

Managed Long Term Services & Supports (MLTSS)

Provider Contracting & Services

August 2019



MLTSS traditional services

- Assisted living
- Cognitive therapy
- Community residential
- MLTSS personal care assistant
- Nursing facility
- Occupational therapy
- Physical therapy
- Private duty nursing
- Respite services
- Structured day care
- Supported day care services

MLTSS non-traditional services

- Caregiver/participant training
- Chore services
- Community transition services
- Home-based supportive care
- Home delivered meals
- Medication dispensing device
- Non-medical transportation
- Personal Emergency Response System
- Residential modifications
- Social day services
- Vehicle modifications

MLTSS eligibility

- Be a resident of New Jersey
- Meet eligibility:
 - Age 65 years or older
 - Under 65 years of age with a disability or blind*
- Meet financial eligibility
- Meet clinical eligibility

*As defined by the Social Security Administration or the State of New Jersey.

Enrollment

- County Welfare Agency (Board of Social Services)
- County Area Agency on Aging (AAA) – Aging and Disability Resource Connection (ADRC)
- The Office of Community Choice Options (OCCO) makes the final decision about enrollment into the MLTSS program


Non-participating providers


- Must complete a credentialing application and sign a MLTSS contract

Verify eligibility and benefits

- Call MLTSS Provider Services: **1-855-777-0123**
- Log in to **NaviNet.net**
- Access *Horizon NJ Health* within the Plan Central drop-down menu
- Click *Eligibility & Benefits*, then select *Eligibility & Benefits Inquiry*

MLTSS member ID card

 Horizon NJ Health	
Managed Long Term Services and Supports (MLTSS)	
NAME	Dental Benefit
MEMBER ID NO: YHZ	No Copayments
PCP	
PHONE	
ISSUE DATE	
EFFECTIVE	
BC/BS Plan Codes 280/780 www.horizonNJhealth.com	Pharmacies Group: HORIZON, BIN 610606, ProCtrl: HMC

 Horizon NJ Health	
<small>Independent licensees of the Blue Cross and Blue Shield Association, Horizon NJ Health, a product of Horizon HMO*</small>	
<ul style="list-style-type: none">• Always carry this ID card. You must use your selected Primary Care Provider (PCP) for medical care. Members with Medicare Advantage or other insurance must use that plan's PCP. If you need to see a Specialty doctor, you must get a referral from your PCP. You do not need a referral to see a Horizon NJ Health Eye Doctor, Dentist, OB/GYN provider, get ER care or a mammogram. Refer to the member handbook for specific copay information.• EMERGENCIES — If you are having an emergency, call "911." You do not need approval to go to the ER. If you get emergency care, you should follow up with your PCP within 24 hours or as soon as possible.	
www.horizonNJhealth.com MLTSS Member Services (including dental and vision): 1-844-444-4410 TTY/TDD: 711 MLTSS Provider Services: 1-855-777-0123 Dental Provider Services: 1-855-878-5368 Prior Authorization: 1-800-682-9094	
<ul style="list-style-type: none">• Hospitals must call to verify eligibility and obtain precertification for inpatient and outpatient hospital services.• Standard Claims: Horizon NJ Health Claims Processing Department PO Box 24078 Newark, NJ 07101-0406• Dental Claims: Horizon NJ Health, P.O. Box 299, Milwaukee, WI 53201• Outside of NJ, the member only has coverage for urgent and emergent care. Out of state, non-Horizon NJ Health providers: submit claims to local BCBS plan.	

- Confirm eligibility as with any other member
 - **NaviNet.net**
 - **MLTSS Provider Services: 1-855-777-0123**

MLTSS Member Services

- Member Services: **1-844-444-4410**
- Connection with the member Care Manager
- Dedicated call center team
- Care coordinators to facilitate services and medical issues

Care Management

- All members will be assigned a Care Manager
- Individualized care plans will be developed in conjunction with member and caregivers
- Care plans will be reviewed every 90 days or when member's condition changes

Critical Incident Reporting

- A Critical Incident is defined by the State's Managed Care Organization Medicaid Contract (Article 9.10) as: “an occurrence involving the care, supervision, or actions involving a member that is adverse in nature or has the potential to have an adverse impact on the health, safety and welfare of the member or others. Critical Incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.”

Critical Incident Reporting *(continued)*

- All contracted MLTSS and Fully Integrated Dual Eligible Special Need Plan providers are responsible for reporting Critical Incidents to Horizon NJ Health within one business day of discovery by faxing the “Critical Incident Reporting Guide” form to **1-609-583-3003**.
- To access the Critical Incident Reporting Guide, visit **horizonNJhealth.com/cireportingguide**.

Critical Incident Reporting *(continued)*

- The initial report of a Critical Incident must be made within one business day of discovery.
- Contracted providers must immediately take steps to prevent further harm to any and all members and respond to emergency needs of members.

Critical Incident Reporting *(continued)*

- Providers with a Critical Incident are required to conduct an internal Critical Incident investigation and submit a report on the investigation within 15 calendar days via fax to **1-609-583-3003**.
- Providers are still required to report incidents to the appropriate state entities, as necessary.

Prior Authorization

- Authorizations are created when a care plan is agreed upon
- Once servicing provider is identified and confirmed:
 - Authorization is finalized
 - Provider demographics confirmed
 - Start and end date of the service confirmed
 - Type of service to be provided will be listed
- Authorization number is faxed to provider

Authorization status

- To check a prior authorization request:
 - Visit **NaviNet.net**
 - Visit the *Horizon NJ Health Plan Central*
 - Select *Report Inquiry* then,
 - *Administrative Reports* then,
 - *Authorization Summary Status Report*
 - Call **1-800-682-9094**

Appeals of Benefit Authorization

- Denials
 - Providers are notified
 - Notification letters include appeal right details
- Appeals can be filed orally or in writing
- Peer-to-peer discussions
 - Medical Directors are available at
1-800-682-9094 x89469

Appeals of Benefit Authorization *(continued)*

- Expedited appeals
 - Member's health or wellness is at risk
 - Timeframe
 - Verbal and written notification within 72 hours
- Standard provider appeals
 - Written notification within 20 business days
- Appeals hotline
 - Questions related to denials or appeals
 - **1-800-682-9094 x89606**, prompt 2

Electronic claims submission

- Quickest method for submission and payment.
- Provides electronic proof of claims submission.
- Trizetto Trading Partners Solutions (TTPS)
 - Preferred electronic claims submission accepted by Horizon NJ Health. To enroll with Trizetto call **1-800-556-2231**.
 - Submit all electronic claims to the Horizon NJ Health Electronic Data Interchange (EDI) Payer Number **22326**.
- Must include NPI number and Taxonomy Code.

Electronic claims submission (continued)

- To contact the EDI Technical Support Hotline
 - Call: **1-800-556-2231**
 - Email: **ttpssupport@cognizant.com**

Paper claims submission

- To ensure accurate payment:
 - Submit claims using Centers for Medicare & Medicaid Services 1500 claim form
- Must include NPI number, if applicable
- Must include Taxonomy Code (refer to the Provider Administrative Manual)
 - Mail to:
Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406

Claims payment

- Horizon NJ Health pays claims twice a week
- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA-835) via Emdeon
- To enroll in Emdeon, EFT, call **1-877-461-9605**
- For more information
 - Visit **horizonNJhealth.com/EFT**

How to check claim status

- Online
 - **NaviNet.net**
 - Access *Horizon NJ Health* within the Plan Central drop-down menu
 - Click *Claim Management*, then select *Claim Status Inquiry*
- By phone
 - **1-855-777-0123**

Administrative claim appeals

- All claim appeals:
 - Must be submitted with the Department of Banking and Insurance (DOBI) required claim appeal application form
 - **horizonNJhealth.com**
 - Must have a separate claim appeal application
 - Must be submitted within 90 calendar days from the date of the denial or finalized claim (date of the Horizon NJ Health explanation of benefits)

Administrative claim appeals (continued)

- What **NOT** to submit
 - Corrected claims
 - Coordination of benefits (EOBs from primary carrier)
 - First-time claim submissions
 - Referrals
 - Pending claims
 - Invoices

Appeals staff does not have the ability to adjust claims.

Administrative claim appeals (continued)

- Prior authorization is required to use a nonparticipating provider
- Claim Appeals are resolved within 30 calendar days from the date of receipt
- If a claim is adjusted as a result of an overturned claim appeal, the adjustment is completed within 30 calendar days from the date of the appeal decision letter

Administrative claim appeals (continued)

- Appeal responses/decisions should be faxed to the provider (if Horizon NJ Health has provider's fax number)
- Mail Claim Appeals to:
 - Horizon NJ Health
 - Attention: Claims Appeals Department
 - PO Box 63000
 - Newark, NJ 07101
- Or fax: **1-973-522-4678**
- Use NaviNet to check appeal status

Claim inquiries

- Provider Services should be your first point of contact at **1-800-682-9091**.
- If you are dissatisfied with claim determination, file an Appeal. See next slide for more details on the Appeal process.
- Only utilize Ancillary&MLTSSClaimResolutionTeam@HorizonBlue.com when submitting large claim issues, i.e. claims with same denial code, where you have exhausted all other avenues to getting your claim issue resolved, Provider Service and Appeals. Include the Provider Service reference number and/or the Appeal number, if applicable.

Claim inquiries (continued)

- Once the mailbox team receives your email, you will receive an auto generated response. Within 7 to 10 business days of that response, you will receive the requisition (REQ) number to track your project.
- Once the REQ is established and the project is triaged, the mailbox team will provide an estimated turnaround time for resolution.
- If you have not received a response within 30 business days of your last email where you are requesting a status of your REQ, send an email with the word “**ESCALATION**” in the subject line of your email. This will alert the mailbox team to investigate.
- Please ensure the name and TIN of your entity is in the subject line for all emails sent to the mailbox.

The mailbox team and senior management are working together to stabilize the mailbox and ensure processes are in place.

Handling claim disputes

- Claim inquiries must first be directed to Provider Services at **1-800-682-9091**

Claim Appeals

- When a physician, facility or health care professional is dissatisfied with a claim payment, including determinations, prompt payment or no payment made by Horizon NJ Health, he or she may file a claim appeal, as described herein.
- All claim appeals must be initiated on the applicable appeal application form created by the DOBI.
- The appeal must be received by Horizon NJ Health within 90 calendar days following receipt by the physician, facility or health care professional of the payer's claim determination.
- To file a claim appeal, a physician or health care professional must send the appeal application form, which is available at **horizonNJhealth.com/for-providers**, and any supporting documentation to Horizon NJ Health using one of the following methods:
 - Fax: **1-973-522-4678**
 - Mail: Horizon NJ Health
Attn: Claim Appeal
PO Box 63000
Newark, NJ 07101-8064

Handling claim disputes (continued)

- **IMPORTANT** – Please do not send medical records with administrative claim appeals. Supporting documentation, e.g., proof of timely filing, may be submitted. Please follow all appropriate procedures as defined in the *Provider Administrative Manual* before submitting an appeal.
- Please note, corrected claims should be sent to:

Horizon NJ Health

Claims Processing Department

PO Box 24078

Newark, NJ 07101- 0406

These claims should not be submitted through the appeals process, unless the original submission is considered to be correct

- Decision is **final**
- Ancillary/MLTSS Claim Resolution Team:
Ancillary&MLTSSClaimResoultionTeam@HorizonBlue.com

Provider demographic changes

- Provider data change requests can be submitted to the following email address:
ProviderFileOps2@HorizonBlue.com
- Please submit the request on provider letterhead outlining the required updates and provide additional documentation (W-9, HIPAA 5010, etc.)
- Inaccurate information can cause:
 - Issues with submitting referrals
 - Claim denials and payment delays
 - Payments being sent to incorrect address

Provider demographic changes (continued)

- Request to Change Information form
 - Send a letter (on letterhead) to:
Horizon NJ Health
Attn: Provider File Operations (HL-03)
1700 American Blvd
Pennington, NJ 08534

Horizon NJ Health website features

horizonNJhealth.com

- Searchable provider directory
- Provider forms and guides
- Formulary
- Medical policies
- Utilization Management requirements
- Contact information
- Program information

NaviNet features

NaviNet.net

- Online referral submission
- Referral inquiries
- Searchable eligibility and benefit information
- Claim status inquiries
- Administrative reports

Available administrative reports

- Authorization status summary
- Claim appeal summary
- Claim status summary
- Panel rosters

NaviNet help section

- You can view:
 - User tips
 - How to change timeout rules for all office users in your office
 - How to add/delete a user
 - How to generate passwords

- NaviNet Customer Care: **1-888-482-8057**

Options counseling (OC)

- Is a process by which the MLTSS Care Manager meets with the member, his or her family and/or caregiver, to discuss the proposed Plan of Care.
- OC takes into consideration:
 - Member's personal history and lifestyle preferences
 - Functional limitations and capacities
 - Support system (formal and informal)
 - Financial situation
- The Care Manager explores choices and options in collaboration with the member to create a person-centered Plan of Care.
- Providers must understand that members have the choice to select providers in the health plan's network.

Cultural competency

Providers shall demonstrate cultural competency in the following ways:

- Assess members and document in the medical record the presence of cultural and/or language barriers to care
- Seek information from members, families and/or community resources to assist in servicing and responding to the needs and preferences of culturally and ethnically diverse members and families
- Display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of members and families
- Provide magazines, brochures and other printed materials that reflect diverse cultures in waiting areas
- Understand that folk and religious beliefs may influence how families respond to illness, disease, death and their reaction and approach to a child born differently-abled
- Understand that the family unit can be defined differently by different cultures
- Whenever possible, seek to employ bilingual staff or trained personnel to serve as interpreters
- Understand that a member and/or family's limitation in English proficiency is in no way a reflection of their level of intellectual functioning

Questions?

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