Managed Long Term Services and Supports (MLTSS)
MLTSS Services

- Assisted Living
- Cognitive Therapy
- Community Residential
- MLTSS PCA
- Nursing Facility
- Occupational Therapy
- Physical Therapy

- Private Duty Nursing
- Respite Services
- Social Day Services
- Structured Day Care
- Supported Day Care Services
MLTSS Non Traditional Services

- Caregiver/Participant Training
- Chore Services
- Community Transitional Services
- Home Based Supportive Care
- Home Delivered Meals
- Medication Dispensing Device
- Non-Medical Transportation
- Personal Emergency Response System
- Residential Modifications
- Vehicle Modifications
MLTSS Eligibility

- Be a resident of New Jersey
- Meet categorical eligibility:
  - Age 65 years or older
  - Under 65 with a disability or blind*
    *as defined by the Social Security Administration or the State of New Jersey
- Meet Financial Eligibility
- Meet Clinical Eligibility
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 must sign an MLTSS contract
Verify Eligibility & Benefits

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

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

- Dedicated Member Services number:
  - 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 developed in conjunction with member and caregivers
- Care plans reviewed every 90 days or when member’s condition changes
Critical Incident Reporting

- All contracted MLTSS/SNP Providers are responsible for reporting Critical Incidents to HNJH within 1 Business Day of discovery by faxing the “Critical Incident Reporting Guide” Form to 609-583-3003
- [http://www.horizonnjhealth.com/for-providers/resources/forms](http://www.horizonnjhealth.com/for-providers/resources/forms)
Critical Incident Reporting
(continued)

- A Critical Incident is defined by the state 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)

- 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 609-583-3003

- Providers are still required to also report incidents to the appropriate state entities, as necessary
Prior Authorization

- Authorizations are created when care plan is agreed upon

- Once servicing provider is identified & 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 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, extension 89469
Appeals of Benefit Authorization

- **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, extension 89606, 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 EDI Payer Number 22326
  - Must include NPI number
  - Must include Taxonomy Code
Electronic Claims Submission (continued)

- To contact the Electronic Data Interchange (EDI) Technical Support Hotline
  - Call: 1-800-556-2231
  - E-mail: ttpssupport@cognizant.com
Paper Claims Submission

- To ensure accurate payment:
  - Submit claims using CMS 1500 claim form
- Must include NPI number (if applicable)
- Must include Taxonomy Code (reference Provider 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
- EFT and Electronic Remittance Advice (ERA-835) via Emdeon
- To enroll in Emdeon, electronic funds transfer service (EFT), call 1-877-461-9605
- For more information
  - Visit www.horizonnjhealth.com/for-providers/resources/claims-information/emdeon-electronic-funds-transfer-eft-forms
How to Check Claim Status

- **Online**
  - **NaviNet.net**
    - Access Horizon NJ Health within the Plan Central drop-down menu
    - Click Claim Management, then click Claim Status Inquiry

- **By phone**
  - 1-855-777-0123
Administrative Claim Appeals

- All claim appeals
  - Must be submitted with the DOBI required claim appeal application form
    - www.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
  - Co-ordination 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 Claims 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 can be faxed to the provider (if Horizon NJ Health has provider’s fax number)
- Mail Claims Appeals to:
  Horizon NJ Health
  Attention: Claims Appeals Department
  P.O. Box 63000
  Newark NJ 07101
  Or By Fax at 973-522-4678
- Use NaviNet to check appeal status
Claim Inquiries

• Customer Service should be your first point of contact - 800-682-9091
• File an Appeal if dissatisfied with claim determination. See next slide for more detail on the Appeal process.
• Only utilize the following mailbox 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, Customer Service and Appeals. Include the Customer Service reference number and/or the Appeal number if applicable.

Ancillary&MLTSSClaimResolutionTeam@horizonblue.com

• Once the mailbox team receives your email, you will receive an auto generated response. Within 2 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.
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/she may file a claim appeal, as described herein.

All claim appeals must be initiated on the applicable appeal application form created by the Department of Banking and Insurance.

The appeal must be received by Horizon NJ Health within 90 calendar days following receipt by the physician, facility or health care professional of the payer’s claim determination.

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

Fax: 973-522-4678 / Mail: Horizon NJ Health, Claim Appeal, P.O. Box 63000, Newark, NJ 07101-8064

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 this manual before submitting an appeal.

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&MLTSSClaimResolutionTeam@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
  - By Mail:
    Send a letter (on letterhead) to
    Horizon NJ Health
    Princeton Place
    1700 American Blvd
    Pennington, NJ 08534
    Attn: Provider File Operations (HL-03)
Horizon NJ Health Website Features

WWW.HORIZONNJHEALTH.COM

- Searchable Provider Directory
- Provider Forms and Guides
- Formulary
- Medical Policies
- Utilization Management Requirements
- Contact Information
- Program Information
Horizon NJ Health

NAVINET FEATURES
WWW.NAVINET.NET

- On line Referral Submission
- Referral Inquires
- Searchable Eligibility & Benefit Information
- Claim Status Inquiries
- Administrative Reports

Available Administrative Reports
- Authorization Status Summary
- Claim Appeal Summary
- Claim Status Summary
- Panel Rosters
NaviNet Help

- NaviNet help section
  - You can see:
    - User tips
    - How to change timeout rules for all office users
    - How to add/delete a user
    - How to generate passwords
- NaviNet Customer Care: 1-888-482-8057
Options Counseling

- Is a process by which the MLTSS Care Manager meets with the member, their 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 CM explores choices and options in collaboration with the member to create a person-centered Plan of Care.

- Providers must understand that member’s have choice of 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?