healthfirst NJ for members who meet certain diagnostic criteria listed below. In addition, benefits are covered for clients of the Division of Developmental Disabilities (DDD). Please note that non-DDD NJ FamilyCare/Medicaid members, except in the instance of meeting the diagnostic criteria, are covered under the fee-for-service Medicaid program outlined below.

NJ FamilyCare/Medicaid members, including non-DDD members, who have a condition that alters mental status, will be covered through the Healthfirst NJ program. Please see *Appendix XVII* for a list of diagnoses that have been categorized as altering the mental status and having an organic origin.

Partial care and partial hospitalization is covered by the New Jersey State fee-for-service program for all NJ FamilyCare/Medicaid members.

#### Access to Care for Healthfirst NJ DDD Members

In general, all behavioral health or substance abuse services require prior authorization for eligible covered services by Healthfirst NJ. All Healthfirst NJ DDD members, may however, have direct access to Behavioral Health and Substance Abuse Services for one (1) in-network mental health visit per twelve (12)-month period and one (1) alcohol/substance abuse assessment visit per twelve (12)-month period. A referral from the member's PCP is not required for these direct access visits.

After the initial visit, the Behavioral Health provider must contact the Healthfirst NJ Behavioral Health Unit for authorization of additional visits. The Healthfirst NJ Behavioral Health Unit is able to approve up to five (5) initial visits for one (1) month. **These five (5) visits will include any combination of the following CPT-4 codes: 90801, 90804, 90805, 90806, 90846, 90807, 90847, 90853, and 90862.** Services provided after the initial appointment without prior approval from Healthfirst NJ will not be covered.

Self-referrals for children may originate at the suggestion of a school guidance counselor or other such professional. After the initial visit, the behavioral healthcare or substance abuse provider must contact the Healthfirst NJ Behavioral Health Unit at **1-866-467-7178** for authorization of continuing treatment. Services provided after the initial appointment will not be covered unless prior approval has been obtained from Healthfirst NJ.

### **Access to Care for Healthfirst NJ non- DDD members**

The following mental health/substance abuse services will be managed by the State or its agent for non-DDD NJ FamilyCare/Medicaid members, including all NJ FamilyCare members. (Healthfirst NJ will retain responsibility for furnishing mental health/substance abuse services, excluding partial hospitalization and partial care services, and the cost of the drugs listed below, to Medicaid members who are clients of the Division of Developmental Disabilities):

1. Substance Abuse Services—diagnosis, treatment and detoxification
2. Costs for Methadone maintenance and its administration
3. Mental Health Services Drugs.
4. The following drugs will be paid fee-for-service by the Medicaid program for all NJ FamilyCare/Medicaid members:
  - Atypical antipsychotic drugs within the Specific Therapeutic Drug Classes H7T and H7X
  - Methadone maintenance – cost and its administration. Except as provided in Article 4.4 of the Medicaid managed care contract, Healthfirst NJ will remain responsible for the medical care of NJ FamilyCare/Medicaid members requiring substance abuse treatment
  - Generically-equivalent drug products of the drugs listed in this section.
  - Up to twelve (12) inpatient hospital days required for social necessity in accordance with Medicaid regulations.
  - DDD/CCW waiver services: individual supports (which includes personal care and training), habilitation, case management, respite, and Personal Emergency Response Systems (PERS).

A Healthfirst NJ non-DDD member may access behavioral healthcare and chemical dependency services provided by Medicaid by directly contacting Medicaid providers of these services and presenting his or her Medicaid card. Healthfirst NJ is prepared to assist members in accessing this set of services. Members in need of care, or providers wishing to arrange these services for Healthfirst NJ non-DDD members, may call the Healthfirst NJ Behavioral Health Unit at **1-866-467-7178** for assistance.

## **9.3 Utilization and Medical Management Guidelines**

### **Authorization of Services**

All behavioral healthcare and chemical dependency services are subject to utilization and medical management to ensure that the most appropriate treatment and level of care is being provided. Authorization from the Healthfirst NJ Behavioral Health Unit is required for the services listed below.

### **Authorization of Services When Care is Managed by Healthfirst NJ**

Providers must contact the Healthfirst NJ Behavioral Health Unit at **1-866-467-7178** to speak with an Intake Coordinator to ensure that all care is appropriately authorized. Healthfirst NJ has developed an *Outpatient Treatment Report (OTR) Form (Appendix VIII)*, which is used to obtain authorization for additional visits upon completion of an initial evaluation and prior authorization of outpatient services once the patient has reached the initial number of authorized visits. OTRs should be faxed to 1-866-506-7060

### **Continued Extended Services Review**

Healthfirst NJ has implemented a continued extended services review process utilizing the OTR to assess the medical necessity and appropriateness of outpatient behavioral health treatment. Short-term and long-term goals of outpatient treatment are key measurements. Severity of Illness and Intensity of Services criteria are applied to review the following five types of outpatient treatment:

- Crisis stabilization/resolution
- Focused symptom reduction or behavior change
- Supportive maintenance
- Insight
- Psychopharmacological care (medication management)

Medical Management review is conducted after each request for routine outpatient behavioral healthcare services. Providers are required to submit an OTR to document information. The complexity of an individual patient's situation determines whether follow-up telephone calls to discuss the treatment plan or obtain further information are necessary.

If the OTR is incomplete or missing information, Healthfirst NJ will telephone the provider for details or the OTR will be returned with an information request. Providers will be notified of the number of visits authorized, the authorization number and the time frame within which those visits must be used. The provider must resubmit an OTR at least fourteen (14) days before the current authorization expires to request additional visits. All OTRs must be submitted according to these time frames to receive continuation of authorization for services. Services will not be authorized retrospectively. Any major deviation from the authorized treatment plan such as moving the patient to a different level of care requires timely authorization by a Healthfirst NJ Clinical Care Manager.

### Healthfirst NJ Treatment Principles

Healthfirst NJ has developed eight (8) general treatment principles and guidelines for outpatient behavioral healthcare services. They are consistent with established clinical practice and standards for behavioral healthcare. The principles are as follows:

1. **Therapeutic Environment:** An appropriate therapeutic environment must include face-to-face, in person contact between the therapist and the patient.
2. **Duration of Therapy Sessions:** Individual therapy sessions should ordinarily be a minimum of 30 minutes, customarily 45 minutes, unless they are only for medication management by a psychiatrist. Group/family/couple therapy sessions are usually required to run between forty-five (45) and ninety (90) minutes unless they are for crisis intervention. Crisis intervention sessions ordinarily should not exceed two (2) hours per day for individual therapy or three (3) hours per day for family therapy.
3. **Individual Psychotherapy:** Only one therapist may provide individual psychotherapy to a patient. Therefore, separate claims should not be submitted when two (2) or more therapists are treating the same patient concurrently. Ordinarily, no more than two (2) family members should receive individual therapy from the same provider. When more than two (2) family members require treatment, the provider would be expected to use family therapy as the treatment of choice.
4. **Composition of Therapy Group:** Group therapy sessions usually consist of four (4) to ten (10) patients unless they are multifamily or multi-couple groups.
5. **Electroconvulsive Therapy (ECT):** Psychotherapy should not be rendered within twenty-four (24) hours of ECT. Conventional practice does not recognize more than one ECT treatment per day or more than twelve (12) ECT treatments in a thirty (30)-day period. Indications for a greater number of treatments should be discussed with a Healthfirst NJ psychiatrist.
6. **Pharmaceuticals:** The use of prescription medications should follow national professional standards.
7. **Contraindications for Psychotherapy:** Psychodynamic psychotherapy is generally considered inappropriate for patients with a sole diagnosis of organic brain syndrome, substance abuse or chemical dependence, or developmental disorders.
8. **Documentation:** Documentation regarding the patient's progress should reflect movement toward defined treatment goals with measurable objectives. When a patient's diagnosis or treatment plan is changed, the documentation should include clinical information substantiating the reasons for the change.

## 10. Ancillary and Other Special Services

### 10.1 Overview of Services and the Provider Network

Healthfirst NJ has arrangements in place to provide a full range of ancillary and other special services to its members depending on the program enrolled. These services include:

Audiology and Hearing Services	Hospice
Behavioral Health	Laboratory Services
Cardiac Monitoring	Orthotics and Prosthetics
Chiropractic Care	Outpatient Rehabilitation
Dental Care	Pharmacy Services
Diagnostic Imaging Services	Physical/Occupational/Speech Therapy
Dialysis	Routine Vision Care
Durable Medical Equipment (DME)	Skilled Nursing Facility
Home Healthcare and Home Infusion Therapy	Transportation

This section of the Provider Manual describes the scope of services and network arrangements in place for selected ancillary and special services covered by Healthfirst NJ. Please refer to *Appendix IX* for additional instructions on our prior authorization guidelines for Ancillary Services.

#### Ancillary Services Provider Responsibilities

Healthfirst NJ expects participating ancillary service providers to adhere to the following service guidelines:

When ordering services for a member, the requesting provider should identify the patient as a NJ FamilyCare/Medicaid member and provide the member's Healthfirst NJ ID Number as well as their own provider ID number.

- Promptly report all findings, clinical reports, test results and recommendations to the PCP and/or ordering physician in writing by mail or fax.
- Consult the Healthfirst NJ Medical Management staff to obtain required authorization for services.
- Collaborate with the member's PCP and Medical Management staff to ensure continuity of care and appropriate integration of services.

### 10.2 Laboratory

Laboratory services are provided by Healthfirst NJ hospital laboratories and Quest. Providers must comply with service delivery system guidelines for referring members to laboratories. Refer to the Provider Directory for a list of laboratories.

Physicians are responsible for notifying members of laboratory and radiology results as follows:

- Urgent/ Emergent Results: Within twenty-four (24) hours or receipt of the results in urgent or emergent cases
- Routine Results: Within ten (10) business days of receipt of the results

### 10.3 Pharmacy

#### Programs and Covered Services

Healthfirst NJ provides coverage for pharmacy services for most NJ FamilyCare/Medicaid members excluding the Aged, Blind and Disabled members (ABD). ABD Members may receive fee-for-service Medicaid pharmacy benefits from any Medicaid-participating pharmacy. Members should present their Medicaid cards to pharmacy staff when accessing services.

All prescriptions must be filled at a Healthfirst NJ participating pharmacy. NJ FamilyCare/Medicaid members must present their identification card to the participating pharmacy. Healthfirst NJ may require prior authorization of certain pharmaceuticals. To help your patients maximize their pharmacy benefit, consider the following:

### Prescription Formulary

Healthfirst NJ plans with drug coverage have a restricted formulary. Providers are encouraged to consider the comparative cost and efficacy of pharmaceutical alternatives when prescribing medication for NJ FamilyCare/Medicaid members. As a part of the Healthfirst NJ prescription drug plan, pharmacists may contact providers to discuss whether an alternative drug might be appropriate for the member. The provider always has the final decision on the member's medication, and the member can always choose to keep the original prescription. A provider can request an exception to cover a non-formulary prescription. All prescription coverage determinations are made by Express Scripts – Healthfirst NJ's prescription benefit manager.

### Generic Drugs

Healthfirst NJ strongly encourages the use of generic drugs when clinically appropriate. The member's copayment will be less if a generic equivalent is prescribed. Please note the following maximum days supply:

Retail – 34 days ■ Mail order – 90 days

If a request for override on a prior authorization or non-formulary drug coverage is under review, Express Scripts will be able to administer the provision of a seventy-two (72) hour supply of medication. Grandfathering will apply to members where the medication is medically necessary and their prior history supports continuation of a non-formulary brand.

### Brand Name Medications

Under no circumstances will Healthfirst NJ permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. When deemed medically necessary by prescribers, Healthfirst NJ allows the use of brand name drugs as long as the formulary includes generic equivalents.

Providers can request that members receive a brand name drug by calling Express Scripts at **1-800-824-0898 (TTY 1-800-899-2114)** 24 hours a day, 7 days a week. The pharmacy can provide a 72-hour supply of medication while members wait for a prior authorization decision.

### Specialty Medications

Healthfirst NJ uses CuraScript as its specialty pharmacy vendor to help Healthfirst NJ manage the care members receive who need oral and injectable specialty medications. CuraScript is a leading provider of specialty medications, offering many products and services for members using these medications. CuraScript verifies eligibility, submits requests for prior authorization and bills the member applicable copayments or co-insurance for medications. Providers must order specialty medications directly through CuraScript (*except if the provider is an oncology and hematology specialist provider who may opt to supply medications directly and bill Healthfirst NJ directly.*)

### Protocol:

The Healthfirst NJ protocol for **specialty pharmacy** products is as follows:

1. Order medications through CuraScript. Call CuraScript at **1-866-848-9870**
2. Replacement medications – This process should be used for urgent situations only. CuraScript can provide medications for a specific member that may have been treated using medication from your own supply. **However, the medication provided by CuraScript will be marked and labeled with the specific member's name.** CuraScript cannot provide replacement medication in a bulk format. Replacement orders must be completed within four (4) weeks of medication administration.

#### The protocol above only applies to:

- Skilled Nursing Facilities (SNF), Nursing Facilities and Custodial Care Facilities
- Federally Qualified Health Centers (FQHC)
- Physician Offices
- Indian, Public and Rural Clinics
- Ambulatory Surgical and End-Stage Renal Disease Centers

**Protocol for Oncology and Hematology Specialty Providers ONLY** (*program is optional*):

The Healthfirst NJ protocol for oncology and hematology **specialty pharmacy** products is as follows:

1. Order medications through CuraScript. Call CuraScript at **1-866-395-1256**.
2. Medications can also be secured via the “Buy and Bill” option. Your office can secure the medication through another source and bill Healthfirst NJ at the contracted rate.
3. When submitting claims to Healthfirst NJ for reimbursement, you must use the correct J or Q codes. To expedite claims processing in accordance with State regulations, Healthfirst NJ requires you to include the National Drug Code (NDC) numbers. If submitting via EDI, please include the NDC’s in the comments field. If using a HCFA 1500 claim form, please include the NDC in field 24K.

Visit our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org) for more information

**The following items are not covered or otherwise restricted:**

- OTC drugs (applicable to NJ FamilyCare D only)
- Appetite suppressants agents when used for anorexia, weight loss or weight gain
- Rogaine (Minoxidil) or agents for cosmetic purposes
- Nicorette gum or agents used to promote smoking cessation
- Erectile dysfunction medication agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration
- Barbiturates and benzodiazepines
- Fertility drugs
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products except prenatal vitamins and fluoride preparations
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Non-prescription drugs

**The following items are covered under the member’s medical benefit when medically necessary:**

- Needles or syringes (except for diabetes which are covered under the pharmacy benefit)
- Growth hormones

#### **10.4 Durable Medical Equipment (DME), Orthotics & Prosthetics and Medical Supplies**

DME, orthotics and prosthetics, and medical supplies are covered benefits for NJ FamilyCare/Medicaid members who require such services to aid in the treatment of illness or injury or to improve bodily function. The provider must document in the member’s medical record that these items are medically necessary. Covered benefits are limited for members with NJ FamilyCare D benefits.

DME and supplies may be obtained through a participating DME provider with a physician’s written order and the appropriate authorization from Healthfirst NJ.

If a member is receiving home healthcare services, DME and supplies are obtained from the home healthcare provider. This may be a hospital-owned or hospital-operated certified home health agency (CHHA), or another contracted home health agency or home infusion therapy provider. Members who are not receiving home healthcare services may be referred to or may have their provider order directly from DME and/or orthotic and prosthetic vendors that participate with Healthfirst NJ.

**DME and orthotic and prosthetic vendors must call to obtain prior authorization from Medical Management for all items.**

#### **10.5 Home Healthcare**

NJ FamilyCare/Medicaid members are eligible to receive home healthcare services provided by a Certified Home Health Agency (CHHA). Home care providers participating with Healthfirst NJ include CHHAs maintained by Member hospitals, and other contracted CHHAs. For a listing of participating CHHAs, see the Provider Directory.

## Services and Eligibility

The services listed below comprise the scope of covered home healthcare benefits.

- Intermittent or part-time nursing visits rendered by a registered nurse.
- Intravenous therapy as ordered by a physician.
- Home health aide services provided under the direction and supervision of a registered nurse.
- Other services to be delivered in the home setting as requested by the PCP or attending specialist and approved by Medical Management.
- DME, oxygen, respiratory devices and other equipment and supplies required to care for the member in the home.

In order to be eligible to receive home healthcare services, members must meet all of the following criteria:

- Confined to the home;
- Under a plan of treatment established and periodically reviewed by a physician; and
- In need of intermittent skilled nursing care, physical therapy, speech therapy or in certain situations, occupational therapy.

## Responsibilities of Certified Home Health Agencies

All participating CHHAs must complete the following steps when providing care for NJ FamilyCare/Medicaid members.

- Verify member eligibility for NJ FamilyCare/Medicaid members by calling **1-866-889-2523** or by calling Member Services at **1-888-GO-4-HFNJ (1-888-464-4365)**. Refer to Section 4.4 for our eligibility verification process.
- Develop a treatment plan based on an assessment of the member's physical, psychological, and social needs.
- Obtain the signature of the physician who initially recommended home healthcare services on the treatment plan.
- Call the Medical Management at **1-866-467-7178** for prior authorization of services.
- If changes to the treatment plan are required within the period for which home health services have been approved, the CHHA will notify the PCP or specialist and contact Medical Management to obtain further authorization.
- If the duration of the home healthcare service period needs to be extended, the CHHA will notify the treating physician and will obtain authorization from Healthfirst NJ for the extension. Healthfirst NJ will also notify the PCP or specialist of authorized changes.
- If DME is a required part of the approved treatment plan, the CHHA will request separate and simultaneous prior authorization of the home healthcare treatment plan and associated DME and/or home infusion therapy from Healthfirst NJ.
- Issue the Healthfirst NJ *Notice of Non-coverage* to NJ FamilyCare/Medicaid members two days prior to end of services and retain a signed copy of the notice.

## Prior Authorization Process: General Guidelines

Home healthcare providers are responsible for obtaining authorization from Medical Management before providing services. Home healthcare services must be coordinated with the member's PCP or attending specialist in accordance with the prescribed plan of care. It is expected that home care providers will inform members under their care about specific healthcare needs requiring follow up and will teach members appropriate self-care and other measures to promote their own health. Medical necessity guidelines are used to determine the appropriateness of setting for home healthcare. Homecare services requested solely for convenience for activities of daily living or are custodial in nature are not a covered benefit.

NJ FamilyCare/Medicaid members may be referred for home healthcare services by PCPs, specialists or hospital discharge planners.

## 10.6 Dental

Dental services for NJ FamilyCare/Medicaid members are provided and managed by a delegated vendor which maintains a comprehensive network of dental providers. Members may access any network dental provider without a referral. To assist a member in obtaining dental services, please contact Healthfirst NJ Member Services at **1-888-GO-4-HFNJ (1-888-464-4365)**. Members may contact Member Services if they have questions regarding dental benefits. NJ FamilyCare/Medicaid members should refer to their member handbook to determine the extent of their dental benefit.

In addition to providing primary care dental services, the network includes specialty care dental providers such as orthodontists, endodontists and oral surgeons. These providers see NJ FamilyCare/Medicaid members without a referral, but with approvals

obtained from the delegated vendor. In general, the oral surgery performed by these providers is done in the provider's office and involves procedures such as the extraction of impacted wisdom teeth. However, there may be oral surgery cases involving small children that must be performed under general anesthesia in a hospital setting. In these situations, the delegated vendor authorizes the oral surgery and reimburses the surgeon, but the hospital service component of the treatment must be pre-authorized by Healthfirst NJ. This may be handled through communication initiated by either the hospital or the member's PCP.

In situations when oral surgery is required to treat medical problems such as head and neck cancers, the member's PCP or oral surgeon is required to obtain prior authorization from the Healthfirst NJ Medical Management Department. In these cases, all services are authorized and reimbursed by Healthfirst NJ.

NJ FamilyCare/Medicaid members with special needs may select a special needs dentist by contacting the Doral Dental Customer Service Department at **1-800-896-2373**.

## **10.7 Routine Vision**

Routine vision services are provided by a delegated vendor which maintains a comprehensive network of vision providers. NJ FamilyCare/Medicaid members may be entitled to routine eye examinations and eyeglasses provided by participating vendors (members should review their Member Handbook). Members may access these services without a referral from the PCP by making an appointment and presenting their Healthfirst NJ identification card at the office of the appropriate vision care provider. Information on the vision care benefits and the vision care network is provided in the Member Handbook and in the Provider Directories.

## **10.8 Hospice**

Hospice is a coordinated program that is designed to provide comfort and alleviate the pain of symptoms connected with a terminal illness.

The hospice benefit covers physician services, nursing care, pain and symptom management, physical, occupational and/or speech therapy, home health aide services, homemaker services, counseling, short term inpatient care and respite care.

## **10.9 Transportation**

### **Emergency Transportation**

All NJ FamilyCare/Medicaid members are eligible for emergency ambulance transportation benefits. To obtain emergency transportation to the nearest emergency facility when there is a life-threatening situation, dial 911.

## 11. Emergency and Urgent Care

### 11.1 Overview

NJ FamilyCare/Medicaid members are covered for inpatient and outpatient emergency care services within the Healthfirst NJ geographic operating area and also when members are traveling in or visiting out-of-area locations. Emergency services are reimbursed when an emergency medical and/or dental condition exists or when a Healthfirst NJ provider instructs the member to seek emergency care either in or out-of-network as is appropriate to the member's situation. Services must be provided by facilities or healthcare professionals qualified to render emergency medical and dental care. **Prior authorization from Healthfirst NJ is never required for treatment of an emergency medical or dental condition.**

#### Definition of an Emergency Medical and Dental Conditions

Emergency medical and dental conditions manifests themselves by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine, health and dentistry, could reasonably expect the absence of immediate medical and/or dental attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or serious impairment to the growth and development of the member's teeth.

#### Emergency Dental Services

Dental Emergencies consist of treatment to alleviate pain and swelling and to stop bleeding that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious damage to the member's teeth or place the person's oral health in serious jeopardy.

Healthfirst NJ members have access to emergency dental services on a twenty-four (24) hour, seven (7) day a week basis.

Members are able to seek emergency dental services from any licensed dental provider without the need for prior authorization while outside the service area.

Healthfirst NJ will bear full responsibility for the provision of emergency dental services, and will assure the availability of a back-up provider in the event that an on-call provider is unavailable. HFNJ's policies reinforce the responsibility of Healthfirst NJ and the dental vendor to ensure a dental provider is always available for dental emergencies.

#### Definition of Urgent Medical Condition

Urgent medical conditions are conditions that are potentially harmful to a patient's health and for which his/her physician has determined that is medically necessary for the patient to receive medical treatment within twenty-four (24) hours to prevent deterioration. Urgent Medical conditions are those illnesses and injuries of a less serious nature than emergencies, but that require services to prevent a serious deterioration of a member's health, which cannot be delayed without imposing undue risk to the member's well-being, until the member either returns to the Healthfirst NJ service area or until the member can secure services from his or her regular physician.

If the member is within the Healthfirst NJ geographic service area, and an urgent situation arises, he/she should receive care from their PCP or another Healthfirst NJ participating provider. Preauthorization is not required. The PCP may have the patient seen in his or her office, or may approve treatment of an urgent, but non-emergent condition in the emergency room. The PCP should document this contact with the member as well as the recommended course of action in the member's medical record. If the member is out-of-area at the time urgent care services are required, the PCP should be contacted as soon as possible for direction, but the member should seek appropriate care in the immediate location. Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition are not subject to prior authorization. If a member believes that a medical emergency exists, they should go the nearest emergency room or call 911 for assistance.

### **Definition of Urgently Needed Services**

Urgently needed services are covered services that are provided when an member is temporarily absent from Healthfirst NJ's service area, when the services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it was not reasonable given the circumstances to obtain the services through Healthfirst NJ's plan.

### **Emergency and Urgent Care Guidelines**

When a NJ FamilyCare/Medicaid member presents in the emergency room for care, the hospital is responsible for providing medically necessary and appropriate treatment. The hospital must contact the PCP as soon as possible to obtain clinical information that may be necessary to provide appropriate treatment. If a member presents in the emergency room with a nonemergency condition, the hospital should contact the PCP and document that contact. The hospital is then responsible for deciding and carrying out the necessary and appropriate course of action. Referral to the PCP for nonemergency treatment may be arranged.

If the PCP is referring the member for emergency care, the PCP should send the member to his or her assigned hospital whenever possible, or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information. Patients should be instructed to return to the PCP's office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency or urgent care services out-of-area, and the follow-up care cannot be safely postponed until the patient returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

### **Emergency Inpatient Admissions**

Healthfirst NJ must be notified of all emergency inpatient admissions as soon as possible, but no later than the next business day. Providers should contact Medical Management. In addition, hospitals are responsible for contacting the member's PCP to advise of the proposed admission, and to obtain any relevant information regarding the patient's condition, past medical history, etc. Healthfirst NJ PCPs who practice in private, community-based settings and do not have admitting privileges at Healthfirst NJ hospitals (Level III providers), should contact their hospital liaison to arrange for admission to the appropriate participating hospital in emergency situations as well as elective cases.

If a NJ FamilyCare/Medicaid member is hospitalized for emergency care in a nonparticipating institution, Healthfirst NJ will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely transported to a participating facility. Healthfirst NJ's Medical Management staff will work with staff at both hospitals to arrange the transfer when it is judged to be safe by the member's attending physician. Notification requirements and transfer guidelines related to emergency inpatient admissions are discussed in detail in *Section 11*.

## 12. Medical Management

### 12.1 Program Overview

The Healthfirst NJ Medical Management Program is designed to maximize quality of care while providing services in a cost-effective manner. The program focuses on assisting providers in planning for, organizing and managing the healthcare services provided to NJ FamilyCare/Medicaid members. Information and data collected through medical management procedures are used by the Medical Management Department to properly allocate resources and to foster efficient and effective care. Medical Management collaborates with network providers, contracted vendor organizations and other Healthfirst NJ staff to ensure that high-quality medical care is provided at the most appropriate level by the most qualified mix of providers.

The Medical Management Department is responsible for the following areas:

- Authorization and Notification Processes
- Continuity of Care
- Continued Extended Services Review and Retrospective Review
- Care Management
- Disease Management
- Lead Care Management

### 12.2 PCP-Directed Care

Written referrals **are not** required for NJ FamilyCare/Medicaid members to receive care from in-network specialists.

#### General Guidelines:

- Members must be directed by the PCP to specialty providers who can best communicate with the patient in accordance with the principles of cultural competence. This is to ensure optimal communication between members of various racial, ethnic and religious backgrounds, as well as disabled individuals, with their providers. For example, members should be referred to specialists who speak the member's language when the member does not speak or understand English. The Provider Directories provide data on languages spoken by the provider, as well as other relevant information, or you may contact Medical Management for assistance.
- The PCP is expected to refer the member for specialist care with **written instructions** to guide both the member and the specialist. It remains the PCP's responsibility to monitor and promote the return of the member to primary care for services and management.
- Specialists may assume primary care responsibility for patients with life-threatening, degenerative or disabling conditions that require prolonged specialty care services. In certain cases, it is more effective for a specialist or specialty care center to manage the full-spectrum of care for a particular member. Under these circumstances, the member's assigned PCP should contact Medical Management to arrange for the member's primary and specialty care services to be coordinated and managed by a designated specialty care provider with expertise in the member's condition.
- If possible, the PCP, Ob-Gyn or the office staff should assist the member in making appointments with specialists and should provide directions to the specialist's office. This is important for ensuring patient compliance with specialty requests and for obtaining prompt access to specialty services for members requiring urgent care. NJ FamilyCare/Medicaid members are entitled to assistance with transportation. Please see *Section 10* for additional details.

#### Ancillary Services

The PCP or specialty care provider may refer a member for ancillary services such as laboratory or routine x-ray services by filling out a prescription to order these services. Prior authorization may be required for some ancillary services. Refer to *Section 10* and *Appendix IX* for additional information on this process.

## Behavioral Health and Chemical Dependency Services

NJ FamilyCare/Medicaid members may obtain behavioral healthcare and chemical dependency services by contacting the Behavioral Health Unit at **1-866-467-7178**.

## Obstetrical Services

Healthfirst NJ does not require female members to obtain referrals before accessing routine gynecological care. Healthfirst NJ provides comprehensive prenatal care services to its members, including but not limited to: prenatal risk assessment, health education, mental health and related social services, labor and delivery, and postpartum care.

During pregnancy, the obstetrician assumes the responsibility of coordinating and managing the member's care. The Ob-Gyn may treat and/or make specialty referrals for any medical conditions arising during pregnancy without referring the member back to her PCP. However, if illness or injury occurs that is clearly not related to the pregnancy, the Ob-Gyn should refer the member to her PCP for further evaluation and treatment. In addition, when caring for a high-risk pregnant member, the provider should register the member in the Obstetric Care Management Program by calling the Obstetric Care Manager at **1-866-467-7178**.

## 12.3 Authorization of Services

### General Requirements

Providers must obtain prior authorization from Medical Management for all Healthfirst NJ programs for acute inpatient admissions, selected outpatient procedures and services, including certain ancillary services, and all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist who is caring for a member.

The following information must be supplied when requesting prior authorization of services:

- Healthfirst NJ Provider ID number
- Attending/requesting physician's name and telephone number
- PCP's name (if not the attending/requesting provider)
- Diagnosis and ICD9 Code
- Procedure(s) and CPT-4 Code(s) and procedure date(s)
- Services requested and proposed treatment plan
- Medical documentation to demonstrate medical necessity
- For inpatient admissions: hospital/facility name, expected date of service and expected length of stay

Please be sure that ALL of the above information is included when you fax a prior authorization request. If you are calling in the request, please have the information available when you call Medical Management.

### Standard Time Frames for Prior Authorization Determinations

Medical Management will make an authorization determination as listed below. In the event that a requested service does not meet the designated screening criteria, the case will be pended for review by the Medical Director.

- **Prior Authorization Review**
  - **Urgent determinations.** Prior authorization determinations for urgent services will be made **within twenty-four (24) hours** of receipt of the **necessary information**, but **no later than three (3) business days after receipt of the request for service**.
  - **Routine determinations.** Prior authorization determinations for non-urgent services will be made and a notice of determination provided by **telephone and in writing to the provider** within **ten (10) business days** (or sooner as required by the needs of the member) **of receipt of necessary information** sufficient to make an informed decision
- **Continued Extended Services Review**

Healthfirst NJ will make a determination involving continued or extended health care services, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider and provide **notice of the determination to the member or the member's designee and to the member's health care provider**, by telephone and in writing **within one (1) business day of receipt of the necessary information**. In the case of a member currently receiving inpatient hospital service or emergency room care, Healthfirst NJ shall make the determination involving continued or extended health care services within twenty-four (24) hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

Determination decisions are issued to the requesting provider, the member or the member's representative and the PCP. Authorization for services is valid for ninety (90) days from the date of issue for medical/surgical services.

**Authorization status may be checked on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org). After requesting an authorization for outpatient service, providers are given a notification number that can be used to obtain pending, approved or denied authorization status. This notification number can be used within one (1) to three (3) business days after Medical Management has received all the medical necessity information.**

#### **Authorization of Inpatient Admissions: Elective Admissions**

All elective inpatient admissions require prior authorization. This applies to hospital admissions for medical/surgical services as well as to facility admissions for inpatient behavioral healthcare and substance abuse services. The prior authorization process allows for pre-admission review of the proposed hospitalization.

Elective admissions must be scheduled in advance of the hospitalization. The admitting provider must contact Medical Management at **1-866-467-7178** for prior authorization no later than seven days prior to admission. The admitting provider must obtain an authorization number from Medical Management for an approved admission. This number must be included on all claims submitted in relation to the admission. If questions arise during the prior authorization review as to the appropriateness of the admission, the case will be referred to the Healthfirst NJ Medical Director or his or her designee. If the requested admission is not approved, the provider may initiate an appeal. The appeal process is discussed in *Section 15*.

#### **Emergency Admissions**

Prior authorization from Healthfirst is not required for emergency admissions. However, all emergency admissions, including admissions in which the member proceeds directly from the provider's office to the hospital for immediate admission, require notification to Healthfirst NJ. Hospital staff must contact Medical Management within twenty-four (24) hours of the admission or on the next business day. The staff must provide Medical Management with details on the admission, including the same data elements required for prior authorization of inpatient care as listed in this section. Notification from the member's PCP or admitting provider is also acceptable. Providers may call Medical Management at **1-866-467-7178** or fax information to **1-866-506-7060**.

## **12.4 Out-of-Network Services**

At times, a NJ FamilyCare/Medicaid member may require healthcare services from a nonparticipating provider. These situations may arise for reasons of medical necessity or because a particular service or specialty is not available within the Healthfirst NJ network. When this occurs our Medical Management Department should be contacted at **1-866-467-7178** 24 hours a day, 7 days a week. Our nurse case managers, social workers, or intake coordinators will obtain the clinical information needed to address the member's specific health condition. A decision regarding whether or not out of network care is appropriate will be determined by the Healthfirst NJ Medical Director. Healthfirst NJ will inform you of our decision within three business days of receiving all the information we need to make a decision. Out-of-network care for all programs must be approved by Medical Management who evaluates the case in conjunction with the attending practitioner and the member's PCP. When a NJ FamilyCare/Medicaid member is referred for out-of-network inpatient hospitalization, the hospital must:

- Verify the member's eligibility at the time of admission.
- Contact Medical Management to verify that the member's scheduled admission has been preauthorized and to obtain the authorization number for submission with the claim.

Additionally, when a NJ FamilyCare/Medicaid member is referred by their PCP, or by our Medical Management Department, to a provider who is not a Healthfirst NJ participating provider, the member is not financially responsible for the medical visit other than any regular copayments.

#### **Prior Authorization Required When an Out-of-Network Provider Covers For an In-Network Provider**

Providers must contact the Healthfirst NJ Medical Management Department for authorization when an out-of-network provider, in the same practice or an affiliated practice with the Participating provider, renders services to a Healthfirst NJ FamilyCare/Medicaid member. Obtaining authorization from Medical Management prior to services being rendered is the easiest and fastest way to ensure proper claim processing.

An out-of-network provider may cover for an in-network provider in his/her practice or an affiliated practice if one of the two following situations occurs:

- The participating provider is unexpectedly unavailable to see Healthfirst NJ patients with previously scheduled appointments during the participating provider's period of unavailability; or
- The participating provider has a planned absence, during which time he/she is being covered by an out-of-network affiliated provider, and a HFNJ member needs an urgent/emergency appointment.

If one of these two situations occurs, an authorization should be requested from Medical Management prior to services being rendered by the out-of-network provider. If an authorization is not requested, the in-network provider and the out-of-network provider must complete the Out-of-Network Covering Provider Attestation form in its entirety and submit this, along with the corresponding claim form, to the NJ Claims department. Failure to obtain an authorization or failure to submit this attestation form along with the claim will result in denial of payment.

*Please refer to Appendix IX for a complete list of prior authorization guidelines.*

## 12.5 Out-of-Area Services

Healthfirst NJ will provide or arrange for out-of-area coverage of contracted benefits in emergency situations and non-emergency situations when travel back to the service area is not possible, is impractical, or when medically necessary services could only be provided elsewhere. Except for full-time students, Healthfirst NJ will not be responsible for out-of-state coverage for care if the member resides out-of-state for more than thirty (30) days. In this instance, the individual will be disenrolled. This does not apply to situations when the member is out of State for care provided/authorized by Healthfirst NJ, for example, prolonged hospital care for transplants. For full time students attending school and residing out of the country, Healthfirst NJ will not be responsible for health care benefits while the individual is in school.

## 12.6 Continuity of Care

Healthfirst NJ has established mechanisms to ensure that continuity of care is maintained for members under a variety of circumstances. Each of these situations is discussed in detail below. All questions regarding continuity of care issues should be addressed to Medical Management at **1-866-467-7178**. For information on specialists as PCPs and specialty care centers, please refer to *Section 8*.

### Standing Authorizations

Healthfirst NJ allows standing authorization for specialty care in cases in which the member's diagnosis or condition requires ongoing care from a specialist, specialty center, or specialty institution. In these situations, the PCP or requesting provider must coordinate a standing authorization with the member, the specialist and Healthfirst NJ. To arrange this authorization, the requesting provider must call Medical Management to discuss the treatment plan and the need for the extended authorization. When appropriate, Medical Management, in consultation with the requesting provider/PCP and the specialist, will issue an authorization designating the approved number of visits, the services to be rendered and the time period covered by the standing authorization.

### Transition from Nonparticipating to Participating Providers

Healthfirst NJ has special policies to address transition periods when a new member currently undergoing a course of treatment with a nonparticipating provider joins Healthfirst NJ, or when a member's physician leaves Healthfirst NJ. These transition policies apply only in situations when the member is being seen regularly for management of a complex, life-threatening or degenerative and disabling disease, or is pregnant and under the care of an Ob-Gyn.

In all cases, continuation of care with a nonparticipating provider depends on the provider's acceptance of Healthfirst NJ reimbursement rates as payment in full. The provider must also agree to do the following:

- Adhere to Healthfirst NJ's quality assurance requirements;
- Abide by all Healthfirst NJ policies and procedures;
- Provide Healthfirst NJ with medical information related to the member's care;
- Obtain prior authorization from Medical Management for applicable services; and
- Agree not to "balance bill" the member for services provided.

### Medical Records

When a member selects a new PCP, upon their request, their former PCP should transfer the member's records to the new provider in a timely manner to ensure continuity of care.

### Continuity of Care Guidelines

Specific Situation	Healthfirst NJ Policy
New member—existing plans of care	<ul style="list-style-type: none"> <li>■ Healthfirst NJ will honor and pay for plans of care for new members initiated prior to enrollment with Healthfirst. Services will be continued until the member is evaluated by his/her primary care provider and a new plan of care is established with Healthfirst NJ. Services include:               <ul style="list-style-type: none"> <li>- Prescriptions;</li> <li>- Durable medical equipment;</li> <li>- Medical supplies;</li> <li>- Prosthetic and orthotic appliances; and</li> <li>- Any other on-going services members initiated prior to enrollment with Healthfirst NJ.</li> </ul> </li> <li>■ <b>Contacting Members:</b> Healthfirst NJ will use its best efforts to contact the new member or, where applicable, authorized person and/or Healthfirst NJ care manager. However, if after documented, reasonable outreach (i.e., mailers, certified mail, use of MEDM system provided by the State, contact with the Medical Assistance Customer Center (MACC), DDD, or DYFS to confirm addresses and/or to request assistance in locating the member) the member fails to respond within twenty (20) working days of certified mail, Healthfirst NJ may cease paying for the pre-existing service until the member or, where applicable, authorized person, contacts Healthfirst NJ for re-evaluation.</li> </ul>
When a provider leaves the network	<p>When a provider's status as a participating provider is terminated, <b>regardless of the party initiating the termination</b>, the provider, if a physician, will remain obligated to provide services for covered persons in accordance with the following:</p> <ul style="list-style-type: none"> <li>■ <b>When Medically Necessary:</b> In cases where it is medically necessary for the covered person to continue treatment with the health care professional, for <b>up to four (4) months</b> following the effective date of the termination.</li> <li>■ <b>Pregnancy:</b> In cases of the pregnancy of a covered person, through the postpartum evaluation of the covered person, <b>up to six (6) weeks after delivery</b>.</li> <li>■ <b>Post-operative care:</b> In the case of post-operative care, <b>up to six (6) months</b> following the effective date of the termination.</li> <li>■ <b>Oncology Treatment:</b> In the case of oncological treatment, <b>up to one (1) year</b> following the effective date of the termination.</li> <li>■ <b>Psychiatric Treatment:</b> In the case of psychiatric treatment, <b>up to one (1) year</b> following the effective date of the termination.</li> </ul>

### Authorization of Care for New Members

Healthfirst NJ will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment until the PCP evaluates the member and establishes a new plan of care.

### 12.7 Continued Extended Services Review

Healthfirst NJ has implemented a continued extended service review program to monitor the allocation of resources during an episode of care. The program uses evaluation criteria from InterQual to review services provided to members. These criteria are available to providers upon request.

### **Inpatient Review**

The inpatient review program is comprised of three basic components. They are as follows:

- **Admission Review:** Admission review is based on clinical information provided to verify the appropriateness and medical necessity of the hospitalization. Emergency admissions that occur during weekends or holidays may be called in to the Medical Management after-hours call line at **1-866-467-7178** and a medical necessity determination will be made.
- **Continued Stay Review:** Continued stay review is conducted to reestablish that inpatient hospitalization continues to be appropriate and medically necessary.
- **Discharge Planning:** Discharge planning begins prior to admission for elective admissions. For emergency admissions, the process begins with the first review of the case. The goal of discharge planning is to move members efficiently and effectively through the different levels of care required to manage and treat their medical condition.

### **Outpatient Continued Extended Services Review**

**Medical/Surgical Services:** Outpatient review focuses on the effective allocation of resources during an episode of care to ensure that care is provided at the most appropriate level, is coordinated among all disciplines, that continued benefits exist for the service, and that problem cases and quality issues are identified. Providers must furnish clinical information to Medical Management to support continued authorization of services before the expiration of the authorized treatment period. Providers requesting continuation of service authorization will receive a verbal determination followed by written confirmation, which will include the authorized service(s), the number of authorized visits or sessions, and the expected date of service.

**Behavioral Healthcare Services:** Continued Extended Services review of outpatient behavioral healthcare services is conducted after five (5) sessions of routine behavioral healthcare or more frequently as appropriate for patients at risk or receiving higher levels of care. Providers must use the *Outpatient Treatment Report (OTR) (Appendix VIII)* to document requests for continued services. OTR requests are authorized for a six-month period of services. OTR requests must be submitted fourteen (14) days prior to the expiration of the authorized treatment period. See *Section 9* for more information.

## **12.8 Retrospective Review**

Retrospective reviews are performed after healthcare services have been provided.

Retrospective review is also performed to evaluate the medical necessity for services which were not pre-authorized or were denied for failure to provide clinical information. Healthfirst NJ will perform Medical Management review activities that afford timely, comprehensive retrospective review based on the Healthfirst NJ clinical criteria.

## 13. Medical Management and Care Management Programs

### 13.1 Overview

Medical Management brings added value to our members by providing proactive and comprehensive care management and outreach programs for those diagnosed with high-risk conditions, illnesses, special situations and special needs. Our collaborative process of assessment, planning, facilitation and advocacy coupled with a comprehensive portfolio of programs help our members better manage their overall health and well-being, and navigate the complexities of the healthcare system.

Care Management encompasses a variety of clinical, outreach and educational programs that cover:

#### Care Management Program for Special Needs

##### Disease Management:

- Asthma
- Congestive Heart Failure (CHF)\*
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes\*
- Hypertension

##### Medical Management also directs the following programs:

- Lead Case Management
- Behavioral Healthcare/Domestic Violence
- Healthy Mom/Healthy Baby
- HIV/AIDS

Members may self-refer or be referred in a variety of ways, including by their PCP or specialist through data (i.e. reports, questionnaires, claims, etc) or by a member of the Healthfirst team (i.e. Care Manager or home care request, Member Services, etc). Care Managers work with members and their families, PCPs, other attending physicians, facilities and other service providers to assess, plan, coordinate, monitor and evaluate the optimal mix of services to best meet an individual member's needs. After an initial assessment, the Care Manager develops a care plan that includes educational programs for both the member and the caregiver. These are designed to provide the specific knowledge and skills necessary to support management of the member's ongoing healthcare condition. The care plan is organized to encourage and monitor member compliance. Ongoing assessments of the member's understanding of his or her medical condition and plan of care are incorporated into the program.

### Asthma

The Asthma Program provides members with up-to-date asthma educational materials and resources to better manage their asthma.

This Program is staffed by registered nurses who work in conjunction with PCPs, members and family members and other providers such as home health nurses and respiratory therapists to assess, educate, manage and monitor members with asthma. Members with asthma receive educational literature that highlights information on how to control asthma, appropriate use of medications and steps to take to manage an asthma episode. Healthfirst NJ encourages participating providers to use this literature for their patients. It is both easy to read and understand.

In addition, Healthfirst NJ promotes the age-appropriate use of peak flow meters and spacers and appropriate referrals to specialists such as pulmonologists and allergists within the Healthfirst NJ provider network. Asthma Care Managers can be reached at **1-866-467-7178** to assist with coordinating asthma care services.

**Please be sure to refer patients with ICD-9 diagnosis codes 493, 493.0, 493.1, 493.2, 493.9, 493.11, 491, 491.8, 491.9, 496, 519.8 and 786.9 to the Asthma Program.**

*Reminder to PCPs: Please offer your pediatric and adult asthma patients the influenza injection each fall/winter season.*

### **Congestive Heart Failure (CHF)**

The CHF Program provides the member with outreach; coordination of care; educational materials; a self-assessment of the signs and symptoms related to CHF; an understanding of the medications used, including the possible effects/side effects and drug interactions; lessons on healthy food choices; and blood pressure and weight monitoring.

### **Chronic Obstructive Pulmonary Disease (COPD)**

Program goals are to aid in preventing disease progression, help relieve symptoms and improve exercise tolerance and overall health status by preventing and treating complications and minimizing side effects from treatment.

### **Diabetes**

The Diabetes Program focuses on patient identification, education and prevention of recurrent events. It emphasizes intensive education and interventions to empower the members to manage their disease and improve their quality of life. Members with diabetes are defined as those members identified through Healthfirst NJ established identification methods and Quality Improvement stratification methods.

### **HIV/AIDS**

Healthfirst NJ is committed to increasing the quality of life and decreasing mortality and morbidity in the HIV/AIDS population. Emphasis of the program is based on member assessment and coordination of care with the PCP, Infectious Disease Clinic, Immunologist or HIV Specialist Provider. The goal is member education, coordination of medical care to help prevent opportunistic infections, and early identification of behavioral health and/or community resource needs.

### **Hypertension**

The program provides education, assessment and care planning in collaboration with the member's Primary Care Provider (PCP) and other providers. Through the HTN Program, members are given information on the importance of proper diet, nutrition, and blood pressure control.

### **Lead**

Healthfirst NJ supports and implements the provider's screening with outreach to parents and caregivers. The Lead Case Management Program focuses on the management of children with blood lead levels greater than or equal to 10 µg/dl ( $\geq 10$  µg/dl) and other members of the same household who are between the ages of six months and six years of age. To assist us in identifying children needing lead case management, please complete and return the Healthfirst NJ *Lead Level Notification Form* (Appendix VIII).

### **Behavioral Health/Domestic Violence**

Behavioral Care Management is a process for coordinating care over the continuum of an illness or condition requiring clinical intervention. Behavioral Health Care Management focuses on the achievement of desirable patient outcomes, appropriate lengths of stay, efficient utilization management and patient satisfaction and involvement. This is achieved by ensuring services are furnished on a timely basis and by coordinating service delivery between mental health/substance abuse physical health treatment services, community based services and programs that compliment or are collateral to the treatment. Healthfirst NJ Care Managers are available to provide outreach to members who may be victims of domestic violence and to help them to obtain needed services. Victims may include women, children, gay/lesbian partners or senior citizens. If you think a NJ FamilyCare/Medicaid member may be a victim of any type of abuse, please call a Healthfirst NJ Care Manager at **1-866-467-7178**.

### **Care Management Program for Special Needs**

This program provides assistance and coordination of care for members identified as aged, blind or disabled; members with developmental disabilities; members with special needs with complex, chronic medical conditions along with complex psychosocial issues such as mental health, substance abuse and home environmental issues. Our goal is provide members education to improve their health, link them to available community resources and provide all the necessary healthcare services to avoid preventable hospitalization and ensure that they remain healthy or improve their health within their home environment.

**Adults with special needs** – those who have or at increased risk for complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental/substance abuse, and/or developmental disabilities, including such persons who are homeless.

**Children with special needs** - those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.]

Healthfirst NJ has established methods for well child care, health promotion, and disease prevention. Healthfirst NJ Care Management Department coordinates specialty care for those who require such care. Diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications are addressed in the member's complex needs assessment and implemented in the individual healthcare plan.

### **Early Identification and When to Do Complex Needs Assessment**

When any of the following conditions are identified, Healthfirst NJ will ensure that a Complex Needs Assessment is conducted. The following are indicators for early identification of members that may require care management:

- poor health or functional status that may indicate the member would be considered special needs, as reported by the member or authorized person
- existence of a care management plan from any other source/agency
- existence of a care manager from any other source/agency
- request for a care management assessment from the member or authorized person or physician
- request for a care management assessment from a State agency or private agency involved with the a member or health care provider
- a chronic condition that is likely to result in a designation as a special needs member or program status code for special needs

Healthfirst NJ has a process in place to respond to after-hours calls regarding special needs members. The available clinical staff has the credentials to provide appropriate response to crisis situations and to authorize medical care 24 hours a day, 7 days a week and make decisions in accordance with the contract between the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and Healthfirst NJ.

- When members and/or providers call the Medical Management after-hours call line at **1-866-467-7178**, the following occurs: Clinical On Call Staff Medical Management establishes a monthly on call list of Registered Nurses who respond to after hours calls regarding medical care
- Medfone answers calls after 5:00 p.m. until 8:00 p.m. of the next business day and secures caller member or provider information for the clinical staff but does not perform any clinical functions
- Medfone follows up with clinical staff by phone
- The clinical staff contacts the member or provider to handle the issue regarding medical care within 15 minutes for crisis situations, 30 to 45 minutes for non-emergent, symptomatic issues, and same day for non-symptomatic concerns

### **Existing Relationships with Out of Network Providers**

Healthfirst NJ maintains policies and procedures to allow for the continuation of existing relationships with nonparticipating providers, when appropriate providers are not available within network or it is otherwise considered to be in the best medical interest of the member. Section 12.4 contains more specific information for use of Out of Network Providers.

### **Dental**

Healthfirst NJ has specific policies and procedures for the provision of dental services to enrollees with developmental disabilities. At a minimum, the policies address:

- Special accommodations for members with developmental disabilities, including consultation and assistance to member's caregiver.
- Special provisions for dental providers and adequate support staff treating members with developmental disabilities and recognizing the additional time that may be required.
- Allowance for 4 visits annually without prior authorization.

- A provision for home visits when medically necessary and where available.
- Care Management coordination for members with developmental disabilities, including dentally required hospitalization.

### **Healthy Mom/Healthy Baby Program**

Healthfirst NJ has implemented patient education programs and care management programs focused on pregnancy and newborn care. All pregnant women enrolled in these programs are sent educational materials. These include information about prenatal care, fetal development, nutrition, pre-term labor and vaccinations. Please contact the obstetrical case manager at **1-866-467-7178** regarding all pregnant NJ FamilyCare/Medicaid members under your care so they can receive these educational materials. Members identified as “high-risk” are followed by a registered nurse for education, outreach and prenatal and postnatal care.

The Healthy Mom/Healthy Baby Program provides care management and outreach services for all obstetrical patients. The program is designed to improve outcomes for mothers and newborns, with an emphasis on member outreach and education. The program links the member and her family with appropriate providers and community resources to ensure that she receives needed services and to identify any obstacles to care. The Obstetric Care Management staff proactively contacts identified members to perform initial and ongoing comprehensive risk assessments, to encourage early and continuous prenatal care, to develop a prenatal plan of care and to coordinate that care, to encourage and/or provide HIV testing and counseling with clinical recommendation, and to coordinate postpartum and newborn care.

Specific program components include:

- Identifying pregnant members
- Assessment of members to identify “high-risk” pregnant members
- Providing community outreach services through affiliated hospitals and clinics
- Educating patients by telephone and through literature mailed out to members
- Assessing pregnant patients for risk factors and complications
- Coordinating care in collaboration with the member’s obstetrical provider for high-risk pregnancies

**High Risk Codes:** Healthfirst NJ considers members with the following ICD-9 diagnostic codes as well as pregnant members living in shelters to be at high risk:

**640.0, 641, 641.0, 641.1, 642, 642.4, 642.5, 642.6, 642.7, 643, 644.0, 645, 646, 647, 648.0, 651, 654.5, 656.1, 656.6, 657, 658.0, 658.1, 659.5, 671.3 and 673.**

**Please note: Please refer ALL pregnant women under your care as well as any high-risk Healthfirst NJ obstetrical patients to the Healthy Mom/Healthy Baby Program by calling 1-866-467-7178 or faxing the OB Notification Form (*Appendix XA*) to 1-866-506-7060.**

***NOTE: All educational materials must have prior approval from DMAHS.***

## 14. Quality Improvement Program

### 14.1 Overview and Philosophy

Healthfirst NJ's Continuous Quality Improvement (CQI) Program will support a well-defined structure, utilize systematic processes and implement evidence based outcomes measurements. This will be the foundation by which Healthfirst NJ aims to deliver the highest quality and safest care possible to its membership. Through the cyclical process of *Plan, Do, Study and Act*, Healthfirst NJ with its Board of Directors and exemplary management team is committed to implementing a Quality program that will ensure delivery of health care that is safe, effective, patient-centered, timely, efficient and equitable within the bounds of its conduct of running a health care organization and in compliance with the contractual requirements of the New Jersey Quality Assessment and Performance Improvement (QAPI) Standards of the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services (DMAHS) and 42 Code of Federal Regulations (CFR) 438 Subparts D (QAPI) and E (External Quality Review).

#### Key Objectives of the Healthfirst NJ Continuous Quality Improvement Program:

1. To establish and maintain activities that are instrumental in promoting preventive health and improving the quality of life of our members including those with chronic conditions and members with special needs.
2. To ensure that members receive quality, comprehensive, personalized care in a service delivery system that fosters and improves the delivery of cost effective quality care and services.
3. To ensure that the health care service that it provides is medically necessary with emphasis on the promotion of health in an effective and efficient manner.
4. To ensure that members have timely and adequate access to culturally and linguistically appropriate health care services.
5. To assess the appropriateness and timeliness of the care provided.
6. To evaluate and improve as necessary access to care and quality of care with a focus on improving member outcomes.

#### Program Scope

The scope of the CQI Program is comprehensive; addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

The CQI Program methodology provides for review of the entire range of care provided by the Healthfirst NJ providers and its networks, by assuring that all demographic groups and recipients of the NJ FamilyCare/Medicaid Program including but not limited to Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF), Division of Youth and Family Services (DYFS)/Department of Children and Families (DCF), Supplemental Security Income (SSI) and New Jersey Aged, Blind and Disabled (ABD), NJ FamilyCare, pregnant and parenting women, racial and linguistic minorities. The care in settings where services are rendered to its members such as inpatient, ambulatory, including care provided in private practice offices, and home care, as well as types scope of the CQI review. The CQI review of this entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis. The CQI Program describes how it will meet the outcomes and performance standards specified in the contract with DMAHS.

## 14.2 Reporting Requirements and Quality Programs

Healthfirst NJ is required to report to CMS and the New Jersey regulatory authorities on a variety of data elements including clinical studies and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst NJ relies upon its provider network to supply it with comprehensive, accurate and timely information. Healthfirst NJ also expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets.

This section of the Provider Manual describes the range of regulatory reporting requirements and provider data requirements mandated by CMS and Healthfirst NJ. It also describes the Quality Programs, tools, support and educational initiatives that Healthfirst NJ has implemented to help providers meet and satisfy these regulatory requirements. Please direct questions regarding these reporting requirements and Quality Programs to the Quality Improvement (QI) Department at **1-866-889-2524**.

### Encounter Data – DMAHS

Healthfirst NJ submits encounter (proxy claim) and claims data at least quarterly to DMAHS. The data is NJ FamilyCare/Medicaid member specific, listing all encounter data elements of the services provided. Encounter report files are used to create a database that can be used in a manner similar to fee-for-service history files to analyze plan utilization, reimburse Healthfirst NJ for supplemental payments, and calculate capitation premiums. DMAHS edits the data to assure consistency and readability. If data are not of an acceptable quality or submitted timely, Healthfirst NJ will not be considered in compliance with its contract requirement until an acceptable file is submitted. Therefore, it is imperative that providers submit all applicable encounter (proxy claim) information to Healthfirst NJ for this required contract requirement.

### CMS Coding Requirements

To ensure compliance with CMS' policy on accuracy and specificity in diagnostic coding, Healthfirst NJ will deny all claims that do not contain an appropriate fourth and/or fifth digit in the ICD-9CM diagnostic code. Providers must state ICD-9-CM codes to the highest level of specificity and add whatever modifier is applicable as stated in the current version. Medical records must contain information to substantiate and support 4th and/or 5th digit coding including the main reason for the episode of care; and all coexisting, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded.

Guidelines when managing medical records:

- Ensure office staff is up-to-date on the basics of ICD-9-CM coding conventions.
- As per provider and member agreement with Healthfirst NJ, access to medical records must be available for verification of diagnosis (please refer to your agreement).
- Use current ICD-9-CM diagnosis coding conventions.
- Code in the highest level of specificity known.
- Verify codes are supported by the medical record.
- Medical records must reflect the codes submitted.

### Healthcare Effectiveness Data and Information Set (HEDIS®)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used set of performance measures in the managed care industry and is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. HEDIS is part of an integrated system to establish accountability in healthcare. HEDIS consists of seventy-four (74) measures across eight domains of care. The three domains presented below are greatly impacted by the performance of Healthfirst NJ's participating providers.

DOMAIN	MEASURES
Effectiveness of Care	<ul style="list-style-type: none"> <li>■ Childhood Immunization Status</li> <li>■ Lead Screening</li> <li>■ Adolescent Immunization Status</li> <li>■ Breast Cancer Screening</li> <li>■ Cervical Cancer Screening</li> <li>■ Chlamydia Screening in Women</li> <li>■ Controlling High Blood Pressure</li> <li>■ Cholesterol Management for patients with cardiovascular conditions</li> <li>■ Comprehensive Diabetes Care</li> <li>■ Use of Appropriate Medications for People with Asthma</li> <li>■ Follow-Up After Hospitalization for Mental Illness</li> <li>■ Antidepressant Medication Management</li> <li>■ Medical assistance with smoking and tobacco use cessation</li> <li>■ Flu Shots for Adults Ages 50-64</li> <li>■ Appropriate Treatment for Children with Upper Respiratory Infection</li> <li>■ Appropriate Testing for Children with Pharyngitis</li> <li>■ Persistence of Beta Blocker Treatment</li> <li>■ Use of Imaging Studies for Low Back Pain</li> <li>■ Use of Spirometry Testing in the Assessment &amp; Diagnosis of COPD</li> <li>■ Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis</li> <li>■ Follow Up Care for Children Prescribed ADHD Medications</li> <li>■ Annual Monitoring for Patients on Persistent Medications</li> <li>■ Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</li> </ul>
Access/Availability	<ul style="list-style-type: none"> <li>■ Adult's Access to Preventive/Ambulatory Health Services</li> <li>■ Children's and adolescent's Access to Primary Care Practitioners</li> <li>■ Prenatal and Postpartum Care</li> <li>■ Annual Dental Visit</li> <li>■ Initiation and engagement of alcohol and other drug dependence treatment</li> </ul>
Use of Services	<ul style="list-style-type: none"> <li>■ Frequency of Ongoing Prenatal Care</li> <li>■ Well Child Visits in the First 15 Months of Life</li> <li>■ Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</li> <li>■ Adolescent Well-Care Visits</li> <li>■ Outpatient drug utilization</li> <li>■ Antibiotic utilization</li> </ul>

**HEDIS® Follow-up After Hospitalization for Mental Illness Measure** measures the percentage of NJ FamilyCare/Medicaid members who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis after discharge or who were in intermediate treatment with mental health professionals such as Psychiatrists, Psychologists or Social Workers. The measure looks at both seven (7)-day and thirty (30)-day follow up rates. It is very important to submit all claims for all follow-up appointments to help improve Healthfirst NJ's HEDIS rates.

**Codes to Identify Mental Health Diagnoses:**

ICD-9 CM Codes: 295-299, 300.3, 300.4, 301, 308, 309, 311-314

**Codes to Identify Ambulatory Mental Health Encounter or Intermediate Treatment:**

Description	CPT Codes	UB-04 Revenue Codes
Ambulatory and Intermediate care	90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875-90876, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99223, 99231-99233, 99238, 99239 99241-99245, 99251-99255, 99261-99263, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0904, 0909-0916, 0917, 0919, 0961, 0982, 0983, 0905-0907

### **HEDIS® Antidepressant Medication Management Measure:**

Ensure that NJ FamilyCare/Medicaid members diagnosed with new episode of depression and treated with Antidepressant Medications and who:

- Remain on an antidepressant drug during the entire eighty-four (84) days (12 weeks) **Acute Treatment Phase** to ensure an adequate continuous trial of medication.
- Remain on antidepressant drug for at least one hundred eighty(180) days (six months) to maximize the effectiveness of the established drugs. **(Continuation Phase Treatment)**

Codes to identify Major Depression: 296.20-296.25; 296.30-296.35; 298.0, 300.4; 309.1; 311

Codes to identify Depression: 296.26; 296.36; 296.4-296.9; 309.0; 309.28

To assist PCPs in ensuring that NJ FamilyCare/Medicaid members comply with follow-up appointments, please complete and return the *Antidepressant Medication Notification Form (Appendix VIII E)*. When information on follow up visits is received, Medical Management staff will contact the NJ FamilyCare/Medicaid member by telephone twenty-four (24) to seventy-two (72) hours prior to the scheduled appointment to remind him/her of the appointment date and encourage them to keep the appointment.

Performance in the HEDIS data sets is one of the core indicators by which Healthfirst NJ plan-wide quality improvement efforts have been focused. It is extremely important to note the following:

- HEDIS measures are primarily based on preventive health standards and clinical practice guidelines issued by expert panels and community respected organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), American Diabetes Association (ADA), American College of Obstetrics and Gynecology (ACOG) and the American College of Cardiology (ACC).
- HEDIS requires specific technical specifications on how data is reported for each measure.
- EPSDT Services – Providers' adherence to preventive care guidelines is one of the key measures reviewed.
- Documentation is key – starting from the medical records (patients' charts) to the business office submission of encounter and claims data.

### **Provider Network Reports**

On a quarterly basis, Healthfirst NJ submits its Health Provider Network (HPN) report to the State, listing all participating providers. This submission includes provider license and NPI numbers, Medicaid provider numbers, office locations and hours, provider types and specialties, etc. Healthfirst NJ must attest to the accuracy of this provider information with a notarized affidavit. It is imperative that the information you give us about your practice, such as office address and office hours, your credentials and license/provider numbers be accurate and updated promptly, whenever there is a change. To submit any change in your information, fill out the *Change of Information Form* on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org) or call **1-866-889-2523**.

### **Reporting Requirements for the New Jersey State Cancer Registry (NJSCR)**

New Jersey regulations require hospitals, physicians, ambulatory care facilities, radiation treatment facilities and private laboratories to report cancer cases to the NJSCR within six (6) months of diagnosis. The information collected by the NJSCR includes detailed information about each case which profiles each patient including demographic and medical information on each cancer diagnosis (such as the anatomic site, histological type, stage of disease and treatment). All patients are followed annually and vital status is recorded. For deceased cases, the underlying cause of death is also included. The primary site, behavior, grade and histology of each cancer are coded according to the *International Classification of Disease for Oncology (ICD-O)*, third edition. The NJSCR follows the data standards promulgated by the Surveillance, Epidemiology, and End Results (SEER) program and the North American Association of Central Cancer Registries (NAACCR). For more information regarding the NJSCR and how to report cases, visit their web site at [www.state.nj.us/health/ces/njscrs.html](http://www.state.nj.us/health/ces/njscrs.html) or call **1-609-588-3500**.

### **Additional Information Regarding Public Health Reporting**

Providers must cooperate with local department of health efforts to address and identify community health problems and gaps in service. Refer to Appendix XXI for the NJ Disease and Injury Reporting Requirements

## HIV/AIDS

- Report new cases of HIV infection and HIV illnesses, along with AIDS cases to the NJ DHSS on a timely basis. Cases of HIV infection, HIV-related illness and AIDS are reportable by telephone through the NJ AIDS/STD Hotline at **1-800-624-2377**.
- Please ensure that HIV positive NJ FamilyCare/Medicaid members receive necessary preventive care services and that appropriate documentation is found in the patients' charts.
- **Encounter data/claims should contain the following appropriate coding:**
  - **ICD-9 Codes: 042, 079.5-079.59, 795.71**
  - **CPT-4 Codes: 86701-86703, 86689, 87390, 8739, 87534-87536, 87537-87539**
- The HIV/AIDS practice guidelines are downloadable at [www.hivguidelines.org](http://www.hivguidelines.org). If you need a hard copy of the above guidelines, please feel free to call our QI Department at **1-866-889-2524**. For additional information visit [www.cdc.gov](http://www.cdc.gov).
- Encourage patients to get tested for HIV infection, especially populations at risk such as drug users, homosexual males and bisexual males/females.
- Today's test technologies afford individuals the ability to receive an HIV test result in a single visit. If your office or organization offers HIV counseling and testing and has not yet adopted rapid testing, you should consider doing so.

## Sexually Transmitted Diseases (STDs)

Disease surveillance indicates that over fifty percent of all infections reported on a national level are sexually transmitted. STDs represent the most commonly reported infectious diseases among sexually active adolescents. It is extremely important that both the healthcare provider and the health plan from which a young person may seek help and advice regarding these diseases are sensitive to the issues and challenges that face this population. Suggestions to improve performance:

- Be sure encounter data/claims contain appropriate coding.
- Encourage patients to get tested for STDs, especially members of high risk populations and populations at risk such as drug users, homosexual males, bisexual males/females, sexually active teenagers, etc. For additional information, visit [www.hivguidelines.org](http://www.hivguidelines.org).
- Provide members with the following hotline for information and testing sites:  
**CDC INFO: 1-800-232-4636**
- Remind NJ FamilyCare/Medicaid members that confidential STD services are available for non-Healthfirst NJ sexual and needle sharing partners for no charge.
- Document all care and services rendered in the patient's chart and submit claims and encounter forms using the above appropriate codes.

## Child Abuse and Domestic Violence

It is important that providers and their staff be alert to potential cases of child abuse, domestic violence, adult and elder abuse. An assessment screening is recommended for all new patients, during annual follow-ups and when child abuse/domestic violence is suspected (including in same-sex relationships). Reporting of child abuse or maltreatment is mandatory for all healthcare professionals. Your local department of health is also a resource for additional information and referral resources for domestic violence and abuse. The following telephone numbers provide resources for information and reporting:

- General Information on Child Abuse: **1-800-792-8610**
- General Information on Domestic Violence: **1-800-572-SAFE (7233)**

## Reporting Child Abuse

In New Jersey, anyone with reasonable cause to believe a child is being abused should immediately call the Child Abuse Hotline at **1-877-NJ-ABUSE (1-877-652-2873)**. If a child is in immediate danger, call 911.

Whenever possible, you should provide all of the following information:

- **Who:** The child and parent/caretaker's name, age and address and the name of the alleged abuser and that person's relationship to the child.
- **What:** Type and frequency of alleged abuse/neglect, current or previous injuries to the child and what caused you to become concerned.
- **When:** When the alleged abuse/neglect occurred and when you learned of it.

- **Where:** Where the incident occurred, where the child is now and whether the alleged abuser has access to the child.
- **How:** How urgent the need is for intervention and whether there is a likelihood of imminent danger for the child.

When a report indicates that a child may be at risk, an investigator from the Division of Youth and Family Services will promptly investigate the allegations of child abuse/neglect within twenty-four (24) hours of receipt of the report.

Any person who, in good faith, makes a report of child abuse or neglect or testifies in a child abuse hearing resulting from such a report is immune from any criminal or civil liability as a result of such action. All calls to the hotline remain anonymous.

Any person who knowingly fails to report suspected abuse/neglect according to the law or to comply with the provisions of the law is a disorderly person and subject to a fine of up to \$1,000 or up to six (6) months imprisonment, or both.

For a listing of physical and behavioral indicators of child abuse/neglect, see *Appendix XVIII*.

### Smoking Cessation

Tobacco has been linked to lung cancer and other deadly chronic diseases. We urge providers to help your patients fight tobacco addiction as part of your standard of care rendered to your patients. For every patient at every clinic visit, the healthcare provider should:

- Identify whether a patient is a smoker or uses any tobacco products.
- Document smoker status in the patient's chart as a vital sign.
- Provide smoking cessation resources, such as:
  - **1-866-NJSTOPS (1-866-657-8677)** (NJ State Smoker's Quitline)
  - Web sites: [www.nj.quitnet.com](http://www.nj.quitnet.com), [www.cdc.gov/tobacco/how2quit.htm](http://www.cdc.gov/tobacco/how2quit.htm)
- Treat by introducing pharmacological counseling therapies.
- For youth cessation: <http://www.tobaccoprogram.org/quit2win.htm> and <http://www.alanewjersey.org>.

Healthcare providers can call the Quitline to obtain concise, up-to-date information on stop smoking techniques and medications, or to order office materials that can be shared with their patients.

## 14.3 Programs and Registries

The following programs and initiatives were implemented to assist the providers in meeting quality performance standards including HEDIS. For any inquiry or questions regarding any of these programs please call **1-866-889-2524** unless otherwise specified.

### Immuni-Kids Program

Immunizations are a critical part of preventive care. It is not enough, however, to simply give the immunization. Providers must administer them in a timely manner in order to get credit for their Healthfirst NJ members receiving them. To support our providers in rendering this care, we offer the following services:

- Registered Nurse to answer questions about preventive guidelines for children from birth to eleven (11) years old
- Children's Immunizations: schedule, contraindications, etc.
- Requirements in documenting care: appropriate codes to use, HEDIS timing, lead poisoning prevention, EPSDT, etc.
- Educational materials for members and providers.
- Tool kits: copies of guidelines, helpful web sites, checklist to use in patients' charts, posters, etc.
- List of provider's members with missing services according to Healthfirst NJ encounter and claims data.

### Adolescent Registry and Healthy Teen Program

Adolescence is a difficult time. To help you get your members through it, Healthfirst NJ offers a Registered Nurse to answer questions about Preventive Health Guidelines for children and adolescents ages twelve (12) to twenty-one (21) years, including immunizations. In addition, educational materials for members and providers are available as are Tool Kits which include copies of guidelines, helpful web sites, checklists to use in patient's charts, posters, and screening kits (for tobacco and drug use, sexual activities, etc.).

To assist providers, the QI Department will periodically prepare and forward listings of adolescent members to the appropriate providers indicating services that were not reflected on the encounter and claims data submitted. The QI Department promotes the use of the EPSDT, GAPS and Bright Futures as guidelines in providing services to children and adolescents. Providers are asked to review their records to see whether these services were rendered but not reported to Healthfirst NJ. If the services were rendered, providers are asked to submit the claims/encounter data to Healthfirst NJ as soon as they are identified. If they were not, but would be beneficial to the member, the provider is asked to reach out to the member to offer the service.

### **Diabetes Control for Life**

The QI Department works in conjunction with the Medical Management's Diabetes Care Management Program. The QI Department's clinical staff reaches out to members to provide education regarding the ADA's standards of care and to encourage members to go for a physical and diabetes-related service. Reminder mailings are sent to encourage members to obtain diabetes-related services.

To assist providers, the QI Department will periodically prepare and forward listings of members with diabetes to the appropriate providers indicating services that were not reflected on the encounter and claims data submitted. Providers are asked to review their records to see whether these services were rendered but not reported to Healthfirst NJ. If the services were rendered, providers are asked to submit the claims/encounter data to Healthfirst NJ as soon as they are identified. If they were not, but would be beneficial to the member, the provider is asked to reach out to the member to offer the service.

### **Heartwise Program**

Prevention of heart disease and community outreach is what this program is all about. For those who already have heart disease, we have information on how to maintain a healthy lifestyle by eating right, exercising, staying smoke-free and taking medications for high blood pressure and high cholesterol.

### **Adult Preventive and Women's Health Program**

The Adult Preventive Program includes women and men preventive health screenings and mental health services. The program will provide information on preventive guidelines and focus on education and preventive screenings. Members will also receive information on how to live a healthy and active lifestyle such as:

- Educational material on women's and men's health issues.
- Find out how to get screenings for certain health conditions.
- Learn about the preventive guidelines they should follow to stay healthy.
- Get access to free and confidential mental health resources.

## **14.4 Clinical Practice Guidelines**

Clinical practice guidelines (*Appendix XXIV*) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst NJ the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by the NJDHSS and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst NJ.

Healthfirst NJ has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two years, unless otherwise specified. Healthfirst NJ adopts guidelines upon the recommendation and approval of the Quality Improvement Committee. They are communicated to providers, including performance indicators chosen by the clinical members of the Committee, through the Provider Manual, annual mailings, newsletters, and the Healthfirst NJ web site. Performance against chosen indicators is measured annually – preventive guidelines are measured utilizing HEDIS measurement tools and clinical guidelines are measured using focused studies methodologies.

*Please note: Healthfirst NJ disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our members. These guidelines provide a tool for objective comparison of clinical practices among network providers and ensure appropriateness of care to our members. These guidelines are readily available by virtue of their already broad publication and distribution.*

## 14.5 Quality Improvement Projects, Surveys and Investigations

### Continuous Quality Improvement (CQI) Projects

Each year, Healthfirst NJ conducts quality improvement projects in priority topic areas or on topics relevant to the population demographics and topics defined by the state. Projects selected must achieve demonstrable improvement, sustained over time. Significant improvement includes reaching a targeted benchmark or improving and sustaining performance and benchmarks must reflect performance in national or local norms. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. Projects and other performance measurement activities are scheduled in the QI Work Plan. Through these projects, Healthfirst NJ and providers determine what processes need to be improved and how best to accomplish that action. Providers are strongly encouraged to participate in the conduct of these projects as well as in the implementation of action plans to improve performance. Participation can be accomplished by becoming a member of the Healthfirst NJ Quality Improvement Committee.

At a minimum, participating providers are expected to cooperate with medical record reviews necessary to conduct the project, comply with medical record standards and meet required performance thresholds established for the projects. For information on how to become a member of Healthfirst NJ's Quality Improvement Committee, please contact the Quality Improvement Department. Additional information on current projects is available on our web site at [www.healthfirstnj.org](http://www.healthfirstnj.org).

### Member Satisfaction Surveys

CMS conducts member satisfaction surveys and provides Healthfirst NJ with their individual results. CMS utilizes the Consumer Assessment of Health Plans (CAHPS®) surveys as its survey tool. The CAHPS® surveys are a set of standardized surveys that assess patient satisfaction with the experience of care. The surveys are based on randomly selected samples of members from the MCO and summarize satisfaction with the experience of care through ratings and composites. The members' perception and experience with their provider's impact a major portion of these ratings and composites. It is important that providers participating with Healthfirst NJ conduct the delivery of services in their offices and facilities at the highest quality level ensuring that the needs of their patients (our members) are met to their satisfaction. Results of these surveys are communicated to providers through newsletters, our web site and/or special mailings. If you need more information about the CAHPS® surveys, please visit the NCQA web site at [www.ncqa.org](http://www.ncqa.org).

### Quality of Care Investigations

To ensure the quality and safety of the services provided to its members as well as to improve member satisfaction, Healthfirst NJ responds to any identified concerns or issues regarding provider performance through a quality review process. Review of quality of care referrals can include, but is not limited to, medical record review, provider contact, member contact, referral for peer review, interdepartmental review, review by the Medical Director and review by the clinical members of the Quality Improvement Committee. All clinical quality of care referrals are trended and tracked to identify patterns. When the inquiry/review has been completed and a final disposition is assigned to the referral, the outcome/recommendation is communicated to the referring and concerned parties as appropriate. Information about the inquiry and review are forwarded to the Credentialing Department for inclusion in the provider's files.

## 15. Appeals and Grievances

Information about complaints, appeals and dispute resolutions regarding provider compensation is located in Section 16.8.

### 15.1 Action Denial Notice

Action means, at a minimum, any of the following:

- An adverse determination under a utilization review program;
- Denial of access to specialty and other care;
- Denial of continuation of care;
- Denial of a choice of provider;
- Denial of coverage of routine patient costs in connection with an approved clinical trial;
- Denial of access to needed drugs;
- The imposition of arbitrary limitation on medically necessary services;
- Denial in whole or in part, of payment for a benefit.
- Denial or limited authorization of a requested service, including the type or level of services;
- The reduction, suspension, or termination of a previously authorized service;
- Failure to provide services in a timely manner; or
- Denial of a service based on lack of medical necessity.

### 15.2 Action Appeals

#### Internal Appeal Process (Stage 1 Appeal)

Healthfirst NJ maintains an informal internal appeal process as follows:

- Any member, or any provider acting on behalf of a member, with the member's written consent, who is dissatisfied with any utilization management determination, including drug utilization, will have the opportunity to speak to and appeal that determination with the medical director and/or physician designee who rendered the determination.
- **All such stage 1 appeals will be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event will exceed seventy-two (72) hours (see below "Expedited Appeals) in the case of appeals from determinations regarding urgent or emergency care (including all situations in which the member is confined as an inpatient), and five (5) business days in the case of all other appeals.**
- **If the appeal is not resolved to the satisfaction of the member** at this level, Healthfirst NJ will provide the member and/or the provider with a **written explanation of his or her right to proceed to a stage 2 appeal, including the applicable time limits**, if any, for making the appeal, and to whom the appeal should be addressed. Members have the right to continuation of benefits during the appeal process but may be required to pay for the cost of these services if the appeal is denied.

#### Formal Internal Utilization Management Appeal Process (Stage 2 Appeal)

Healthfirst NJ has established and maintains a formal internal appeal process as follows:

- Any member or any provider acting on behalf of a member with the member's written consent, who is dissatisfied with the results of the stage 1 appeal, will have the opportunity to pursue his/her appeal before a panel of physicians and/or other healthcare professionals selected by Healthfirst NJ who have not been involved in the utilization management determination at issue
  - The formal internal utilization management appeal panel will have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. In no event, however, will the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional will participate in the panel's review of the case, if requested by the member and/or provider
- All such stage 2 appeals will be acknowledged by Healthfirst NJ, in writing, to the member or provider filing the appeal within ten (10) business days of receipt.

All such stage 2 appeals will be concluded as soon as possible after receipt by Healthfirst NJ in accordance with the medical exigencies of the case, which in no event will exceed seventy-two (72) hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the member is confined as an inpatient) and, except as set forth below, twenty (20) business days in the case of all other appeals.

- Healthfirst NJ may extend the review for up to an additional fourteen (14) calendar days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written explanation for the delay to the satisfaction of the Division of Medical Assistance and Health Services (DMAHS), with written notice to the member and/or provider within the original twenty (20) business day review period.

### External Appeal (Stage 3 Appeal)

- If the stage 2 appeal is not resolved in the member's favor, Healthfirst NJ will provide the member and/or provider with written notification of stage 2 appeal decision and his or her right to proceed to an external (stage 3) appeal. This notification will include specific instructions as to how the member and/or provider may arrange for an external appeal and will also include any forms required to initiate such an appeal
- In the event that Healthfirst NJ fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in N.J.A.C. 11:24-8.5 or 8.6, or in the event that the Healthfirst NJ for any reason expressly waives its rights to an internal review of any appeal, then the member and/or provider will be relieved of his or her obligation to complete Healthfirst NJ's internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 11:24-8.7.

### 15.3 Expedited Resolution Appeals

Healthfirst NJ has established and maintains an expedited review process for appeals:

- When Healthfirst NJ determines (by a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- Healthfirst NJ will ensure that the expedited resolution of an appeal and notice to affected parties is no longer than:
  - Seventy-two (72) hours after Healthfirst NJ receives the appeal.
  - This timeframe may be extended by up to fourteen (14) calendar days if
    - The member requests the extension; or
    - Healthfirst NJ shows (to DMAHS' satisfaction, upon its request) that there is need for additional information and how the delay is in the member's interest.

### 15.4 Notice of an Action Appeals Determination

Notice of Action will be in writing and will meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. In the case of expedited appeal process, Healthfirst NJ will also provide oral notice.

Written notification will be given on a standardized form approved by the Division of Medical Assistance and Health Services and will inform the provider, NJ FamilyCare/Medicaid member or authorized person of the following:

- Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other medical coverage determination;
- The NJ FamilyCare/Medicaid member's rights to, and method for obtaining, a State hearing (Fair Hearing and/or IURO) to contest the denial, deferral or modification action;
- The NJ FamilyCare/Medicaid member's right to represent himself/herself at the State hearing or to be represented by legal counsel, friend or other spokesperson;
- The action taken or intended to be taken by Healthfirst NJ on the request for prior authorization and the reason for such action including clinical rationale and the underlying contractual basis or Medicaid authority;
- The name and address of Healthfirst NJ;
- Notice of internal (Healthfirst NJ) appeal rights and instructions on how to initiate such appeal;
- Notice of the availability, upon request, of the clinical review criteria relied upon to make the determination;
- The notice to the NJ FamilyCare/Medicaid member will inform him/her that he/she may file an appeal concerning Healthfirst NJ's action using the Healthfirst NJ's appeal procedure prior to or concurrent with the initiation of the State hearing process;
- Healthfirst NJ will notify NJ FamilyCare/Medicaid members, and/or authorized persons within the time frames set forth in the NJ FamilyCare/Medicaid contract and in 42 CFR 438.404(c);
- The NJ FamilyCare/Medicaid member's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal and how to request that benefits be continued;
- In no instance will Healthfirst NJ apply prior authorization requirements and utilization controls that effectively withhold or limit medically necessary services, or establish prior authorization requirements and utilization controls that would result in a reduced scope of benefits for any NJ FamilyCare/Medicaid member.

### 15.5 Member Rights to a Fair Hearing

Medicaid and certain NJ FamilyCare beneficiaries (i.e., NJ FamilyCare A members and beneficiaries with a PSC of 380 under NJ FamilyCare D) may access the Medicaid Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C and D (except for D. individuals' with a program status code of 380), do not have the right to a Medicaid Fair Hearing, by Federal rule.

A written request for a Medicaid Fair Hearing must be made within twenty (20) days of the date of the initial denial letter to the following address:

State of New Jersey  
Division of Medical Assistance and Health Services  
Fair Hearing Section  
P.O. Box 712  
Trenton, NJ 08625-0712

The communication must include member's name, address, telephone number, and a copy of the denial letter. Request for continuation of benefits must be in writing within 10 days of the date of the letter. As with the HMO Appeal Process, members have the right to continuation of benefits, but may be required to pay for the cost of these services if the appeal is denied.

Note: during any stage of the Appeal Process or the Medicaid Fair Hearing Process (if a member is eligible for a Medicaid Fair Hearing), the member has the right to continue to get the HMO service until the end of the Appeal Processes if:

- The appeal was requested timely;
- The appeal involves the termination, suspension or reduction of a previously authorized service;
- The service was ordered by a network provider;
- The time period covered by the original authorization has not ended or adequate notice was given for you to make a timely appeal; and
- Continuation of benefits were requested in writing within 10 days of the date of the initial denial letter, and again within 10 days of the date of the Stage 3 denial letter for those eligibles who requested the Medicaid Fair Hearing Process.

Healthfirst NJ's A&G or Medical Management Department will issue Fair Hearing Rights with instructions on how to request a Fair Hearing. If you have questions about the Fair Hearing process, or would like additional information, please call **1-866-889-2523**.

## **15.6 Member Complaints**

If a member has a problem he/she can speak with his/her PCP, call, or write to Member Services. Most problems can be solved right away. If a member has a problem or dispute with the care he/she is receiving, he/she can file a complaint with Healthfirst NJ. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

Members can ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint for them. If a member needs help because of a hearing or vision impairment, or if he/she need translation services, or help filing the forms we can help. Healthfirst NJ will not take any action against the member for filing a complaint.

A member also has the right to contact, the Department of Banking and Insurance, in the case of NJ FamilyCare/Medicaid members, the Division of Medical Assistance and Health Care Services within the Department of Human Services if dissatisfied with the resolution reached through the HMO's internal grievance system.

### **How to File a Complaint for Non-UM Issues with Healthfirst NJ**

#### **What happens next?**

Healthfirst will call back the member within twenty-four (24) hours of the initial contact if Healthfirst is unavailable for any reason or the matter cannot be readily resolved during the initial contact. Whenever a delay would significantly increase the risk to a member's health, complaints will be resolved within 72 hours after receipt of the complaint at Healthfirst NJ. If Healthfirst NJ does not solve the member's problem right away over the phone or within five (5) business days, Healthfirst NJ will treat the complaint as a grievance and send the member a letter within fifteen (15) business days

#### **After Healthfirst NJ reviews the grievance:**

- The letter will tell the member who is working on the grievance, how to contact this individual, and if more information is needed.
- Healthfirst NJ will let the member know its decision within thirty (30) calendar days of receipt of the grievance.
- A Utilization Management (UM) grievance regarding a denial, termination, or other limitation in coverage and/or access to health care services is acknowledged as a UM appeal and is immediately transferred to the UM Appeals Process

## 16. Provider Compensation

### 16.1 Primary Care Services/Primary Care Providers

Healthfirst NJ has established a set of healthcare services which Healthfirst NJ considers to be Primary Care Services and which are to be rendered by PCPs within the Healthfirst NJ provider network. These services support the member's primary care needs in both an ambulatory (office or clinic) and inpatient setting, and include the following:

- EPSDT services (including preventive office visits and immunizations)
- Primary care office visits for urgent conditions
- Primary care inpatient visits
- Basic hearing and vision screenings
- Urgent laboratory services for diagnosis and/or treatment of members with acute conditions
- Urgent radiology services for the diagnosis and/or treatment of members with acute conditions
- Other basic diagnostic tests and simple treatments of urgent and chronic conditions

A complete list of reimbursable services, listed by CPT code, is included in Appendix XXVIII in the separate NJ FamilyCare Appendices document.

**Given the important role that PCPs play in the Healthfirst NJ network and in providing primary care services to members, PCPs are not expected to provide specialty or other healthcare services which are not primary care services as described in this Provider Manual.** As explained more fully in Section 3.1, PCPs are responsible for coordinating all of the care a member receives, and are expected to refer members to specialists in the Healthfirst NJ network for care that is outside of the scope of primary care. Consistent with this requirement, Healthfirst NJ will not reimburse PCPs for services other than the listed primary care services unless the PCP is also credentialed and designated by Healthfirst NJ as a specialist. Note, however, that Family Practice Physicians who provide minor surgery, gynecological and obstetrical care for members will also be reimbursed for those services.

**If you are not yet credentialed as a specialist and wish to be credentialed by Healthfirst NJ as a Specialist in addition to being a Primary Care Provider, please speak to your network representative.**

To also ensure that PCPs are able to coordinate members' care, in cases where a Healthfirst NJ member seeks primary care from a clinic/practice, and that member is not part of the clinic/practice's assigned member panel, the clinic/practice must direct the member back to their assigned PCP for care, or refer the member within their PCP's own network, as appropriate. Members however are free to change their PCP. If the member is in need of an appointment immediately and wishes to switch to your panel, Member Services can make the appropriate changes right away. Members must call Member Services at **1-888-GO-4-HFNJ** for assistance in switching PCPs.

**PCPs are reimbursed on a fee-for-service basis depending on the terms and condition of their provider agreement with Healthfirst NJ.**

All PCPs must submit claims for all services in order to provide encounter data. Healthfirst NJ uses encounter data to verify the types and level of services provided and for mandatory reporting to federal and state regulatory agencies. See *Section 14* for Reporting Requirements.

## 16.2 Obstetrical Care

Healthfirst NJ reimburses for obstetrical care on a fee-for-service basis, or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and postpartum visits, as well as for delivery. Cases requiring more than seven (7) prenatal visits, or more than one (1) postpartum visit, may be subject to retrospective medical record review by the Healthfirst NJ Medical Management Department.

## 16.3 Family Planning Services

Healthfirst NJ reimburses for family planning services provided to Healthfirst NJ members. Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers. No Authorization or referral is required for Family Planning Services. Out of Network Family Planning Services are covered fee for service for NJ FamilyCare A, B, and C. Out of Network Family Planning Services is not a covered benefit for NJ FamilyCare D.

## 16.4 Healthfirst NJ Payment in Full/Member Hold Harmless

Pursuant to their provider contract, participating providers are prohibited from seeking payment, billing or accepting payment from any member for fees that are the legal obligation of Healthfirst NJ, even if Healthfirst NJ becomes insolvent or denies payment on a claim, regardless of the reason. Participating providers must refund all amounts incorrectly collected from Healthfirst NJ members or from others on behalf of the member. Healthfirst NJ is not financially responsible for reimbursing noncovered services provided to members. Please see *Section 2* for additional information on the procedure to be followed in order to bill and collect from members for noncovered services.

**Except for permitted copayments and deductibles, all payments for services provided to Healthfirst NJ members constitute payment in full. Providers may not “balance bill” members for the difference between their actual charges and the reimbursed amounts, except for deductibles, copayments or coinsurance. Any such billing is a violation of the provider’s contract with Healthfirst NJ and applicable New Jersey State law. Where appropriate, Healthfirst NJ will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.**

Additionally, per requirements set forth by the Centers for Medicare & Medicaid Services (CMS), dual-eligible members will not be held responsible for any cost-sharing for Medicare services when the state is responsible for paying those amounts. Providers must accept Healthfirst NJ’s payment as payment in full, or bill the appropriate state source (i.e., Medicaid FFS). This requirement applies to all dual-eligible individuals, not just those enrolled in a Medicare Advantage Dual-Eligible Special Needs Plan (SNP).

## 17. Billing & Claims Processing

### 17.1 Overview

All participating Healthfirst NJ providers are required to submit claims for services and will be reimbursed according to their contract. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.

All claims are reviewed within the Healthfirst NJ Claims Department for completeness and correctness of the data elements required for processing payments, reporting and data entry into the Healthfirst NJ utilization systems. If key information is missing from the claim, or if a provider has not included the tax ID number on the claim and cannot be reached, the claim will be returned.

Payment for services rendered is subject to verification that the member was enrolled in Healthfirst NJ at the time the service was provided and to the provider's compliance with the Healthfirst NJ medical management and prior authorization policies at the time of service.

- **Providers should verify member eligibility at the time of service to ensure that the member is enrolled in Healthfirst NJ.**
- **Failure to do so may affect claims payment.**
- **Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made.**

Payment is made directly to the participating hospital for all employed providers who are covered by the hospital's participation agreement with Healthfirst NJ and who practice in hospital outpatient departments and hospital owned community-based sites. For all other providers, payment is made directly to the provider or to the designated payee.

In certain cases, a managed care plan member may change health plans during the course of a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

Providers are prohibited from holding any member liable for payment of any fees that are the legal obligation of Healthfirst NJ, including in the event that Healthfirst NJ becomes insolvent. Providers must refund all amounts incorrectly collected from Healthfirst NJ members or from others on behalf of the member. Healthfirst NJ is not financially responsible for reimbursing non-covered services provided to members. Please see *Section 2* for additional information.

Additionally, per requirements set forth by the Centers for Medicare & Medicaid Services (CMS), dual-eligible members will not be held responsible for any cost-sharing for Medicare services when the state is responsible for paying those amounts. Providers must accept Healthfirst NJ's payment as payment in full, or bill the appropriate state source (i.e., Medicaid FFS). This requirement applies to all dual-eligible individuals, not just those enrolled in a Medicare Advantage Dual-Eligible Special Needs Plan (SNP).

**All payments for services provided to Healthfirst NJ members constitute payment in full. Providers may not balance bill members for the difference between their actual charges and the reimbursed amounts, except for applicable copayments or coinsurance.**

If the member is in need of an appointment immediately and wishes to switch to your panel, Member Services can make the appropriate changes right away. Members must call Member Services at **1-877-GO-4-HFNJ (1-877-464-4365)** for assistance in switching PCPs.

## 17.2 General Billing Requirements

All claims should be submitted within one hundred eighty (180) days of the date of service. If claims for services from in-network providers are submitted more than one hundred eighty (180) days after the date of service, Healthfirst NJ reserves the right to deny payment of the claim in accordance with regulations established by the Commissioner of the New Jersey Department of Banking and Insurance.

The following information must be included on the claim form to ensure timely claims payment. If claims are missing any of this information, the claim will be denied or returned.

- Member's name, ID number, sex, and date of birth and relationship to the subscriber
- Subscriber's name, address and ID number
- Name, signature, 'Pay To' address and phone number of physician or provider performing the service
- National Provider Identifier (NPI) number
- Physician's or provider's federal tax ID number
- Physician's or provider's Healthfirst NJ ID number (paper claims only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT-4 and HCPCS procedure codes with modifiers where appropriate
- Current ICD-9 diagnostic codes by specific code to the highest level of specificity
- Referring physician's name (if applicable)
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available

The following additional information is required, in addition to the above information, for a complete UB-04 claim:

- Date and hour of admission and discharge as well as patient status-at-discharge code
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current revenue code and description
- Current principal and secondary diagnosis with the applicable Present on Admission (POA) indicator on hospital inpatient claims.
- Attending physician ID
- Bill all outpatient surgeries with the appropriate revenue and CPT codes

CMS 1500 claims and UB-04s submitted electronically must include the Healthfirst NJ Payer ID Number 80141 on each claim (refer to Section 16.6 for additional information on electronic billing).

CMS 1500 forms and UB-04 can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and facilities billing on behalf of employed providers.

Payment for all approved Healthfirst NJ "clean" paper claims will be made within forty (40) days of receipt of the completed claim. Payment for all approved Healthfirst NJ "clean" electronic claims will be made within thirty (30) days of receipt of the completed claim. If payment or a determination is not rendered, interest will be paid at an annual rate of 12%.

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

## Facilities

- Submit inpatient and outpatient facility claims on the UB-04 form or on electronic media.
  - Report the name, NPI and the Healthfirst NJ provider number of the attending provider in Field 76.
  - Include the Healthfirst NJ authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in the Healthfirst NJ system and processed in accordance with applicable Healthfirst NJ policies and procedures.
- Professional services that are not part of the facility claim should be billed on a CMS 1500 form.
- Payment for emergency admissions is contingent upon timely notification to Healthfirst NJ and the submission of the required billing/encounter information, including requested medical records.

## Facilities Billing on Behalf of Employed Providers

These facilities must submit claim reporting data on the UB-04 for outpatient services or directly to Healthfirst NJ via electronic claim submission. The name, NPI and the Healthfirst NJ provider number of the attending provider must be reported in Field 76.

## Present of Admission (POA)

The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission.

Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 Institutional (837I) forms.

Healthfirst NJ requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes; regardless of the manner in which claims are submitted (i.e. paper or electronic) for dates of service on or after October 1, 2008.

## 17.3 Reimbursement

### Hospital Reimbursement

Payment is made directly to the participating hospital for all of its employed providers who are covered by the participating hospital contract with Healthfirst NJ and who practice in hospital outpatient departments and hospital owned community-based sites.

### Provider Reimbursement

- Payment is made directly to the provider or designated payee.
- Behavioral Health services are reimbursed based on a fee schedule that is uniform for Healthfirst NJ providers, community-based providers, non-institutional providers and behavioral health providers.

### Obstetrical Care

Healthfirst NJ reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and postpartum visits, as well as for delivery. Cases requiring more than seven (7) prenatal visits, or more than one (1) postpartum visit, may be subject to retrospective medical record review by the Healthfirst NJ Medical Management Department.

## 17.4 Use of Provider Numbers for Billing

### For paper claims

If the members' PCP is affiliated with the same hospital as the specialist, the specialist should choose the provider number by first matching the hospital code and then selecting the letter (A,B,C etc.) that corresponds to the practice site where the services were rendered. To confirm the correct provider number, please call **1-866-889-2523**.

### For electronic claims

Healthfirst NJ provider identification numbers are not required on electronic submissions.

### National Provider Identifier (NPI)

Effective May 23, 2007, all providers should have acquired an NPI number to electronically transmit healthcare information to Healthfirst NJ.

Healthfirst NJ does not accept provider identification numbers submitted on HIPAA standard transactions.

## 17.5 Coordination of Benefits (COB)

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help hold down copayments and premiums. Healthfirst NJ follows all standard guidelines for COB. The birthday rule, which determines the primary payer based on the coverage of the parent or guardian whose birthday falls earlier in the year, is applied when Healthfirst NJ coordinates benefits. Members are asked to provide information about other insurance plans under which they are covered.

### Healthfirst NJ does not pay for services provided under the following circumstances when there is COB:

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services); and
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider.

Healthfirst NJ will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, Healthfirst NJ is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP),
- Most EGHPs for disabled members, and
- All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just ESRD. If the individual entitlement changes from ESRD to over sixty-five (65) or disability, the coordination period will continue.)

## 17.6 Billing Instructions

### Electronic Billing

Healthfirst NJ utilizes the Emdeon (WebMD) clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 receive a status report indicating which claims were accepted, rejected and/or pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

1. **Healthfirst NJ Payer ID Number 80141** on each claim;
2. Complete **Healthfirst NJ Member ID Numbers** (see Member ID card or monthly enrollment roster)
3. A **National Provider Identifier (NPI)**, which should reside in:
  - **837 Professional (HCFA)** - Loop 2310B Rendering Provider Secondary ID, Segment/Element NM109. NM108 must qualify with an XX (NPI).

- **837 Institutional (UB04)** - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI).

To sign up for electronic billing, Providers must contact their software vendor and request that their Healthfirst NJ claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Call Healthfirst NJ at **1-866-889-2523** to setup electronic billing.

Providers who sign up for electronic billing may also sign up for electronic fund transfer/electric remittance advice (EFT/ERA). See Section 17.9 for more information on EFT/ERA.

Reports are available through billing software vendors to review electronic submission of claims and rejection errors. Although this may be an optional feature, providers are encouraged to obtain this reporting tool to better manage their submissions. Providers are encouraged to review claim submission errors and resubmit corrections.

### Paper Claim Submission

All paper claims should be submitted to:

**Healthfirst NJ Claims Department**  
**P.O. Box 958436**  
**Lake Mary, FL 32795-8436**

All in-network providers must bill Healthfirst NJ within 180 days of the date of service or the claim will be denied as permitted by law.

### Claim Inquiries

Providers can view claims for a specific date of service or claims for a twelve (12)-month period through our web site at **www.Healthfirstnj.org**. Providers may also call **1-866-889-2523** twenty-four (24) hours a day, seven (7) days a week to access claim status.

## 17.7 Provider Complaints, Appeals and Dispute Resolution

### Part One: Provider Claims Payment Disputes

#### I. Internal Appeals Mechanism

The following provisions shall govern Healthfirst NJ's internal appeals mechanism to resolve claims payment disputes between Healthfirst NJ (or its agents) and provider as required by N.J.S.A. 26:2J-8.1 e and all succeeding and superseding regulations promulgated by applicable governmental agencies regarding this matter, such as DOBI. It is expressly understood that these internal appeals mechanisms do not include appeals related to utilization management determinations and do not require any action by the member.

1. Provider may appeal of Healthfirst NJ or its agents claim determination:
  - Within ninety (90) calendar days of receipt of Healthfirst NJ's or its agent's determination that is the basis of the appeal; or
  - Within ninety (90) calendar days of Healthfirst NJ's or its agent's missed due date for the claim determination, including at provider's option, a claim that has been pended.
2. Provider shall initiate an appeal by submitting to Healthfirst NJ or its agent a complete *Health Care Provider Application to Appeal a Claims Determination* form, which will include all substantiating documentation required by Healthfirst NJ. Healthfirst NJ will not reject an appeal based on provider's failure to notify its patient of the appeal. The application form above can be downloaded from DOBI's web site at **<http://www.state.nj.us/dobi/chap352/352genapplication.doc>**. Healthfirst NJ has made the application form and instructions available on its website at **www.Healthfirstnj.org** to allow for electronic submission of

applications. **Forms may also be submitted to:** Healthfirst NJ Health Plan of New Jersey, Inc. Provider Payment Dispute Unit, P.O. Box 12107, Newark, NJ 07101-3407

3. Healthfirst NJ will acknowledge receipt of an application within five (5) business days in the same manner in which the application was received (that is, in writing or electronically). The acknowledgment shall state the following:
  - Whether the application is complete or incomplete;
  - If incomplete, whether the application is being accepted for review or rejected;
  - If rejected, the reason(s) for rejection and any procedure for correcting the deficiencies within the ninety (90)-day timeframe set forth in this section. If provider fails to correct any deficiencies in its application within the ninety (90)-day timeframe, provider may proceed to arbitration pursuant to Section II (b) below.
4. If an application is accepted for review, Healthfirst NJ will conduct a review of the appeal and notify provider of its determination within thirty (30) calendar days of receipt of the complete application. The internal review conducted by employees of Healthfirst NJ will be personnel other than those responsible for claims payment on a day-to-day basis and will be provided at no cost to provider. If Healthfirst NJ or its agents fails to notify provider of its determination within thirty (30) calendar days of receipt of the complete application, provider may initiate an arbitration proceeding pursuant to Section II(c) below.
5. Healthfirst NJ will communication the results of the internal review in a written decision to provider, which will include:
  - The names, titles and qualifying credentials of the persons participating in the internal review;
  - A statement of provider's grievance;
  - The decision of the reviewer(s), together with a detailed explanation of the basis for such decision;
  - A description of the substantiating documentation which supports the decision, including any relevant fee schedule(s), relevant formula(s) for payment of the claim(s) and controlling contract provision(s); and
  - If payment decision is adverse to provider in any respect, a description of the method to obtain an external review of the decision by arbitration.
  - If the decision favors provider in any respect, Healthfirst NJ will be required to pay within thirty (30) calendar days of the date of issuance of Healthfirst NJ's determination of the appeal, the amount due as determined by the internal appeal, if applicable, with accrued interest at the rate of twelve (12) percent per year calculated from the date of receipt of the internal appeal by Healthfirst NJ at its designated address.

## II. External Appeals and Arbitration for Non-Utilization Management Disputes

- a) Any dispute regarding the determination of an internal appeal conducted pursuant to the proceeding Section 1 may be referred to arbitration as set forth below. It is understood that the following types of disputes are not eligible for arbitration under this Section II:
  - Disputes involving whether a treatment or service is medically necessary;
  - Disputes involving whether a treatment or service is experimental or investigational;
  - Disputes involving whether a treatment or service is cosmetic; and
  - Disputes involving whether a treatment or service is medical or dental.
- b) Provider may file for arbitration of an appeal determination made by Healthfirst NJ pursuant to Section 1 above within ninety (90) calendar days of the receipt of the appeal determination; or within thirty (30) days of Healthfirst NJ's or its agent's receipt of the internal appeal pursuant to Section I above, if the provider has not been notified by Healthfirst NJ its determination on the internal appeal.
- c) Provider may initiate an arbitration proceeding by submitting a complete *Request for Arbitration Application* directly to Maximus, the arbitration organization with which DOBI has contracted to handle arbitration cases. Instructions and application forms required to file for arbitration are available on the Maximus web site at <https://njpicpa.maximus.com>. Applications may be submitted electronically or by mail pursuant to the instructions accompanying the application form.

- d) Following receipt of the completed Request for Arbitration Application, Maximus will review the application and make a determination regarding the eligibility of the claim(s) and the completeness of the application. Maximus will render a decision within thirty (30) calendar days following receipt of the required documentation.
- e) The arbitrator's determination will be nonappealable and binding on Healthfirst NJ and the provider.
- f) If the arbitrator determines that Healthfirst NJ or its agent has erroneously withheld or denied payment of a claim, the arbitrator will order Healthfirst NJ or its agent to make payment of the claim on or before the tenth business day following the issuance of the determination, together with interest at the rate of twelve (12) percent per annum accruing from the date the appeal was received by Healthfirst NJ or its agent for resolution. If the arbitrator determines Healthfirst NJ or its agent has withheld or denied payment on the basis that information requested by Healthfirst NJ or its agent was not submitted by provider when the claim was initially processed by Healthfirst NJ or its agent or reviewed by Healthfirst NJ or its agent pursuant to its internal appeal process, Healthfirst NJ or its agent will not be required to pay any accrued interest.
- g) If the arbitrator determines that provider has engaged in a pattern and practice of improper billing and a refund is due to Healthfirst NJ or its agent, the arbitrator may award Healthfirst NJ or its agent a refund, including interest accrued at the rate of twelve (12) percent per annum. Interest will begin to accrue on the date the appeal was received by Healthfirst NJ or its agent for resolution through the internal appeal process described in Section 1 above.

## Part Two: Provider Complaints and Appeals Not Involving Claims Payment or Medical Necessity Issues

The following provisions shall govern the resolution of non-claims and non-compensation issues and non-medical necessity issues, such as other types of complaints and issues regarding Healthfirst NJ, its agents, members or other providers.

- A. If a provider has a dispute with Healthfirst NJ that is not within the scope of Part One (1) of the policy (set forth above) and that is not a dispute with respect to a utilization management determination, provider should first seek to informally resolve such dispute by contacting Provider Services at **1-866-889-2523**. A Provider Services Representative will endeavor to resolve the dispute on an informal basis.
- B. If the dispute is not resolved on an informal basis, a provider may **submit a formal written complaint to the Healthfirst NJ Provider Services to:** Healthfirst NJ Health Plan of New Jersey, Inc., Provider Services, P.O. Box 12180, Newark, NJ 07101-3480. Providers may submit formal complaints directly to the address above without having previously endeavored to resolve the matter informally pursuant to Paragraph A immediately preceding.
- C. Upon receipt of a formal written complaint from provider an internal review will be conducted by employees of Healthfirst NJ. Such review shall be conducted at no cost to provider.
- D. The internal review will be conducted and its results communicated in writing to provider within thirty (30) business days of the receipt of the complaint. The written response will include:
  - The names, titles and qualifying credentials of the persons participating in the internal review;
  - A statement of provider's grievance; and
  - The decision of the reviewer(s), together with a detailed explanation of the contractual basis for such decision;
  - A description of the evidence or documentation which supports the decision.

### 17.8 Explanation of Payment (EOP)

The EOP describes how claims for services rendered to Healthfirst NJ members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

The EOP is arranged numerically by patient account number. Inpatient facility claims are sorted separately from all other claims.

Each claim represented on an EOP may be comprised of multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- **Paid Claim Lines:** If the *Paid Amount* field reads greater than zero (0), the claim was paid in the amount indicated.
- **Denied Claim Lines:** If the *Not Covered* field is greater than zero (0) and equal to the allowed amount, the service was denied.
- **Claim Processed as a Capitated Service:** If the amount in the *Prepaid Amount* field is greater than zero (0), the service was processed as a capitated service.
- **End of Claim:** Each claim is summarized by a claim total.

Providers may view EOPs on our web site at [www.HealthfirstNJ.org](http://www.HealthfirstNJ.org). If internet access is not available, providers may request a copy of an EOP by calling Provider Services at **1-866-889-2523**.

### 17.9 Electronic Funds Transfer / Electronic Remittance Advice (EFT/ERA)

Healthfirst NJ's Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of Healthfirst NJ claims.

**EFT** is the direct electronic deposit of claim reimbursements into your bank account and **ERA** is the statement that allows you to reconcile these reimbursements to your patient accounts. Advantages of these programs include:

- Prompt payment – no waiting for checks to clear
- Reduced paper work
- No lost checks or mail delay
- Savings of administrative and overhead costs
- Simplified and organized record keeping
- Improved cash flow

You **must** be able to submit claims electronically to use EFT/ERA. When claims are submitted for payment, the payment is deposited electronically into your bank account. When you enroll in EFT/ERA, you will continue to receive an Explanation of Payment (EOP) for a sixty (60)-day grace period. The EOP shows the patient's name, dates of service, services rendered and amounts of Healthfirst NJ payments. After the grace period, you will only receive the ERA. Bank statements will continue to reflect deposited amounts and dates of deposit. Your clearinghouse / software vendor must be able to accept the ERA file which is in the 835 HIPAA standard format.

Please refer to our web site at [www.Healthfirstnj.org](http://www.Healthfirstnj.org) for information on how to enroll in EFT/ERA. You can also call Provider Services at **1-866-889-2523**.

### 17.10 Overpayments

#### Overpayment Recovery Procedures

If Healthfirst NJ has determined that an overpayment has occurred, Healthfirst NJ will provide, in writing, a notice of overpayment to the provider requesting repayment.

If a provider fails to dispute a request for repayment concerning an overpayment determination made by Healthfirst NJ within forty-five (45) days from the date the overpayment notice was mailed by Healthfirst NJ, the provider will have acknowledged and accepted the amount demanded by Healthfirst NJ and, subject to the provider's right to arbitration pursuant to the provider agreement, Healthfirst NJ will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by Healthfirst NJ.

If a provider disagrees with Healthfirst NJ's determination concerning the overpayment, the provider must submit a written request for an appeal **within forty-five (45) days from the date the initial notice was mailed by Healthfirst NJ** and include all supporting documentation in accordance with the provider appeal procedure described in Section 16. If, upon reviewing all supporting documentation submitted by a provider, Healthfirst NJ determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. Healthfirst NJ will not proceed with overpayment recovery efforts until the provider's appeal and arbitration rights have been exhausted.

Healthfirst NJ will not pursue overpayment recovery efforts for claims older than 18 months after the date of the original payment to a provider unless the overpayment is based upon claims that were submitted fraudulently or submitted by providers that have a pattern of inappropriate billing.

## **Repayment Options Offered to Providers**

### **Voluntary Refunds**

Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made payable to Healthfirst NJ within forty five (45) days from the date the initial notice was mailed by Healthfirst NJ. Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund. **Refund checks should be mailed to:** Healthfirst NJ Health Plan of New Jersey, Inc., Finance Department, 100 Church Street, 18<sup>th</sup> Floor, New York, NY 10007.

### **Overpayment Offsets**

As noted above, an initial written notice of overpayment will be sent to a provider requesting repayment if Healthfirst NJ has determined that a provider has received payment(s) in error. If after forty five (45) days the provider has not contacted Healthfirst NJ regarding the overpayment, Healthfirst NJ will consider the provider to have acknowledged the overpayment and will offset the amount from current and future claim remittance(s) until the full amount of the overpayment has been collected by Healthfirst NJ.

Notwithstanding the above, if a provider asserts that Healthfirst NJ has underpaid any claim(s) to a provider, Healthfirst NJ may offset any underpayments that may be owed against past underpayments made by Healthfirst NJ dating as far back as the claimed underpayment.

## 17. Glossary of Terms

**Access to Care:** The extent to which a patient/member is able to obtain healthcare services at the time they are needed or within a preset time frame as established by Healthfirst NJ or by regulatory agencies. Access, including telephone access, is defined by the availability and acceptability of medical services to the patient, the location of healthcare providers, transportation, hours of operation, the cost of care and the ability to schedule appointments.

**ACS, Inc.:** The Health Benefits Coordinator under contract with New Jersey to manage the mandatory enrollment process.

**Advance Directives:** Advance directives are legal documents that allow competent adults to provide information on how they want to be treated if they become incapacitated and unable to speak for themselves.

**Ancillary Services/Providers:** A term used to describe the additional services and the providers/facilities of those services that are related to medical care. They include apnea or sleep study centers, fetal/uterine monitoring, audiology and hearing services; chiropractors, dental care; diagnostic imaging and radiology services; dentists, dialysis; durable medical equipment; home healthcare and home infusion therapy; hospice, laboratory services; orthotic and prosthetic equipment; outpatient rehabilitation; pharmacy services; physical, occupational and speech therapy; skilled nursing facilities, and routine vision care.

**Appeal:** A request for review of an action.

**Appropriate Transfer:** One in which the transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records to the receiving hospital, and uses qualified personnel and transportation equipment for the transfer.

**Authorization Number:** This is a unique number generated by the Medical Management Department when a request for authorization of services has been approved. Authorization numbers are communicated to the provider of service; they should be referenced on all claims and correspondence related to those services.

**Authorized Services:** Medical, ancillary or behavioral healthcare services that require authorization from the Medical Management Department. Generally, authorization must be obtained in advance of services being provided in order for the provider to be reimbursed.

**Auto-Assignment:** A process by which an eligible person, mandated to enroll in managed care, but who has not enrolled within sixty (60) days, is assigned to a Prepaid Health Services Plan (PHSP) or HMO contracted with a local Department of Social Services as a Medicaid Managed Care Provider.

**Balance Billing:** The practice of a provider billing a member for the difference between the amount the provider charges for the services rendered and the amount the provider was reimbursed by the health plan. Healthfirst NJ providers are prohibited from balance billing members for any covered services.

**Behavioral Health Services:** Services to address mental health disorders and/or chemical dependency.

**Benefits:** The services to which health plan members are entitled under their designated Healthfirst NJ program.

**Care Management:** A set of member-centered, goal-oriented, culturally relevant, and logical steps to assure that a NJ FamilyCare/Medicaid member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care management emphasizes prevention, continuity of care, and coordination of care, which advocates for, and links NJ FamilyCare/Medicaid members to, services as necessary across providers and settings. Care management functions include 1) early identification of NJ FamilyCare/Medicaid members who have or may have special needs, 2) assessment of an NJ FamilyCare/Medicaid member's risk factors, 3) development of a plan of care, 4) assistance to ensure timely access to providers, 5) coordination of care actively linking the NJ FamilyCare/Medicaid member to providers, medical services, residential, social, and other support services where needed, 6) monitoring, 7) continuity of care, and 8) follow-up and documentation.

**Centers for Medicare & Medicaid Services (CMS):** An organization within the United States Department of Health and Human Services that administers the Medicare program and certain aspects of state Medicaid programs; formerly known as the Healthcare Financing Administration (HCFA).

**Chemical Dependence Services:** Examination, dependency, level of care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence, and includes the provision of alcoholism and/or substance abuse services.

**Claim Review/Reconsideration:** The process by which a claim is reviewed at the provider's request to reconsider the payment determination made when the claim was processed.

**Clean Claim:** A claim for services that includes all required information and documentation passes all system edits and does not require any additional review to determine the medical necessity and appropriateness of services provided.

**Clinical Peer:** A provider having the same or substantially similar specialty as the provider under review during the hearing process.

**Coinsurance:** A fixed percentage of the total amount paid for a healthcare service that can be charged to a member on a per-service basis.

**Continued Extended Services Review:** An assessment of inpatient hospital care or ambulatory services by trained clinical review staff during the period that those services are being provided to assess the appropriateness of care, treatment plans, the duration of care and to facilitate discharge planning.

**Coordination of Benefits (COB):** The process of assigning primary, secondary and residual financial responsibility for coverage of healthcare services when an individual is eligible for benefits from more than one insurer or benefits program.

**Copayment:** A fixed amount that can be charged to a member on a per service basis.

**Cost Sharing:** The amount of deductibles, coinsurance and copayment that the member is responsible for paying on a per-service basis.

**Covered Services:** The healthcare services that Healthfirst NJ will provide, arrange and be held fiscally responsible for.

**Current Procedural Terminology (CPT):** This is a recognized industry standard of descriptive terms and code identifiers for reporting medical services and procedures performed by physicians and other healthcare providers. CPT codes are used in conjunction with ICD-9 diagnostic codes for claims data and other reporting of services provided.

**Credentialing:** This is a process that reviews and verifies a provider's credentials and experience prior to that provider being approved for participation in a health plan. Specific review criteria are applied to ensure that the provider's credentials are appropriately verified initially and at ongoing intervals.

**Cultural Competence:** Cultural competence includes offering members with limited proficiency in English or limited reading skills, diverse cultural and ethnic backgrounds and physical or mental disabilities, an effective method of communicating with providers to facilitate decision-making regarding medical treatment options. In addition, cultural competence includes offering the option of receiving no treatment.

**Custodial Care:** Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by a person without professional skills or training. Custodial care is not covered unless provided in conjunction with Skilled Nursing Care.

**Detoxification Services:** Medically Managed Detoxification Services; and Medically Supervised Inpatient and Outpatient Withdrawal Services as defined in Appendix – Prepaid Benefit Package Definitions of Covered and Noncovered Services of the Medicaid Managed Care Contract.

**Direct Admission:** This is a situation in which a member has been seen in the provider's office and the provider has made a determination that immediate admission to an inpatient hospital facility is medically necessary.

**Disenrollment:** Disenrollment is the process by which a member's entitlement to receive services from a health plan is terminated, and the member is removed from Healthfirst NJ but not from the Medicaid program. Reasons for disenrollment may include but not be limited to loss of eligibility, as well as disenrollment "for cause".

**Discharge Planning:** The planning and arranging for post-hospital services to ensure that patients are discharged from inpatient care with timely arrangements in place for all necessary and appropriate post-hospital care.

**Drug Formulary:** A continuously updated list of preferred prescription medications developed by the Healthfirst NJ Medical Affairs Department taking into consideration cost and efficacy. The formulary contains FDA approved brand name and generic drugs.

**Durable Medical Equipment (DME):** DME is defined a equipment which can withstand repeated use by one patient, is primarily and customarily used to serve a medical purpose, is ordered by a qualified practitioner to address an illness, injury or disability, and is appropriate for use in the member's home, work place/school.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT):** A Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in members under the age of 21

**Effective Date of Enrollment:** This is the date on which a health plan member can begin to receive services from the health plan.

**Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA):** Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of Healthfirst NJ claims. **EFT** is the direct electronic deposit of claim reimbursements into a provider's bank account and **ERA** is the statement that allows providers to reconcile these reimbursements to their patient accounts.

**Eligible Person:** An eligible person is an individual whom the local County Board of Social Services or State authority determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

**Emergency Medical Condition**--a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

**Emergency Services:** covered inpatient and outpatient services furnished by any qualified provider that are necessary to evaluate or stabilize an emergency medical condition.

**Enrollment Broker:** This is an agent or contractor of the State or County that assists in educating and enrolling potential managed care members, assists in explaining the differences between managed care and fee-for-service and offers non-biased enrollment counseling.

**Enrollment Roster:** This report is circulated each month to participating primary care providers to identify and provide demographic information on the health plan members who are in that provider's patient panel for that month.

**Explanation of Payment (EOP):** A form or report that provides a detailed explanation of the payment or denial of payment in response to a provider's claim for reimbursement of services.

**External Appeal:** A request to the state for an independent review of a health plan's denial of services.

**Family Planning Services:** Family planning services means the offering, arranging and furnishing of those health services which enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. Family planning and reproductive healthcare include the following medically necessary services and related drugs and supplies that are furnished or prescribed by or under the supervision of a physician or nurse practitioner:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera;
- Screening and treatment for STDs;
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy and pelvic abnormality/pathology; and
- Termination of pregnancy services (provider must document duration of pregnancy).

Such services include those education and counseling services needed to render the services effective.

**Federally Qualified Health Center (FQHC):** An entity that provides outpatient health programs pursuant to 42 U.S.C § 201 et seq.

**Fee-for-Service (FFS):** The traditional healthcare payment system under which providers receive a payment for each service provided based upon a contractually agreed upon fee schedule.

**Genetic testing:** A process where by members can receive information about genetic disorders, determine their carrier status and receive counseling for intervention. Examining a sample of blood or other body fluid or tissue for biochemical, chromosomal or genetic markers can be used to guide the prevention, diagnosis and treatment of disease. Genetic tests look for alterations in a person's genes or changes in the level of key proteins coded for by specific genes. Abnormal results on these tests could mean that someone has an inherited disorder.

**Genetic counseling:** The process of educating members about their risk of genetic diseases and disorders and providing them with strategies to manage the risk.

**Grievance Process:** The formal process by which a member or provider can communicate complaints and seek remedies from the health plan.

**Guaranteed Eligibility:** This is the period beginning on the member's effective date of enrollment with the health plan and ending six months thereafter, during which the enrollment of and capitation payments on behalf of the member continue even if a change in the member's financial or other circumstances ordinarily would have rendered him or her ineligible to receive any Medicaid reimbursed services.

**Healthcare Proxy:** This is a formal document that enables a health plan member to designate a trusted individual to make healthcare decisions on his or her behalf should the member lose the ability to make decisions on his or her own.

**Healthcare Effectiveness Data and Information Set (HEDIS®):** HEDIS is a set of standardized performance measures designed to ensure that consumers, purchasers and the general public can access information that allows for reliable comparison of the performance of different healthcare plans.

**Home Health Agency:** A licensed or certified agency that provides intermittent skilled nursing care and other therapeutic services in the patient's home.

**Home Healthcare:** Services provided by a Home Health Agency. The services may consist of the following: 1) Intermittent or part-time nursing visits rendered by an RN; 2) Intravenous therapy as ordered by the physician; 3) Home health aid services under the direction and supervision of an RN; 4) Other health services to be delivered in the home setting as requested/approved by the PCP/specialist and Authorized by Medical Management. Home Healthcare services may require the use of Durable Medical Equipment, oxygen and respiratory equipment, and other medical supplies.

**Hospice:** An organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill patients and their families.

**International Classification of Diseases, 9th Edition (Clinical Modification) (ICD9-CM):** This is an industry standard listing and coding system used by providers for reporting medical conditions and diagnoses. ICD9 codes are used in conjunction with CPT-4 codes for claims data and other clinical data reporting.

**Informed Consent:** A legal concept requiring the patient, the patient's guardian or the patient's legal representative to be advised of and to understand the risks of a proposed medical procedure or treatment prior to approving such procedure or treatment. Informed consent is usually provided in writing.

**In-Network:** The designation given to medical care services provided by physicians, hospitals and other providers that have participation agreements with the health plan.

**Lock-In Period:** This period refers to the time beginning 90 days after the effective date of enrollment in the health plan by a social services official, and ending 12 months after the effective date of enrollment during which the member may not disenroll from the health plan except for certain specified reasons.

**Marketing:** Marketing includes any activity of the health plan by which information about the health plan is made known to eligible persons for the purpose of persuading them to enroll with the health plan.

**Managed Care:** A comprehensive, coordinated approach to the provision of healthcare services that combines medical services with administrative procedures to ensure timely access to high-quality, medically appropriate and cost-effective care. Managed care emphasizes primary and preventive care and focuses on the appropriate utilization of specialty care, emergency room services and inpatient hospital care.

**Medicaid:** Medicaid is a joint state/federal program created in 1965 under Title XIX—Medical Assistance of the Social Security Act. The program is administered and operated individually by participating state and local governments, providing medical benefits and services to eligible persons who meet income or medical need criteria. In New Jersey, Medicaid is administered by the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services pursuant to NJSA 30:4D-1 et seq.

**Medical Management:** The Healthfirst NJ Medical Management Department whose function is to promote the efficient use of healthcare services and quality of care.

**Medical Management Program:** The program of utilization management, clinical review and quality improvement established by Healthfirst NJ to assure that the proper level and quality of care is provided to members.

**Medical Record:** The medical record is a complete record that documents care received by the member, including inpatient, outpatient and emergency care, in accordance with all applicable laws, rules and regulations, and is signed by the medical professional rendering the services.

**Medically Necessary:** Services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily

activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the NJ FamilyCare/Medicaid 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, must be consistent with the diagnosis of the condition, and appropriate to the specific medical needs of the NJ FamilyCare/Medicaid member and not solely for the convenience of the NJ FamilyCare/Medicaid member or provider of service and in accordance with standards of good medical practice and generally

recognized by the medical scientific community as effective. Course of treatment may include mere observation or, 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/pediatric community acceptance.

For pediatric NJ FamilyCare/Medicaid members, this definition will apply with the additional criteria that the services, included those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid NJ FamilyCare/Medicaid members, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

**Medical Staff:** A hospital's or ambulatory surgery center's medical staff as that term is defined in the bylaws of the hospital or ambulatory surgery center's medical staff.

**Member:** An individual who is covered by Healthfirst NJ, including newborn children of persons who have enrolled in benefit programs offered by Healthfirst NJ.

**Non-Contracting Medical Provider or Facility:** Any professional, organization, or health facility licensed and/or certified by the state to deliver or furnish healthcare services but not under contract with Healthfirst NJ to provide such services.

**Nonparticipating Provider:** This is a provider of medical care and/or services with which Healthfirst NJ has no Provider Agreement.

**Nonprescription/Over the Counter (OTC) Drugs and Medical/Surgical Supplies:** Nonprescription drugs and supplies listed on the New Jersey Medicaid Fee schedule.

**Obstetric and Gynecologic (Ob-Gyn) Providers:** A group of providers including obstetricians, gynecologists certified nurse midwives and nurse practitioners with training in obstetrics and/or gynecology that provide women's healthcare services to NJ FamilyCare/Medicaid members.

**Participating Provider:** A hospital, physician, ambulatory surgical center, home healthcare agency, pharmacy, multi-specialty group practice, or other healthcare provider that has entered into an agreement to provide services covered under Benefit Plans marketed by Healthfirst NJ.

**Personal Contribution to Care (PCC):** The portion of the cost-sharing requirement for NJ FamilyCare C members in which a fixed monetary amount is paid for certain services/items received from Healthfirst NJ providers.

**Peer Review Organization (PRO):** An independent contractor paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicaid beneficiaries.

**Prior authorization:** The process whereby a provider must receive approval from the Medical Management Department prior to rendering services. Services are authorized in accordance with nationally recognized standards of medical care.

**Prescription Drugs:** Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are: a. prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her professional practice as defined and limited by federal and State law; b. dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and c. dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

**Primary Care Covered Services:** Those physician services covered by Healthfirst NJ as described in the PCP Agreement.

**Primary Care Provider (PCP):** A qualified physician or nurse practitioner or team of no more than four qualified physicians/nurse practitioners who provide all required primary care services contained in the benefit package to members. Medical residents may be used as part of the PCP delivery system under the supervision of a qualified attending physician. PCPs specialize in Internal Medicine, Family Practice, Pediatrics or General Practice.

**Provider Agreement:** Any written contract between the health plan and a participating provider to provide medical care and/or services under this agreement.

**Prepaid Capitation Plan Roster:** This is the monthly reporting mechanism by which all Medicaid Managed Care Plans currently enrolling recipients in New Jersey and any county within which these plans operate are informed of specifically which recipients a managed care plan will be servicing for the coming month.

**Provider's Members:** Those members who have been assigned by Healthfirst NJ to the provider, including newborn children of members who have been assigned to the provider, for the provision of medically necessary covered services. These members comprise the participating provider's panel.

**Provider Network:** The providers with whom Healthfirst NJ contracts or makes arrangements to furnish covered healthcare services to NJ FamilyCare/Medicaid members.

**Quality Improvement Projects (QIP):** A project on topic areas defined annually by the State or topics relevant to Healthfirst NJ's population demographics with the objective of reaching a targeted benchmark or improve and substance performance in national or local norms. These projects provide avenues for reviewing, assessing, ensuring, and making determinations regarding the quality of delivery of care to Healthfirst NJ members.

**Reconsideration:** An appeal of an initial determination that was not favorable.

**Service Area:** The specific geographic area where members reside and Healthfirst NJ is authorized to operate. A geographic area approved by New Jersey and CMS within which an eligible individual may enroll in Healthfirst NJ.

**Skilled Nursing Care:** Services that can only be performed by, or under the supervision of licensed nursing personnel.

**Skilled Nursing Facility (SNF):** A facility that provides inpatient Skilled Nursing Care, rehabilitation services or other related health services. This term does not apply to convalescent nursing homes, rest homes, or facilities for the aged that primarily furnish custodial care, including training in routines of daily living.

**Specialty Care Provider:** A physician or other provider in a medical specialty (e.g. cardiology, dermatology, or orthopedics) who provides clinical services to a NJ FamilyCare/Medicaid member upon request by the member's primary care provider.

**Sterilization:** Any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

**Urgent Medical Condition:** Urgent medical conditions are defined as those illnesses and injuries of a less serious nature than emergencies, but that require services to prevent a serious deterioration of a member's health, which cannot be delayed without imposing undue risk to the member's well-being, until the member either returns to the Healthfirst NJ service area or until the member can secure services from his or her regular physician. Treatment must also be determined to be medically necessary by member's physician, and must be provided within 24 hours to prevent deterioration.