Managed Long Term Services & Supports (MLTSS)
2020 Non-Medical Professional Provider Administrative Manual
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Section 1 - Introduction

1.1 Welcome to Horizon NJ Health

We are pleased you are a participating provider and part of Horizon NJ Health, a Medicaid managed care plan that administers a managed care program for Medicaid/NJ FamilyCare members and those enrolled in Supplemental Security Income (SSI), Division of Child Protection & Permanency (DCPP) and clients of the Division of Developmental Disabilities (DDD) in New Jersey.

As a member of our provider network, you have an opportunity to build a mutually beneficial program for members enrolled in the Managed Long Term Services & Supports (MLTSS) program and for yourself. Horizon NJ Health regards your efforts as indispensable in making this program successful and for providing the highest quality services to our members. Horizon NJ Health is committed to supporting you, and we look forward to working with you to provide the best quality service possible to our members.

1.2 About This Document

The Horizon NJ Health Non-Medical Professional Provider Administrative Manual ("Manual") is a guide to the policies and administrative procedures of Horizon NJ Health. Use this manual as a guide to answer questions about authorization policies, member benefits, claim submissions and many other issues. Your failure to comply with any policies, rules and procedures may constitute a breach of your Participating Provider Agreement (Agreement).

This Manual also provides day-to-day operational details that can be helpful to you and your staff. The Manual will clarify and detail the requirements identified in your Agreement. Periodic updates to the Manual will be provided.

If you, or your staff, have any questions or concerns about the information in this Manual, please contact Horizon NJ Health MLTSS Provider Services at 1-855-777-0123.

1.3 MLTSS Benefits

Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through New Jersey Medicaid’s NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency.

Horizon NJ Health coordinates all services for MLTSS members. The program provides comprehensive services and supports, whether at home, in an assisted living setting, in community residential services, or in a nursing home.

In addition to NJ FamilyCare A benefits, the following services may be available to MLTSS members:

- Adult Family Care
- Assisted Living Services
- Assisted Living Program
- TBI Behavioral Management (Group and Individual)
- Caregiver/Participant Training
- Chore Services
- Cognitive Therapy (Group and Individual)
- Community Residential Services
- Community Transition Services
- Home-Based Supportive Care
- Home-Delivered Meals
- Adult Day Health
- Pediatric Day Health
- Medication Dispensing Device
- Personal Care Assistant
- Non-Medical Transportation
- Nursing Facility Services (Custodial)
- Occupational Therapy (Group and Individual)
- Personal Emergency Response Systems
- Physical Therapy (Group and Individual)
- Private Duty Nursing (Adult)
- Residential Modifications
- Respite (Daily and Hourly)
- Social Adult Day Care
- Speech, Language and Hearing Therapy (Group and Individual)
- Specialized Medical Equipment and Supplies
- TBI-Structured Day Program
- TBI-Supported Day Services
- Vehicle Modifications

Medicaid beneficiaries who were residing in nursing facilities prior to July 1, 2014, have remained in the Medicaid Fee-for-Service program. All nursing facility residents eligible for Medicaid after July 1, 2014, are required to enroll with a managed care plan and must be covered through managed care.
1.4 Horizon NJ Health’s Website

The Horizon NJ Health website, horizonNJhealth.com, is a source of information about plan features, important news, tools and resources, as well as corporate policy. Our goal is to provide relevant information for members, physicians, providers and the general public.

Horizon NJ Health’s Medical Policies and Clinical and Preventive Guidelines are available on the site. Medical policies are posted for a minimum of 30 days prior to their effective date.

Additional materials are posted as a resource for all providers, including the formulary, forms and guide.

If you have any questions please contact Horizon NJ Health’s MLTSS Provider Services at 1-855-777-0123.

1.5 Provider Directory

Horizon NJ Health publishes a searchable Provider Directory at horizonNJhealth.com. All participating providers are listed, including doctors, hospitals, laboratory services, pharmacies, dental and non-medical professional providers. The information is updated daily.

Printed copies of the Provider Directory are available by calling MLTSS Provider Services at 1-855-777-0123.

As a condition of participation in the Horizon NJ Health network, providers are required to update their demographic and practice roster information when it changes.

Please forward documentation to us regarding changes in your practice, such as:

- Office relocation address
- Changing the name of your practice
- Changing your phone number
- Changing your fax number
- Changing your tax ID number
- Adding or removing a physician to or from your practice
- Changing your hospital affiliation
- Receiving new or updated documents related to your credentialing or recredentialing process
- Changing the open or closed status of your panel (this applies to PCPs only and has a 90 day waiting period)
- Changing your address, including your billing address

A copy of the guide for changing provider information can be found at horizonNJhealth.com/demographicupdates. Documentation can be emailed to EnterprisePDM@horizonblue.com or mailed to Horizon BCBSNJ, 3 Penn Plaza East, Mail Station PP 14 C, Newark, NJ 07105.

1.6 Health Literacy

Health literacy is defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.” Low health literacy affects people of every age, ethnicity, background and education level.

Impacts on Patient Care

People with low health literacy are less likely to adhere to prescribed treatment and self-care regimens. They are also less likely to seek preventive care and are at a higher risk for hospitalization. People with low health literacy often require additional care that results in annual health care costs four times higher than for those with a higher literacy level.

Horizon NJ Health has adopted improvements in health literacy as a means of eliminating barriers to care and improving member health outcomes.

What you, the provider, can do:

- Create a safe environment where patients feel comfortable talking openly with you.
- Use plain language instead of technical language or medical jargon.
- Sit down (instead of standing) to achieve eye level with your patient.
- Use visual models to illustrate a procedure or condition.
- Ask patients to perform a return demonstration of the care instructions you give to them.

Visit horizonNJhealth.com for additional health literacy resources.
1.7 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.
Section 2 - Eligibility

2.1 Individuals Eligible to Enroll

To be eligible to enroll in the Horizon NJ Health MLTSS program, a person must:

• Be a resident of New Jersey.
• Be 65 years of age or older, or between the ages of 21 and 64 and determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services.
• Qualify for Medicaid financial eligibility by:
  - Qualifying for SSI in the community, or
  - Qualifying for Medicaid only - Institutional Level, or
  - Qualifying for NJ FamilyCare (with income at or below 100 percent of the Federal Poverty Level and resources at or below $4,000).
• Meet clinical eligibility, which is determined by a state or county professional as needing nursing facility level of care.
• Reside in an approved community living arrangement.
• Want to enroll and receive services in a nursing home or in a community setting instead of living in a nursing home.
• MLTSS members may also be eligible for Horizon NJ TotalCare (HMO D-SNP) if they qualify for both Medicare and Medicaid.

If a provider wishes to refer a current or potential member for consideration for MLTSS services, he or she can call Horizon NJ Health MLTSS Member Services at 1-844-444-4410.

2.2 Horizon NJ Health MLTSS Member Identification Cards

Each Horizon NJ Health MLTSS member is mailed an ID card that has “MLTSS” printed on the front of the card. Members are required to show their card every time they visit their Horizon NJ Health doctor or dentist, when they are referred to a specialist, when they fill a prescription or have lab work done, and if they go to a hospital Emergency Room (ER). Members must keep their Horizon NJ Health MLTSS member ID card safe and never let anyone else use or borrow it. It is illegal to lend a member ID card or number to anyone. Anyone who does so could lose his or her NJ FamilyCare benefits and face prosecution.

2.3 Assessment for Risk of Nursing Home Level of Care

Only individuals who are determined to require Nursing Facility Level of Care (NFLoC) may be enrolled in MLTSS. The process and standardized tool that is used in New Jersey to make this determination is the NJ Choice Assessment System as approved and codified by the State of New Jersey. Upon enrollment, the Care Manager will request an initial assessment of each patient. This initial assessment is conducted by communicating with the member and primary caregiver/family member (if available), observing the member in his or her home environment, and reviewing any secondary documents when available. The member is considered to be the primary source of information; the Care Manager is encouraged to talk with the member in private if at all possible.

The purpose of the NJ Choice Assessment System is to complete a comprehensive assessment of the member with the goal of:

• Maximizing the individual's functional capacity and quality of life
• Addressing health problems through integrated care
• Ensuring that the individual remains in his or her home as long as possible

The Office of Community Choice Options (OCCO) of the New Jersey Department of Human Services’ Division of Aging Services makes the final eligibility determination and is responsible for issuing the final approval or denial letter to the member with a copy to Horizon NJ Health.

When an individual is determined not to require NFLoC, the person is informed by OCCO by letter of his or her right to request a Fair Hearing to appeal the determination.
Section 3 - MLTSS Overview

3.1 Horizon NJ Health MLTSS Service Descriptions

These MLTSS Service Descriptions provide a comprehensive overview of the services available to Horizon NJ Health MLTSS members that are furnished by MLTSS non-medical ancillary providers. Benefits are established by the State of New Jersey and are subject to change.

3.1.1 Adult Family Care

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. AFC providers may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant’s funds when requested by the participant, up to 24 hours a day of supervision and medication administration.

Service Limitations:

Individuals that opt for AFC are not eligible for Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or the Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of AFC services. A person may not receive long-term nursing home care at the same time as AFC. The individual service recipient or authorized representative is responsible to pay the cost of room and board.

AFC members may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Licensed AFC Sponsor Agency (Agency)
- Licensed by Health Facilities Evaluation and Licensing (HFEL)

3.1.2 Assisted Living Services

Assisted Living Services (ALS) are a coordinated array of supportive personal and health services and medication administration. These services are available 24 hours a day to residents who have been assessed to need these services – including persons who require a nursing home level of care. Assisted living services include personal care and medication oversight and administration throughout the day. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, onsite or offsite, to meet the individual needs of residents.

Assisted living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted living promotes a member’s self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings.

An Assisted Living Residence (ALR) is a facility that is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the ALR offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit’s kitchen 24 hours a day, seven days a week, and to facility food and beverages 24 hours a day, seven days a week.

A Comprehensive Personal Care Home (CPCH) is a facility that is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed to four or more adults unrelated to the proprietor. Residential units in CPCHs house no more than two residents and have a lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24 hours a day, seven days a week and, if equipped, access to their own unit’s food preparation area.

Service Limitations:

Individuals that opt for ALS in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), AFC, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite, as the above would duplicate services integral to and inherent in the provision of ALS.

Individuals in an ALR/CPCH are responsible for paying their room and board costs.
Provider Specifications:
Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

3.1.3 Assisted Living Program (ALP)
ALP provides assisted living services to the tenants/residents of certain publicly subsidized housing buildings. ALPs are available in some subsidized senior housing buildings. Each ALP provider shall be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

ALP includes personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an ALP is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP providers shall develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans.

ALP participants, not ALR or CPCH participants, may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Service Limitations:
Individuals that opt for ALP do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of ALP services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

Provider Specifications:
Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs
3.1.4 TBI Behavioral Management (Group and Individual)

Traumatic Brain Injury (TBI) Behavioral Management is a daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior, which is potentially destructive to self or others. The program, provided in the home or outside the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan; implementation of the plan; ongoing training and supervision of caregivers and behavioral aides; and periodic reassessment of the plan.

The goal of the program is to return the individual to the prior level of functioning, which is safe for him/her and others.

Service Limitations:
Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative TBI or be a former TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation from a board-certified and eligible psychiatrist, a licensed neuropsychologist or neuropsychiatrist with subsequent consultation by same on an as-needed basis.

Provider Specifications:
• Board-certified and board-eligible psychiatrist
• Clinical psychologist
• Mental health agency
• Rehabilitation hospital
• Community Residential Services (CRS) provider
• Post-acute non-residential rehabilitative services provider agency

3.1.5 Community Residential Services (CRS)

A package of services provided to a participant living in the community, residence-owned, rented or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision and recreational activities. A CRS is a participant’s home. The CRS provider is responsible for coordinating the service to ensure the participant’s safety and access to services as determined by the participant and Care Manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The Care Manager, in conjunction with CRS staff, evaluates participant, using the “Level of Care Guidelines for CRS” form as a guide.

Service Limitations:
The individual must have a diagnosis of acquired, non-degenerative TBI or be a former TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants’ care. Only one level of service can be billed per 24-hour period (12 a.m. to 11:59 p.m.)
• The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
• The participant or responsible party must pay room and board costs
• The participant must agree to receive the therapy services of the CRS provider

Provider Specifications:
• Current license per N.J.A.C. 10:44C to operate as a group home for individuals with a diagnosis of TBI

3.1.6 Community Transition Services

Those services provided to a participant to aid in transition from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:
• Security deposits that are required to obtain a lease on an apartment or home
• Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens
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- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy
- Necessary accessibility adaptations to promote safety and independence
- Activities to assess need, arrange for and procure needed resources

Service Limitations:
- Limit of up to $5,000

Community Transition Services do not include:
- Residential or vehicle modifications
- Recreational items such as televisions, cable television access or video players
- Monthly rental or mortgage expenses; payment for security deposit is not considered rent
- Recurring expenses such as food and regular utility charges
- Payment for room and board
- Are one time per the life of the individual
- Are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources
- Service is based on identified need as indicated in the Plan of Care

3.1.7 Nursing Facility Services (Custodial)

A nursing facility (NF) is a facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was avoidable.

All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Service Limitations:
The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee.

Provider Specifications:
- Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85

3.1.8 Occupational Therapy (Group and Individual)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MLTSS will include rehabilitation therapies for an individual with a TBI diagnosis. CPT codes are to be used for these services.

Provider Specifications:
- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute, non-residential rehabilitative services provider agency
3.1.9 Cognitive Therapy (Group and Individual)

Therapeutic interventions for maintenance and prevention of deterioration, which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in various settings, including but not limited to the individual’s own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by professionals with the credentials, training, experience and supervision noted in Provider Specifications.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI or formerly a TBI waiver participant who transitions to MLTSS.

Provider Specifications:

• Minimum of a master’s degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification
• Minimum of a bachelor’s degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (e.g., special education)
• Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work and special education
• Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists
• Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met)

Supervision:

• This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below
• Supervision for providers who are not licensed or certified is based on the number of years of experience
  • For staff with less than one year of experience: four hours of individual supervision per month
  • For staff with one to five years of experience: two hours individual supervision per month
  • For staff with more than five years of experience: one hour per month

All individuals who provide or supervise the service must complete six hours of relevant ongoing training in cognitive therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences and in-services.

3.1.10 Caregiver Participant Training

Training/instruction to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long-term care needs; and skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia and seminars to support someone with mobility difficulties. Training needs must be identified through comprehensive evaluation/re-evaluation or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

3.1.11 Chore Services

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the member’s level of safety. Chore services include cleaning appliances; cleaning and securing rugs and carpets; washing walls; windows, scrubbing floors; cleaning attics and basements to remove fire and health hazards; clearing walkways of ice, snow, leaves; trimming overhanging tree branches; replacing fuses, light bulbs, electric plugs, frayed cords; replacing door locks, window catches; replacing faucet washers; installing safety equipment; seasonal changes of screens and storm windows; weather stripping around doors; and caulking windows.
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3.1.13 Home-Delivered Meals
Deliver nutritionally balanced meals to a member’s home when this meal provision is more cost-effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least 1/3 of the current Recommended Dietary Allowance (RDA) established by the Food & Nutrition Board of the National Academy of Sciences and National Research Council.

3.1.14 Residential Modifications
Those physical modifications/adaptations to a participant’s private primary residence required by his/her Plan of Care, which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual. Residential modifications are limited to $5,000 per calendar year, $10,000 lifetime.

3.1.15 Non-Medical Transportation
Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them.

Transportation services shall be offered in accordance with the individual’s Plan of Care. Transportation is a service that enhances the individual’s quality of life.
An approved provider may transport the participant to locations including but not limited to: shopping, beauty salon, financial institution, or religious services of his or her choice.

Service Limitations:
Services are limited to those that are required for implementation of the Plan of Care.
Whenever possible, family, neighbors, friends, public transit, tickets or community agencies, which can provide this service without charge, will be utilized.

Provider Specifications:
• Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.
• Owner must have proof of liability insurance coverage for the vehicle.
• Owners and drivers are required to undergo civil and criminal background checks.
• Evidence of Insurance, i.e. Declaration Page from insurance company, must be produced.
• Provide description of vehicles used in service and copies of any required licenses.
• Vehicle appropriately registered, inspected and insured; Driver licensed to operate the vehicle.
• Provides proof of New Jersey Business Authority, e.g., tax certificate or trade name registration.
• Provides Fee Schedule.
• Participant-Directed Provider.

3.1.16 Vehicle Modifications
The services include needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved Plan of Care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes. The vehicle must be registered in New Jersey and must be owned by the member or the member’s authorized representative.
3.1.17 Medication Dispensing Device (MDD) Set Up and Monthly Monitoring

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner, the unit will “lock” that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person and case management site in that order until a “live” person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:
Per Medical Necessity as defined in the MCO contract, MDD is for an individual who lives alone or who is alone for significant amounts of time per the Plan of Care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

3.1.18 Personal Emergency Response System (PERS) Set Up and Monitoring

PERS is an electronic device that enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment, and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously, the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:
Per Medical Necessity as defined in the MCO contract, PERS is for an individual who lives alone for significant amounts of time per the Plan of Care. Individual might not have a regular caregiver for extended periods of time or would require extensive routine supervision.

3.1.19 Respite (Daily and Hourly)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid caregiver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Service Limitations:
Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a CRS setting, an ALR or CPCH or for individuals that are admitted to a nursing facility. Respite care shall not be reimbursed as a separate service during the hours the participant is in either Adult Day Health Services or Social Adult Day Care.

Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in or companion services are not considered Respite services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (e.g., Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant.

Eight or more hours of respite in one 24-hour period provided by the same provider is the DAILY respite service.

Provider Specifications:
Respite care may be provided in the following location(s):
- Individual’s home or place of residence
- Medicaid-certified nursing facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an ALR, a CPCH or an Adult Family Care (AFC) Home
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3.1.20 Home-Based Supportive Care Services

Home-Based Supportive Care (HBSC) services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC services are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wrap-around service to non-Medicaid programs such as those administered by the Department of Veterans Affairs that are assisting participants with their ADL health-related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond “health-related” services.

HBSC is distinct from the State Plan service of Personal Care Assistant in that it does not include “hands-on personal care.” According to N.J.A.C. 10:60-1.2, Personal Care Assistant (PCA) services means “health-related tasks” performed by a qualified individual in a beneficiary’s home, under the supervision of a registered nurse, as certified by a physician in accordance with a beneficiary’s written Plan of Care.

HBSC services include, but are not limited to, the following: meal preparation, grocery shopping, money management, light housework or laundry.

Service Limitations:

HBSC services are not available for those who have chosen ALR, CPCH, ALP. Since the PCA State Plan Service can assist with IADL, HBSC is offered only when ADL-related tasks are provided by a caregiver or another non-Medicaid program.

Provider Specifications:

- Licensed home health agency
- Licensed health care service firm
- Licensed employment agency or temporary help agency
- Congregate Housing Services Program
- Licensed hospice provider
- Participant-directed provider

3.1.21 Private Duty Nursing (Adult)

Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

Service Limitations:

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program.

Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care.

Approval is provided by the MCO for MLTSS beneficiaries. Approval is provided by the state for fee-for-service beneficiaries.

Provider Specifications:

- RN or an LPN under the direction of the enrollee’s physician.

PDN services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by at least one of the following accrediting entities:

- Commission on Accreditation for Home Care, Inc.
- Community Health Accreditation Program
- The Joint Commission
- National Association for Home Care and Hospice
3.1.22 Social Adult Day Care

Social Adult Day Care (SADC) is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized Plan of Care. SADC is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day, but less than 24-hour care. Individuals who participate in SADC attend on a planned basis during specified hours. SADC assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. SADC services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Service Limitations:

Per the identified need as included in the individual’s Plan of Care:

• SADC services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week
• SADC is not available to those residing in an ALF as it would duplicate services required by the Assisted Living Licensing Regulations
• SADC cannot be combined with Adult Day Health Services
• The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the SADC
• ALP participants, not ALR or CPCH participants, may attend SADC two (2) days a week
• AFC participants may attend SADC two (2) days per week

Provider Specifications:

The provider must be a Medicaid-approved entity that meets the following qualifications:

• Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures
• Personnel: (a) program director designated, (b) has adequate staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant
• Client population: established criteria for target population based on resources and program capabilities of facility
• Program activities: planned and ongoing age appropriate activities based on social, physical and cognitive needs of the target population
• Individualized Plans of Care: based on identified individual client needs, jointly developed with client and family
• Social Services: coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families
• Nutrition: provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary
• Health Management: (a) an initial health profile is completed. (b) monthly weights are taken and other health-related observations are recorded as necessary
• Personal Care: personal assistance as needed with mobility and ADL
• Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes and regulations, including physical plant requirements, fire safety and ADA compliance

3.1.23 Speech, Language and Hearing Therapy (Group and Individual)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MLTSS will include rehabilitation therapies for an individual with a TBI diagnosis. CPT codes are to be used for these services.

Service Limitations:

Per Medical Necessity as defined in the contract. MLTSS rehabilitation therapies for individuals with TBI diagnoses are limited to one session per day.

Provider Specifications:

• A rehabilitation hospital
• Community Residential Services (CRS) provider
• Licensed, certified home health agency
• Post-acute non-residential rehabilitative services provider agency
3.1.24 Structured Day Program

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management and safety. This service will include nutritional supervision, health monitoring and recreation as appropriate to the individualized Plan of Care.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI, or formerly a TBI waiver participant who is transitioning to MLTSS. The program will not cover services paid for by other agencies. The program excludes medical day care.

3.1.25 Supported Day Services

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight at least monthly.

The Supported Day Service is intended to be a home- and community-based service, not provided in an outpatient setting or within a Community Residential Service, although it may be provided by staff that work in either of these settings. The service supports a person's Plan of Care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to therapeutic recreation; volunteer activities; household management; shopping for food, household goods, clothing; negotiating various components of activities in the community; and building social supports in the community.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative TBI, or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to a Structured Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the master's level rehabilitation professional. The amount, frequency and duration of this service are determined by the recommendation made by the qualified professional. The Care Manager develops the Plan of Care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

Provider Specifications:

A professional holding at least a master’s degree in a rehabilitation-related discipline (including but not limited to; psychology, social work, PT, OT, SLP, nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned master’s level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

The following services are state plan services that would be beneficial to the support of a MLTSS member. In developing Plan of Care for a member the services below should be considered.

- Medical Day Services – Pediatric and Adult
- As specified at N.J.A.C. 8:86 (five hours per day/five days per week)
- MLTSS PCA
4.1 MLTSS Care Management

Horizon NJ Health provides every MLTSS member with a Care Manager and Care Management team. The Care Manager, usually a nurse or social worker, leads the coordination and care of the member’s health care needs. The Care Management team also includes a clinical support coordinator.

The Plan of Care is based on the member’s health status and health care needs. The role of the provider (Primary Care Provider, specialist or other provider) is very important. The member, along with his/her Care Manager, will work together to develop a Plan of Care. The Plan of Care will outline the member’s health care needs, focus on the member’s chosen goals, what services the member may receive, frequency of service and name of provider decided upon by the member. MLTSS Services will be provided within 45 calendar days of enrollment and member agreement to the Plan of Care, except for residential modification and vehicle modification. The Plan of Care is facilitated by the Care Manager who ensures direct involvement of the member, member’s family and/or authorized representative. The Care Manager is responsible for facilitating placement/services based on assessed needs and member’s provider. The provider may receive a copy of the Plan of Care via fax.

The Care Manager will conduct a face-to-face visit every 90 days. The Care Manager will review the member’s Plan of Care at least every 90 days or sooner if there are changes in the member’s condition. Horizon NJ Health members must use in-network, contracted providers to get covered MLTSS services.

Horizon NJ Health ensures that its MLTSS Care Managers work in a conflict-free environment. Care Managers cannot work directly with members who are blood relatives or related by marriage. They also cannot be a direct-paid caregiver or be financially responsible for or empowered to make financial or health-related decisions on behalf of a member they are assigned to.

4.2 MLTSS Prior Authorization Process

When the Plan of Care is complete and the Care Manager and member are in agreement with the Plan of Care, authorizations will be entered into the medical management system in accordance with the agreed upon Plan of Care. Services are authorized exactly as written in the signed Plan of Care. If there are questions about authorizations, those questions are discussed with the MLTSS Care Manager prior to completing and signing the Plan of Care.

The MLTSS care management team will make all the necessary arrangements to ensure that services mandated via the Plan of Care are executed in a timely manner. Horizon NJ Health will make every attempt to arrange services with the provider chosen by the member. If the contacted provider cannot provide the service, the MLTSS care management team will try to identify a provider who can provide the services. This process continues until a provider can be found to meet the expectations of the Plan of Care.

Once it is confirmed that the provider is able to provide the service, an authorization is created in the medical management system for that specific provider with the authorization limits/requirements listed in the Plan of Care. The provider is given an authorization number, the start and end date of the service, and the type of service that will need to be provided. An authorization letter with the above information is also triggered from the medical management system and mailed to the provider.
4.3 Defining Critical Incidents

The Centers for Medicare and Medicaid Services (CMS), as well as the State of New Jersey, requires that measures be employed to protect the health and welfare of Horizon NJ Health MLTSS members. This includes guidelines for reporting critical incidents.

Per the State of New Jersey, critical incidents include but are not limited to the following situations:

- Unexpected Death of a Member
- Media involvement\Potential Media involvement
- Physical abuse\seclusion\restraints\physical\chemical
- Psychological\Verbal abuse
- Sexual Abuse or Suspected Sexual Abuse
- Fall resulting in the need for medical treatment
- Medical emerg resulting in need for medical tx
- Medication Error
- Psych emerg resulting in need for medical tx
- Severe Injury or Fall
- Suicide attempt resulting in need for medical tx
- Neglect\Mistreatment, caregiver(paid or unpaid)
- Neglect\Mistreatment, self
- Neglect\Mistreatment, other
- Exploitation, financial
- Exploitation, theft
- Exploitation, destruction of property
- Exploitation, other
- Theft with Law Enforcement Involvement
- Failed Back Up Plan
- Elopement or Wandering
- Inaccessible for Initial On-Site Meeting
- Unable to Contact
- Inappropriate Provider Conduct
- Cancellation of Utilities
- Eviction or Loss of Home
- Facility Closure
- Natural Disaster
- Operational breakdown
- Other

4.4 Reporting Requirements for Critical Incidents

MLTSS providers with suspicion or evidence of critical incidents must report them to Horizon NJ Health. Upon discovery of a Critical Incident, providers are to take steps to prevent further harm to members and promptly respond to these members’ needs. These steps may include reporting potential violations of criminal law to law enforcement authorities.

For MLTSS members, providers are responsible for reporting Critical Incidents to Horizon NJ Health, within 1 Business Day of discovery by faxing the “Critical Incident Reporting Guide” form to 1-609-583-3003.

The reporting form can be found online at horizonNJhealth.com/criticalincidentreportingguide. Horizon NJ Health’s Critical Incident Team will subsequently contact/follow up with the provider as warranted, and has a dedicated fax to receive subsequent Provider Investigation Findings and Resolution summaries from providers to ensure incidents are resolved promptly though appropriate referrals and corrective action. The Horizon NJ Health MLTSS Critical Incident Team will notify the State of New Jersey of any critical incidents via a state-specified web-based system.

MLTSS providers who have reported critical incidents are required to independently conduct an internal critical incident investigation and submit a report on their findings to Horizon NJ Health. The report should be submitted no longer than 15 calendar days after the date of the incident or discovery of its occurrence. Under extenuating circumstances, but only with the approval of Horizon NJ Health, the report can be submitted within 30 calendar days after the date of the Incident.
5.1 Billing

This section is intended to offer MLTSS providers the information required for Horizon NJ Health to accurately and efficiently process claims prepared by or for them for services provided to members of our health plan.

This section contains notes of interest highlighting billing information relevant to the topic detailed above them.

The notes may be titled as follows:

**IMPORTANT** – Reminds the reader of claim submission problems that can be avoided. These errors can result in rejections, inaccurate claim payments or denials, usually because required information is missing, invalid, incomplete or inconsistent with standard billing practices.

**NOTE** – Reviews an associated piece of information, which clarifies or explains specific details about the service, but may not directly impact reimbursement. For example, place of service is required to determine eligibility for payment, but does not necessarily affect payment amount.

**REFER TO** – Directs the reader to another more complete source of explanation or additional resource information within the document.

In the event of additional questions about Horizon NJ Health programs or policies, please review the entire Manual or contact MLTSS Provider Services at 1-855-777-0123.

In order to comply with contractual obligations, regulatory requirements or state and federal law, Horizon NJ Health reserves the right, at any time, to modify or update information contained in this document. Notifications will be posted at least 30 days prior to the effective date unless the effective date of a law or regulation does not permit this timeframe. MLTSS providers may access the For Providers section of the Horizon NJ Health website at horizonNJhealth.com to check for updates on billing requirements and other policies and procedures relevant to reimbursements for services.

**IMPORTANT** – Horizon NJ Health, its subcontracted vendors, or the State of New Jersey, are responsible for payment for all services included in the member’s benefit package. Services not included in the benefit package are reimbursable by the member only if the provider notifies the member in writing and in advance of providing the service(s) of this obligation.

Members should not be billed for any service covered under their benefit package. Should Horizon NJ Health require a copayment for any service or population group, an itemization of these items will be included in the benefit listing and will be available on the website. The practice of balance billing Medicaid/NJ FamilyCare beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under federal and state law. These prohibitions apply to both Medicaid/NJ FamilyCare-only beneficiaries, fully integrated dual eligible special needs (FIDE-SNP) members, as well as those eligible for Medicare coverage or other insurance.

A provider enrolled in the Medicaid/NJ FamilyCare FFS program or in managed care is required to accept as payment in full the reimbursement rate established by the FFS program or managed care plan. All costs related to the delivery of health care benefits to a Medicaid/NJ FamilyCare eligible beneficiary, other than authorized cost sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third-party payer (if applicable). If a provider receives a Medicaid/NJ FamilyCare FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary’s behalf for any additional charges.

5.2 Requirements for Filing Claims

Horizon NJ Health is a Medicaid managed care plan that is under contract with the New Jersey Department of Human Services. Horizon NJ Health will pay claims based only on eligible charges.

Unless the provider contract states otherwise, claims will be paid on the lesser of billed charges or the contracted rate (Horizon NJ Health fee schedule).

Consistent with CFR 42 Part § 447.45 the following definition shall apply to clean claims as used within the Horizon NJ Health Billing Guide:

“Clean claim means 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.”

Under the New Jersey Health Claims Authorization, Processing and Payment Act, claims must also meet the following criteria:

(a) the health care provider is eligible at the date of service

(b) the person who received the health care service was covered on the date of service

(c) the claim is for a service or supply covered under the health benefits plan
(d) the claim is submitted with all the information requested by the payor on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51)

(e) the payor has no reason to believe that the claim has been submitted fraudulently

Other requirements, such as timeliness of claims processing, include:

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing.

For MLTSS services, Horizon NJ Health shall pay all clean claims from hospitals, physicians and other providers within 15 days of the date of receipt of EDI claims and within 30 days for paper claims.

The timeframe does not apply to claims from providers under investigation for fraud or abuse. Nor does it include any claims that have been rejected.

The date of receipt is the date Horizon NJ Health receives the claim, as indicated by its date stamp on the claim.

The date of payment is the date of the check or other form of payment.

Horizon NJ Health is required to report all claims to the State of New Jersey for services provided to members through electronic media. Practitioners and facilities may not use a PO Box as an acceptable billing address. A physical street address must be used. In addition, when submitting ZIP codes anywhere on a claim, practitioners and facilities must use the full nine-digit format.

To have payments sent to a different address, the pay-to provider name and address field on the 837-I and 837-P transaction must be used.

5.3 Procedures for Claim Submission

Horizon NJ Health is required by state and federal regulations to capture and report specific data regarding services rendered to its members. All services rendered, including capitated encounters and fee-for-service claims, must be submitted on the red and white (no black and white or copied) CMS 1500 (HCFA 1500) version 02/12 or UB-04 claims form, or via electronic submission in a HIPAA-compliant 837 or NCPDP format. Horizon NJ Health does not accept black and white (copies or faxed) or handwritten claims or stamped claims. These claims forms and electronic submissions must be consistent with the instructions provided by CMS’ requirements, as stated in the CMS Claims Manual, which can be accessed at cms.gov/Manuals/IOM/list.asp.

The provider, to appropriately account for services rendered and to ensure timely processing of claims, must adhere to all billing requirements.

When data elements are missing, incomplete, invalid or coded incorrectly, Horizon NJ Health cannot process the claims.

- Claims for billable services provided to Horizon NJ Health members must be submitted by the provider that performed the services.
- Claims filed with Horizon NJ Health are subject to the following procedures:
  - Verification that all required fields are completed on the claim
  - Verification that all diagnosis codes, modifiers and procedure codes are valid for the date of service
  - Verification of member’s eligibility for services under Horizon NJ Health during the time period in which services were provided
  - Verification that the services were provided by a participating or nonparticipating provider that has received authorization to provide services to the eligible member
  - Verification that the provider has been given approval for services that require prior authorization by Horizon NJ Health
- Horizon NJ Health is the “payor of last resort” on all claims submitted for members of its health plan. Providers must verify whether the member has Medicare coverage or any other third party resources and, if so, provide documentation that the claim was first processed by this other insurer as appropriate.
Section 5 - Billing Guide

IMPORTANT – Rejected claims are defined as claims with invalid or missing data elements, such as the tax ID number, that are returned to the submitter or EDI source without registration in the claim processing system. Since rejected claims are not registered in the claim processing system, the provider must submit a clean claim within 180 days of the date of service. This guideline applies to claims submitted on paper or electronically. Rejected claims are different than denied claims, which are registered in the claim processing system, but do not meet requirements for payment under Horizon NJ Health guidelines. Submit claims for all medical services to Horizon NJ Health at the following address:

Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406

Horizon NJ Health encourages all providers to submit claims via EDI. You can get more information or enroll by calling TriZetto Trading Partners Solutions (TTPS) at 1-800-556-2231, or you may email physiciansales@trizetto.com.

One other option is the use of TriZetto SimpleClaim, a dedicated direct-data entry (DDE) system through which you can submit claims electronically and monitor them through the reimbursement process. Registration for this service is available at trizettoprovider.com/horizon/simpleclaim. For questions about registering with TTPS for DDE claim submission, please call TTPS at 1-800-556-2231. To submit paper claims (only red and white are accepted without handwriting or stamps), please send to Horizon NJ Health at the following address:

Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406

Note – Be sure to include the member’s Medicaid ID number on all claims submitted to the State of New Jersey.

IMPORTANT – Claims inquiries may be submitted by telephone to:
Provider Claim Services 1-855-777-0123

5.4 Claim Filing Deadlines

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. COB claims must be submitted within 60 days from the date of the primary insurer’s Explanation of benefits (EOB).

• Horizon NJ Health’s Appeals Department utilizes specific criteria when reviewing valid proof of timely filing. The information submitted should consist of a computer-generated ledger that cannot be altered and includes the following information:
  - Member’s name
  - Horizon NJ Health or Medicaid ID number
  - Billed amount
  - Date of service
  - Billed/mailed date
  - Address where the claim form was sent
  (Horizon NJ Health or insurance code)

• For EDI submissions, a 999 report indicating submission to the correct insurance code is required for consideration of timely submission

• Horizon NJ Health’s Appeals Department will also accept certified mail receipts as valid proof of timely filing

REFER TO – Section 6.0 Grievance and Appeals Process for complete instructions of the submission timeframes and procedures for administrative or medical appeals.

NOTE – If the provider’s ledger uses internal insurance codes, he or she must submit a copy of the code descriptions.

Correcting electronic HCFA 1500 claims:
EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

Correcting electronic UB-04 claims:
EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF *F8* with the original claim number for which the corrected claim is being submitted.

Corrected, paper and electronic claims must be submitted within 365 calendar days from the initial date of service. Claims with an EOB from primary insurers that fall beyond the timely filing requirements must be submitted within 60 days from the date of the primary insurer’s EOB.
Fields 21 through 24g cover the types of services performed and the dates you performed them. Do not forget to add the information on authorizations if services require a authorization. Use the codes that are appropriate to your service type.

### 1500 (HCFA 1500) Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Type</th>
<th>Field Description</th>
<th>Instructions</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member Info</td>
<td>Insurance Program Identification</td>
<td>Mark as Medicaid</td>
<td>Yes</td>
</tr>
<tr>
<td>1a</td>
<td>Member Info</td>
<td>Insured Identification Number</td>
<td>Horizon NJ Health member identification number</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Member Info</td>
<td>Patient's Name</td>
<td>Enter the patient’s name as follows: LAST NAME, FIRST NAME, MIDDLE INITIAL</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Member Info</td>
<td>Patient's Date of Birth and Sex</td>
<td>MM/DD/YY and M or F (Male or Female)</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Member Info</td>
<td>Insured’s Name</td>
<td>Enter the member’s name as it appears on the Horizon NJ Health Member ID card as follows: LAST NAME, FIRST NAME, MIDDLE INITIAL</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Member Info</td>
<td>Patient’s Address</td>
<td>Enter the member’s complete address including city and state</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Member Info</td>
<td>Patient Relationship to Insured</td>
<td>Mark as “Self”</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Member Info</td>
<td>Insured’s Address</td>
<td>Enter the member’s complete address including city and state. (Do not punctuate the address or phone number)</td>
<td>Yes</td>
</tr>
<tr>
<td>11d</td>
<td>Member Info</td>
<td>Is there another Health Benefit Plan</td>
<td>Y or N by check box. If yes, complete #9 a-d</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Type</th>
<th>Field Description</th>
<th>Instructions</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Procedure Info</td>
<td>Diagnosis or nature of Illness or injury</td>
<td>Use the Diagnosis Code (DX) from the Type of Service Table</td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
<td>Procedure Info</td>
<td>Prior Authorization Number</td>
<td>Enter the authorization number if services require a authorization</td>
<td>Yes</td>
</tr>
<tr>
<td>24a</td>
<td>Procedure Info</td>
<td>Dates of Service</td>
<td>From date: MM/DD/YY. If the service was performed on one day there is no need to complete the TO Date</td>
<td>Yes</td>
</tr>
<tr>
<td>24b</td>
<td>Procedure Info</td>
<td>Place of Service</td>
<td>Enter the HCFA standard place of service code from the Type of Service Table</td>
<td>Yes</td>
</tr>
<tr>
<td>24d</td>
<td>Procedure Info</td>
<td>Procedures, services or supplies CPT/HCPCS Modifier</td>
<td>Use the HCPC code and Modifier on the Type of Service Table</td>
<td>Yes</td>
</tr>
<tr>
<td>24f</td>
<td>Procedure Info</td>
<td>Charges</td>
<td>Enter charges</td>
<td>Yes</td>
</tr>
<tr>
<td>24g</td>
<td>Procedure Info</td>
<td>Days or Units</td>
<td>Enter quantity</td>
<td>Yes</td>
</tr>
</tbody>
</table>
For all provider types:
Please complete fields 24 through 33 using the instructions in the chart. This section covers your provider information – account number, identification numbers and facility locations/service locations. Horizon NJ Health needs this information for reimbursement.

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Type</th>
<th>Field Description</th>
<th>Instructions</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>24i</td>
<td>Provider Info</td>
<td>ID Qualifier</td>
<td>Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider taxonomy code in the shaded area</td>
<td>Yes</td>
</tr>
<tr>
<td>24j</td>
<td>Provider Info</td>
<td>Rendering provider ID</td>
<td>Enter NPI or provider ID number</td>
<td>Yes</td>
</tr>
<tr>
<td>25</td>
<td>Provider Info</td>
<td>Federal Tax Identification Number SSN/EIN</td>
<td>The Provider’s Federal Tax ID number</td>
<td>Yes</td>
</tr>
<tr>
<td>26</td>
<td>Provider Info</td>
<td>Patient’s Account Number</td>
<td>The Provider’s billing account number</td>
<td>Yes</td>
</tr>
<tr>
<td>27</td>
<td>Provider Info</td>
<td>Accept Assignment?</td>
<td>Always indicate yes</td>
<td>Yes</td>
</tr>
<tr>
<td>28</td>
<td>Provider Info</td>
<td>Total Charge</td>
<td>The total charge of the service</td>
<td>Yes</td>
</tr>
<tr>
<td>29</td>
<td>Provider Info</td>
<td>Amount Paid</td>
<td>REQUIRED, when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Horizon NJ Health. Medicaid programs are always the payers of last resort.</td>
<td>Yes</td>
</tr>
<tr>
<td>30</td>
<td>Provider Info</td>
<td>Balance Due</td>
<td>REQUIRED, when #29 is completed</td>
<td>Yes</td>
</tr>
<tr>
<td>31</td>
<td>Provider Info</td>
<td>Signature of Physician or supplier and date</td>
<td>Please sign and date the paper claim form. If billed electronically then “Signature on file” should be this field</td>
<td>Yes</td>
</tr>
<tr>
<td>32</td>
<td>Provider Info</td>
<td>Service Facility Location Information</td>
<td>Enter the physical location. (PO Boxes are not acceptable)</td>
<td>Yes</td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>National Provider Identification number or Horizon NJ Health provider ID</td>
<td>Enter the Horizon NJ Health assigned provider identification number</td>
<td>Yes</td>
</tr>
<tr>
<td>32b</td>
<td>Provider Info</td>
<td>Other ID Number</td>
<td>Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in. Do not enter a space, hyphen or other separator between the qualifier and the number.</td>
<td>Yes</td>
</tr>
<tr>
<td>33</td>
<td>Provider Info</td>
<td>Billing Provider Information and Phone # (include area code)</td>
<td>Enter the complete name and address of the provider. Do not punctuate the address or phone number. Enter the Horizon NJ Health assigned physician/supplier identification number.</td>
<td>Yes</td>
</tr>
<tr>
<td>33b</td>
<td>Provider Info</td>
<td>Other ID Number</td>
<td>Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in. Do not enter a space, hyphen or other separator between the qualifier and the number.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
5.5 Claim Forms (Paper)

5.5.1. CMS 1500 Claim Form (Paper)

Instructions

The CMS 1500 (HCFA 1500) claim form must be used to bill all professional services to Horizon NJ Health.

How to Complete the CMS 1500 Form

For all provider types:

Complete fields 1 through 11d with the member’s information. The basic member information – name, address, patient relationships and identification numbers – is required.

5.5.2 The UB-04 (CMS 1450) Claim Form (Paper)

The UB-04 (CMS 1450) claim form must be used to bill all facility services to Horizon NJ Health. This section will provide the list of required fields for Horizon NJ Health. However, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

TYPE OF BILL CODES
Code Description
111 Hospital/Inpatient (Part A)/Admit through Discharge
112 Hospital/Inpatient (Part A)/Interim – First Claim
113 Hospital/Inpatient (Part A)/Interim – Continuing Claims
114 Hospital/Inpatient (Part A)/Interim – Last Claim
115 Hospital/Inpatient (Part A)/Late Charge Only
117 Hospital/Inpatient (Part A)/Replacement of Prior Claim
121 Hospital/Hospital-Based or Inpatient (Part B)/Admit Through Discharge
131 Hospital/Outpatient/Admit Through Discharge
211 Skilled Nursing/Inpatient (Part A)/Admit Through Discharge
212 Skilled Nursing/Inpatient (Part A)/Interim – First Claim
213 Skilled Nursing/Inpatient (Part A)/Interim – Continuing Claims
214 Skilled Nursing/Inpatient (Part A)/Interim – Last Claim
321 Home Health/Hospital-Based or Inpatient (Part B)/Admit Through Discharge
331 Home Health/Hospital-Based or Inpatient (Part B)/Admit Through Discharge

711 Clinic/Rural Health Clinic (RHC)/Admit Through Discharge
721 Clinic/Independent Renal Dialysis Facility/Admit through Discharge
731 Clinic/FQHC/Admit Through Discharge
831 Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge

TYPE OF ADMISSION CODES
Code Description
1 Emergency
2 Urgent
3 Elective

PATIENT STATUS CODES
Code Description
1 Discharged to Home or Self Care (routine discharge)
2 Discharged/Transferred to Another Short-Term General Hospital
3 Discharged/Transferred to SNF
4 Discharged/Transferred to ICF
5 Discharged/Transferred to Another Type of Institution (including distinct parts) or Referred for Outpatient Services to Another Institution
6 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
7 Left Against Medical Advice
8 Discharged/Transferred to Home Under Care of an IV Drug Therapy Provider
9 Admitted as an Inpatient to this Hospital
20 Expired (or did not recover – Christian Science Patient)
30 Still Patient or Expected to Return for Outpatient Services
40 Expired at Home (hospice claims only)
41 Expired in a Medical Facility, such as Hospital, SNF, ICF or Freestanding Hospice (hospice claims only)
42 Expired – Place Unknown (hospice claims only)
50 Hospice – Home
51 Hospice – Medical Facility
5.5.3. Paper Claims Submissions

Horizon NJ Health requires that all providers use the standard CMS 1500 (HCFA 1500) or UB-04 claim forms to report services that are reimbursable or capitated. The CMS 1500 (HCFA 1500) claim form must be completed for all non-institutional professional services. The UB-04 claim form must be completed for all facility claims. For timely processing of claims, providers are encouraged to submit electronically. If permitted under your Agreement and until the provider has the ability to submit electronically, to assure clean claim submission, paper claims (UB-04 and CMS 1500, or their successors) must adhere to the following CMS-mandated elements and formatting guidelines:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Information must be aligned within the data fields and must be on an original red ink on white paper claim form.
- The information should be typed. Do not print, handwrite, or stamp any extraneous data on the form.
- The typed information must not contain broken characters, script or italics.
- Stylized font, mini font and dot-matrix font are not acceptable.

5.6 Procedures for Electronic Submission – Electronic Data Interchange

IMPORTANT – All claims submitted electronically must be in a HIPAA compliant 837 or NCPDP format. Electronic data interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the industry's efforts to reduce overhead administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed more quickly. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

5.6.1 Hardware/Software Requirements

There are many different products that can be used to bill electronically. Hospitals, physicians and health care professionals should send EDI claims to TriZetto TTPS whether through direct submission or through another clearinghouse/vendor using payor number 22326. Only TriZetto TTPS can submit claims electronically to Horizon NJ Health.

Contracting with TriZetto and Other Electronic Vendors

If you are a hospital, physician or health care professional interested in submitting claims electronically to Horizon NJ Health but do not have TriZetto EDI services, contact TriZetto at 1-800-556-2231 or tpssupport@cognizant.com. For more information on registering, please go to trizettoprovider.com. You may also choose to contract with another EDI clearinghouse or vendor who already has access to TriZetto EDI services.

Contacting the EDI Technical Support Group

Hospitals, physicians and health care professionals interested in sending claims to Horizon NJ Health electronically may contact the EDI Technical Support Group for information and assistance.

Once Horizon NJ Health is notified of the intent to submit claims through EDI, the organization's contact will receive a complete list of ID numbers for Horizon NJ Health hospitals, physicians and health care professionals, the electronic payor number, TriZetto-specific edits, and any other information needed to initiate electronic billing with Horizon NJ Health.

NOTE: Physicians can contact the EDI Technical Support Group to obtain names of other EDI clearinghouses and vendors.
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Transmission Requirements
Once the materials are received, proceed as follows:

• Read over the materials carefully
• Transmission can begin upon receipt of ID numbers for Horizon NJ Health individual hospitals, physicians and health care professionals

Contact the EDI Technical Support Group to answer any questions you may have. If you wish to receive confirmation to begin electronic submission, the EDI Technical Support Group will contact you via fax, mail or email on the effective day for EDI claim submission.

No approval is necessary. Contact your system vendor and/or TriZetto to inform them that you are now going to submit production claims electronically to Horizon NJ Health. You will be asked for the electronic payor address and the TriZetto-specific edits included in your Horizon NJ Health documentation.

5.6.2 Specific Data Record Requirements
EDI claims should be submitted according to HIPAA standards. These standards can be found in the Implementation Guides written by the Designated Standard Maintenance Organizations (DSMOs) responsible for each transaction. Additional information can be obtained through the CMS’ website at cms.hhs.gov.

5.6.3 Electronic Claim Flow Description
In order to send claims electronically to Horizon NJ Health, all EDI claims must first be forwarded to TriZetto using payor number 22326. This can be completed via a direct submission or through another EDI clearinghouse or vendor. Once TriZetto receives the transmitted claims, they are validated against TriZetto’s proprietary specifications and Horizon NJ Health-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a TriZetto error report. The name of this report can vary, based on the physician’s contract with his or her intermediate EDI vendor or TriZetto. Claims are then passed to Horizon NJ Health, and TriZetto returns a conditional acceptance report to the sender immediately.

Claims forwarded to Horizon NJ Health by TriZetto are immediately validated against physician and member eligibility records. Claims that do not meet this requirement are rejected and sent back to TriZetto, which also forwards this rejection to its trading partner – the intermediate EDI vendor or directly to the hospital, physician or health care professional. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered received under timely filing guidelines if rejected for missing or invalid provider or member data.

Hospitals, physicians and health care professionals are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from TriZetto or other contracted vendors must be reviewed and validated against transmittal records daily.

NOTE – For a detailed list of TriZetto data requirements, contact EDI Technical Support at 1-800-556-2231.

5.6.4 Invalid Electronic Claim Record
Rejections/Denials
All claim records sent to Horizon NJ Health must first pass Cognizant’s proprietary edits and Horizon NJ Health-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Horizon NJ Health. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the rejection notices (the functional acknowledgements to each transaction set and the unprocessed claim report) received from Cognizant TPS or your vendor in order to identify and resubmit these claims accurately.

Common Rejections
• Claims with missing or invalid batch level records
• Claim records with missing or invalid required fields
• Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
• Claims without or that have invalid hospital, physician or provider National Provider Identifier (NPI) numbers whenever applicable. Per federal requirements, atypical providers are excluded
• Missing/invalid member ID
• No physical billing address on file
• Missing Taxonomy code
• NDC code not being billed for J and Q codes with the correct NDC unit of measure and the NDC unit dispensed
• The PPCN field must be populated with the original claim number when billing a corrected claim

NOTE – Provider identification number validation is not performed at TriZetto. TriZetto will reject claims for provider information only if the provider number fields are empty.
5.6.5 Submitting Corrected Claims with EDI

Providers using electronic data interchange (EDI) can submit “professional” corrected claims electronically rather than paper to Horizon NJ Health.

NOTE – A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

The electronic corrected claim submission capability allows for faster processing, increased claims accuracy and a streamlined submission process. For your EDI clearinghouse or vendor to start using this new feature they need to:

- Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- Include the Horizon NJ Health claim number in order to submit your claim with the 6 or 7.
- Bill all services, not just the services that need corrections.
- Do use this indicator for claims that were previously processed (approved or denied).
- Do not use this indicator for claims that contained errors and were not processed (such as claims that did not appear on a remittance advice; i.e., rejected up front).
- Do not submit corrected claims electronically and via paper at the same time.

5.7 Common Coding Requirements

5.7.1 Diagnosis Codes

All claims must include the proper ICD-10-CM diagnostic code.

CMS provides specific guidelines to aid in standardizing U.S. coding practices. The guidelines are summarized below:

- Identify each service, procedure or supply with an ICD-10-CM code to describe the diagnosis, symptom, complaint, condition or problem.
- Identify services or visits for circumstances other than disease or injury, such as follow-up care after chemotherapy, with V codes provided for this purpose.
- Code the primary diagnosis first, followed by the secondary, tertiary and so on. Code any coexisting conditions that affect the treatment of the patient. Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity. Carry the numerical code to the fourth or fifth digit when available. Remember, there are only approximately 100 valid three-digit codes; all other ICD-10-CM codes require additional digits.
- Code a chronic diagnosis, when it is applicable, to the patient's treatment.
- When only ancillary services are provided, list the appropriate V code first and the problem second. For example, if a patient is receiving only ancillary therapeutic services, such as physical therapy, use the V code first, followed by the code for the condition.

Both the State of New Jersey and the HIPAA transaction code sets require the use of a diagnosis code on all claims. To ensure that diagnosis codes are accurate, use the appropriate codes from the most recent ICD-10-CM coding manuals. Using deleted or incorrect codes will result in inability to process your claim or payment delays.

NOTE – Horizon NJ Health does not have the ability to return invalid diagnosis codes to submitters. Invalid diagnosis codes are returned to the providers with zeros (00000) and an explanation that the codes are not valid.
Section 5 - Billing Guide

5.7.2 Procedure Codes

Common Procedure Terminology (CPT)

CPT is a standardized system of five-digit codes and descriptive terms used to report the services provided by providers. It was developed and is updated and published annually by the American Medical Association (AMA). CPT codes communicate to physicians, providers, patients and payors the procedures performed during a medical encounter. Accurate coding is crucial for proper reimbursement from payors and compliance with government regulations.

The AMA revises and publishes the CPT book on an annual basis. Appendix B of CPT always consists of a summary of additions, deletions and revisions to the current edition. Of these three types of changes, only the descriptions of revised codes appear in Appendix B, so you must refer to the manual itself to look at the descriptors of the new codes.

All providers must use the appropriate procedure codes from the most recent HCPCS and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to enrollees.

IMPORTANT – Procedure coding must meet the current criteria set by the AMA for medical practice norms. Horizon NJ Health does not have the ability to return invalid procedure codes to submitters. Invalid procedure codes are returned to the providers with zeros (00000) and an explanation that the codes are not valid.

5.7.3 Modifiers

Modifiers are used to report that the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide coding consistency and editing for Level I (Common Procedure Terminology Codes) and Level II (Healthcare Common Procedure Coding System).

Sometimes, CPT codes require the addition of two-digit modifiers. CPT modifiers allow you to show that a service was altered in some way from the stated CPT Book description. Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is very important to know how to use modifiers correctly.

Modifiers can indicate:

- A service or procedure has both a professional and a technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred

Use the appropriate modifier from the most recent HCPCS and CPT coding manuals. Using deleted or incorrect codes and failing to use a modifier can result in denials, incorrect payments or claim payment delays.

IMPORTANT – The correct modifier must be used when required by the current CPT or HCPCS publications. A valid modifier must be used to indicate the circumstance under which the service or item is being billed. Using appropriate modifiers provides valuable information when evaluating claims for payment. Missing or inaccurate modifiers, as well as missing required medical documentation, may result in inaccurate reimbursements or inaccurate denials for duplicate services.

IMPORTANT – Modifiers should not be used for multiple evaluation and management events unless the activity occurs at separate times on the same day. The Evaluation and Management Services Guide from CMS will be used by Horizon NJ Health to determine the appropriateness of coding submitted by providers, including the use of modifiers. For more information on the Evaluation and Management Services Guide please visit the Medicare Learning Network (MLN) at cms.gov/MLNGenInfo.

NOTE – These modifiers are subject to change. Consult the current CPT or HCPCS publications for the most up-to-date modifier list.

5.7.4 Units

The number of units or times a particular service is performed must be accurately indicated on all claims. When spanning dates of services, the number of units must match the count of the actual days within the spanned dates. If services were performed intermittently throughout the spanned dates of services, each date must be listed separately on the bill or an itemized statement must be submitted along with the claim.

When billing for loaded mileage, exact mileage must be identified on the claim.

When billing for observation, units are equivalent to hours.

IMPORTANT – The number of units and the service dates must be coordinated in order to obtain the most accurate reimbursement for the services billed. Services performed once (one date of service) must be indicated with a “1” in the unit’s field.
5.7.5 Other Coding

Use the appropriate coding as indicated in the official guides for the CMS 1500 and UB-04 claim forms or HIPAA-compliant electronic transaction sets when completing additional fields such as bill type, place of service and type of service. Incorrect coding can cause under- or over-payments or claim payment delays.

5.8 Common Causes of Claim Processing Delays, Rejections or Denials

- Authorization number invalid or missing
- Billed charges missing or incomplete
- Claim information does not match authorization
- Coordination of benefits (COB) information missing or incomplete
- Diagnosis code missing 4th or 5th digit
- Diagnosis, procedure or modifier codes invalid or missing
- DRG codes missing or invalid
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information missing or incomplete
- Eligibility/enrollment is not valid on DOS
- Explanation of benefits (EOB) missing or incomplete
- Illegible claim information
- Incomplete forms
- Payor or other insurer information missing or incomplete
- Place of service code missing or invalid
- Procedure/service code does not match authorization
- Physician name missing or invalid
- Provider identification number missing or invalid
- Revenue codes missing or invalid
- Spanning dates of service do not match the listed days/units
- Signature missing
- Employer identification number (EIN) missing or invalid
- Third party liability (TPL) information missing or incomplete
- Type of service code missing or invalid

5.8.1 Attachments Missing From Original Claim

Providers are required to submit an invoice for implantable items, and other insurance EOBs, if the primary insurance denied the service. If these items are not submitted with the claim or are submitted separately (EDI and paper), incorrect payment or denials may occur. Adjustments to these payments or denials should be submitted as corrected claims, not as a resubmission of the original claim. Please submit to the correspondence address below:

Horizon NJ Health Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406

5.9 Coordination of Benefits (COB)

Any services provided to a Horizon NJ Health member are reviewed against benefits provided for that same individual under other insurance carriers with whom the member has coverage. Horizon NJ Health, as a managed care program for Medicaid and NJ FamilyCare members in New Jersey, is the “payor of last resort” on claims for services provided to members also covered by Medicare, employee health plans or other third party medical insurance. Payors, which are primary to Horizon NJ Health, include (but are not limited to):

- Private health insurance, including assignable indemnity contracts
- Health maintenance organizations (HMOs)
- Public health programs, such as Medicare
- Profit and nonprofit health plans
- Self-insured plans
- No-fault automobile medical insurance
- Liability insurance
- Workers’ compensation
- Long-term care insurance
- Other liable third parties

In cases where another insurer, including Medicare Fee-for-Service, is deemed responsible for payment, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and will not exceed the normal Horizon NJ Health benefits, which
would have been payable had no other insurance existed. Providers should not file a claim with Horizon NJ Health until they receive the EOB from the member’s other insurance carrier(s). Make sure you follow that insurer’s administrative requirements, standard claim submission policies and forms.

Upon receipt of payment, submit applicable claims to Horizon NJ Health for payment of deductibles and coinsurance amounts. Horizon NJ Health reimburses after coordination of benefits and only up to the primary contracted rate for the service. The claim and primary insurer’s EOBs must be submitted within 60 days of the date of the EOB or within 180 days of the dates of service, whichever is later.

When preparing the claim, include a complete record of the original charges and primary (or additional) payor’s payment as well as the amount due from the secondary or subsequent payor. Submit all pages of the primary (or additional) insurer’s EOB to avoid delays in completing claims due to missing information or coding and message descriptions. This information ensures accurate coordination of benefits.

With the exception of Medicare, Horizon NJ Health’s same notification policies that are routinely applied and required must be followed for any claims to be considered for payment. In the case of Medicare as the primary insurer, practitioners and facilities are advised to follow Horizon NJ Health’s procedures, as some services may be exhausted or not covered by Medicare.

**IMPORTANT –** All COB claims must be submitted with a copy of the EOB from the primary insurer.

Submit COB claims for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health**  
**Claims Processing Department**  
**PO Box 24078**  
**Newark, NJ 07101-0406**

**NOTE –** Although a primary insurer may have unique coding specific to its business, providers must bill with valid ICD-10-CM, CPT-4 and HCPCS codes. Unique or invalid codes specific to other insurers will cause claim processing delays or denials.

**IMPORTANT –** The provider may not submit billed charges to Horizon NJ Health that are different than charges submitted to other insurers for the same services. The submitted bill must contain the exact billed amounts by procedure line as is reflected on the primary or additional insurer’s EOB.

**IMPORTANT –** The primary or additional insurer’s EOB must include member name, billed amounts, paid amounts, adjustments, coinsurance amounts, deductibles, copayments and all associated messages and notes. Incomplete information may result in a claim processing delay or denial.

### 5.9.1 Medicare

When both Medicare and Medicaid cover a member and the service is a benefit of both programs, the claim must first be filed with Medicare. Providers should not file a claim with Horizon NJ Health until they receive the Medicare EOB. Upon receipt of payment, submit the claim along with a copy of the Medicare EOB to Horizon NJ Health within 60 days of the date of the Medicare EOB or 180 days from the date of service, whichever is later.

Medicare primary members have no prior authorization requirements and are not required to be seen by a participating Horizon NJ Health hospital, physician or provider, unless Medicare does not cover the service. When Horizon NJ Health, by default, becomes the primary payor, the hospital, physician or provider must comply with all coverage requirements indicated by Horizon NJ Health to be considered for payment. Horizon NJ Health advises that services to members covered by Medicare and Medicaid be reported despite the fact that authorization is not required. This will avoid delays in claims payment for services that Horizon NJ Health must cover.

Medicare-eligible services denied by Medicare due to failure to comply with medical, administrative or filing requirements will not be covered by Horizon NJ Health.

**NOTE –** When Medicare is primary...

- and the procedure is covered by Medicare, an authorization is not required by Horizon NJ Health, even if one is normally required by Horizon NJ Health. Reporting these services to Horizon NJ Health is advised.
- and the procedure is not covered by Medicare, an authorization is required by Horizon NJ Health if one is normally required by Horizon NJ Health.

**IMPORTANT –** The provider may re-bill for services originally denied by Medicare when Medicare overturns the denial. The provider must submit the re-bill within 60 days of the date of Medicare’s EOB.
5.9.2 Other Third Party Medical Insurance

Members covered by a primary insurer including Medicare should be instructed to notify Horizon NJ Health of their primary coverage.

Claims submitted to Horizon NJ Health as the secondary or tertiary insurer are subject to eligibility and benefit coverage. To receive payment for a claim submitted to Horizon NJ Health as the secondary or tertiary insurer, the provider must submit a copy of the primary insurer’s EOB or final denial letter along with the claim to Horizon NJ Health.

**NOTE** – Submit claims to Horizon NJ Health within 60 days of the date of the primary insurer’s remittance and/or EOB or 180 days from the date of service, whichever is later.

Participating providers may not bill Horizon NJ Health members for deductibles and coinsurance or balances above its allowable fees. Medicaid is the “payor of last resort;” therefore, the payments received from the primary insurer and/or Horizon NJ Health must be considered payment in full. Members are not to be billed for any Horizon NJ Health covered service. If the service is not covered by the other insurer or Horizon NJ Health, there must be prior written agreement to bill the member for these non-covered services.

**REFER TO** – Section 6.0 Grievance and Appeals Process for complete instructions of the submission timeframes and procedures for administrative or medical appeals.

**IMPORTANT** – If there is any possibility that the services provided will not be covered by the primary insurer, the providers should obtain the appropriate prior authorizations needed to obtain coverage under Horizon NJ Health. Failure to do so may result in denial of payment.

**IMPORTANT** – If you provide services to a member who is ill or injured as the result of a third party action, you must notify Horizon NJ Health of this information. In the event that this information is determined after the claim is submitted and/or resolved, you are still required to inform Horizon NJ Health. This includes recording the information about the injury or condition on the claim and notifying Horizon NJ Health of any lawsuits or legal action in relation to the injury or condition.

**IMPORTANT** – When completing the CMS 1500 (HCFA 1500) claim form, be sure to complete item #7 on the form.

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**Motor Vehicle Accidents**

Motor vehicle accident-related claims should be submitted to the primary carrier prior to being submitted to Horizon NJ Health. If benefits exhaust or are unavailable, the claim may be submitted to Horizon NJ Health along with an EOB or a denial letter in order to be considered for payment.

In all cases, Horizon NJ Health’s prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the provider will have 60 days from the date of the letter to submit the claim. Upon receipt of an EOB from the primary carrier, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed. In all cases, Horizon NJ Health’s prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

**IMPORTANT** – When preparing the claim, all information relating to the accident must be included on the claim. This includes diagnosis codes, accident indicators and occurrence codes (UB-04 claim forms) where appropriate. Additionally, if a primary insurer has made payment for services, the insurer’s EOB must be included when submitting the claim for payment.

**Workers’ Compensation**

Workers’ compensation covers any injury that is the result of a work-related accident. If Horizon NJ Health is aware of a workers’ compensation carrier, Horizon NJ Health will reject the provider’s claim and direct that the claim be submitted first to the primary workers’ compensation carrier. If insurance coverage is not available at the time the claim is submitted or the workers’ compensation carrier ceases to provide coverage, the claim will be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the provider will have 60 days from the date of the letter to submit the claim.

**IMPORTANT** – When completing the CMS 1500 (HCFA 1500) claim form, be sure to complete #7 on the form.
5.9.3 Reimbursement

Medicare
If a member has Medicaid and Medicare coverage, the provider may bill for charges Medicare applied to the deductible or coinsurance, or both. Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

IMPORTANT – Bills submitted to the secondary insurer must exactly match the services and amount billed to the primary insurer. This information, along with the primary insurer’s EOB, is necessary to complete an accurate COB. Incomplete information could result in processing delays or denials.

Other Third Party Medical Insurance
Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

Guidelines on Billing Mileage for Member Transportation Services
Horizon NJ Health members shall be transported to and from medical appointments in a manner resulting in the accrual of the least number of miles. Mileage is measured by odometer from the place of departure or the point at which the member enters the vehicle to the destination or point at which the member exits the vehicle. At no time shall the transportation provider’s base location be used when calculating mileage.

Professionals may bill Horizon NJ Health for these services without submission of a primary insurer’s EOB.

NOTE – If a service is covered by Medicare Advantage, please supply the resulting EOB.

IMPORTANT – If billing for room and board only at a SNF, reimbursement will be considered without submission of Medicare EOB.

Other Third Party Medical Insurance
An EOB or notice of refusal must be submitted with all commercial and Medicare Advantage insurers’ claims.

5.9.4 Denials from Primary Insurers
If the primary insurer denies payment to the provider based on coverage exclusion, non-coverage, benefit exhaustion or non-compliance with administrative guidelines, the physician must submit a copy of the EOB or notice of refusal. The EOB or notice of refusal must include an explanation of the reason for the denial.

Services denied by the primary insurer and billed to Horizon NJ Health without an explanation of the denial from the primary insurer will be denied payment.

Services denied by the primary insurer for noncompliance with medical or administrative guidelines may be submitted to the secondary with a copy of the EOB or notice of refusal and a copy of the final appeal denial letter or notice of refusal. Medical and/or administrative denials will not be considered without receipt of the final appeal denial letter.

IMPORTANT – Horizon NJ Health will document receipt of notices that the member’s primary carrier does not cover a service or that the service is exhausted. No additional notices will be required until the anniversary date of the member’s policy with that other insurer. Annually, on or after the anniversary date, the hospital, physician or provider must provide notice again that the service is exhausted or not covered by the primary carrier.

NOTE – The provider must file a claim with the primary insurer within the appropriate timely filing deadlines and according to appropriate filing requirements. Failure to submit medical and administrative denial information from a primary insurer could result in processing delays or denials.

IMPORTANT – Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the provider will have 60 days from the date of the letter to submit the claim.
5.10 Remittance Advice Documentation

Overview of Payment Summary Page
Horizon NJ Health provides a comprehensive summary of financial information and activity on the Remittance Advice (RA).

The body of the RA contains claim detail and the Payment Summary page indicates whether the physician/payee has a positive (+) or negative (-) balance.

Many providers have requested ongoing notification of overpayments and negative payee balances in relation to claim adjudication activities, capitation payments, or accounts payable adjustments. The Payment Summary page displays this information as “rolling balances” of overpaid amounts that are owed to Horizon NJ Health. The “rolling balance” is updated on each RA after current claim payments and other adjustments have been applied.

If, after reviewing the RA, you have questions or want to request a reconsideration, contact MLTSS Provider Services at 1-855-777-0123 for assistance.
Section 6 - Grievance and Appeals Process

6.1 Grievance/Appeals Process for MLTSS Providers

Horizon NJ Health has a system and procedure for the resolution of grievances by providers. The grievance procedure is available to all providers; timely resolution will be executed as soon as possible and will not exceed 48 hours from initiation of the grievance for urgent cases and 30 days for all other issues.

The procedure for initiating a grievance is outlined below:

1. When a provider is dissatisfied, a grievance can be initiated through any of the following:
   • Call a Horizon NJ Health representative at 1-800-682-9091
   • Send a written letter to: Horizon NJ Health Member/Provider Correspondence PO Box 24077 Newark, NJ 07101-0406
   • Inform any Horizon NJ Health staff member within any department that you wish to file a formal grievance
   • Submit a verbal or written request directly to the Department of Banking and Insurance, via phone call, fax or online complaint form (www.state.nj.us/dobi/consumer.htm)

2. Once received by the appropriate Horizon NJ Health representative, efforts will be made to resolve the grievance.

3. If you are not satisfied with the resolution offered by the representative, you should request that a formal grievance be filed.

4. A grievance resolution analyst will investigate the grievance, and you will be notified within the following timeframes:
   • Urgent cases, including verbal notification, will be addressed within 48 hours
   • Those grievances resolved within five business days will receive verbal notification of the outcome from the resolution analyst. If Horizon NJ Health is unable to reach the initiator of the grievance through a telephone call, a written notification that includes the outcome will be sent within 30 days

5. Unless an appeal is requested, the grievance is considered to be satisfactorily resolved.

6. Horizon NJ Health investigates all grievances and alleged incidents reported by or related to our members, which may include, but not limited to:
   • Phone call to the health care practitioner or facility by Provider Contracting & Servicing to clarify the circumstances of the grievance
   • Request for medical records and/or a written response from the health care practitioner or facility, which is due within 10 calendar days
   • Site visit

7. Within the grievance process, a vital part of the resolution is the assistance of a health care practitioner or facility. Using the information from the member and provider, all grievances are thoroughly investigated. After all the information is gathered, a medical director makes a determination if there is a quality issue.

8. For provider grievances related to administrative issues, quality of care, actions, sanctions or terminations, refer to Section 8.29 and Section 8.30.

6.2 MLTSS Member Grievance and Appeals Process

Horizon NJ Health has a grievance procedure for resolving disagreements between members, providers and/or Horizon NJ Health. Disputes may involve Horizon NJ Health's benefits, the delivery of services or Horizon NJ Health's operation. This procedure includes both medical and non-medical (dissatisfaction with the Plan of Care, quality of member services, appointment availability, or other concerns not directly related to a denial based on medical necessity) issues. A grievance, by phone or in writing, can usually be resolved by contacting Member Services.

A member may file a grievance and/or appeal in his or her primary language. All steps of the process shall be in his or her primary language, including the notification of the grievance and appeal rights and the decision of the appeal. Issues regarding emergency care will be addressed immediately. Issues regarding urgent care will be addressed within 48 hours in the member's primary language. Horizon NJ Health will not discriminate against a member or attempt to disenroll a member for filing a grievance or appeal.

A member who is not satisfied with the supports and services he or she is receiving should call his or her Care Manager right away. The Care Manager will work with the member and his or her service agencies to try and fix the problem. At times it may be appropriate to contact Member Services at 1-844-444-4410 (TTY 711) for help in resolving the grievance or problem.

Member Advocates are specially trained to advocate on the member’s behalf to assure that the member’s rights are protected.
Section 6 - Grievance and Appeals Process

Filing a Formal Grievance
If a member feels that neither his or her MLTSS Care Manager nor the Member Advocate has resolved his or her issue, the member can file a formal grievance in two ways: either verbally or in writing. The member can call Member Services toll free at 1-844-444-4410 (TTY 711), and speak to a representative. A written grievance can be mailed to:

Horizon NJ Health
Member/Provider Correspondence
PO Box 24077
Newark, NJ 07101-0406

A member can also contact the Department of Banking and Insurance at 1-609-292-5316 or submit an online grievance form at www.state.nj.us/dobi/enfcon.htm#managed.

6.3 Medical Appeals
A member or his or her provider, with the member’s written approval, has the right to ask Horizon NJ Health to review and change our decision if we have denied or reduced the member’s benefits. This is called an appeal. An appeal can be oral or written. All appeals must be submitted within 60 days of the date of the denial determination.

The appeal process is described below. A member also has the right to ask Medicaid to review Horizon NJ Health’s decision about services. This is called a Fair Hearing.

6.4 Utilization Management Appeals Process
Horizon NJ Health has appeals policies to receive and adjudicate utilization management appeals made by members and providers. This procedure ensures timely resolution, provides easy access and offers prompt, fair and full investigation of UM appeals.

The appeal procedure is as follows:
In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.

1. Any member or provider may appeal any UM decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services. Horizon NJ Health must inform the member and provider of its decision using the Notice of Action template letters developed and provided by the state. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. Members and providers must be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

2. A member or provider, acting on behalf of a member and with the member’s documented consent, may request an appeal by contacting the UM Appeals Department. All written appeal requests must be submitted to the following address:

Horizon Medical Appeals
PO Box 10194
Newark, NJ 07101

You can also request an appeal by calling our UM Appeals Department at 1-800-682-9094 x89606, prompt 2 or by fax at 1-609-583-3028

3. All appeals (regardless of level or type) must include the following information:
- Name, address and number (if applicable) of the member(s) and/or physician(s) making the appeal
- Member ID number
- Date(s) of service
- Name(s) of physician, vendor or facility
- Specific details regarding the actions in question
- The nature and reasoning behind the appeal
- The desired outcome
- Supporting documentation, e.g., medical record
Section 6 - Grievance and Appeals Process

Actions that can be appealed include but are not limited to:

- 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 if based on medical necessity
- 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 if based on medical necessity
- 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
- Denial of a service, based on lack of medical necessity

Continuation of Benefits During UM Appeals and IURO Appeals

Horizon NJ Health will continue services automatically during Internal and External Independent Utilization Review Organization (IURO) appeals if all of the following conditions are met:

- Appeal is filed timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- Services were ordered by an authorized provider
- Appeal request is made on or before the final day of previously approved authorization, or within 10 calendar days of the notification of adverse benefit determination, whichever is later. (A later request – one taking place after an interruption – will not constitute a continuation of benefits. An appeal request can still be made after this point – up to 60 days from the notice of adverse determination – but it will not include continued benefits.)
- If the above criteria are not satisfied the member will not be eligible for continuation of benefits.

NOTE: Horizon NJ Health will notify the member and provider at least 10 days in advance of the termination, suspension or reduction of a previously authorized course of treatment. If Horizon NJ Health fails to meet this deadline, Horizon NJ Health will extend the original authorization (and the member’s timeframe to request continued benefits) to a date 10 days after the date of notification.

Internal Appeal

Internal appeals are reviewed by health professionals who are clinical peers; hold an active, unrestricted license to practice medicine or a health profession; are board certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); are in the same profession and in a similar specialty that typically manages the medical condition, procedure or treatment, as mutually deemed appropriate; and are neither the individual who made the original noncertification, nor the subordinate of such an individual.

Urgent or emergent appeals determinations, including verbal and written notification, shall be completed as soon as possible and will not exceed 72 hours after the initiation of the appeal request. Non-urgent and non-emergent internal utilization management appeal determinations, including written notification, shall be completed within 30 calendar days.

If the appeal is not resolved to the member’s satisfaction, Horizon NJ Health will provide a written explanation of how to proceed to an External appeal. All Adverse Determination letters shall document the clinical rationale for the decision, including a statement that the clinical rationale used in making the appeal decision will be provided in writing upon request. A member or physician acting on behalf of a member with the member’s documented consent can obtain, upon request, reasonable access to and copies of all documents relevant to the appeal.

External Appeal – IURO

Following an adverse determination for an Internal Appeal, the External appeal process includes filing an appeal with the Independent Utilization Review Organization (IURO) assigned by the New Jersey Department of Banking and Insurance (DOBI). Send External appeal requests to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329
Phone: 1-609-292-5316 x50998
Toll free: 1-888-393-1062
Section 6 - Grievance and Appeals Process

External appeals must be filed with the IURO within 60 days of the adverse Internal appeal determination. The request must be filed on the application for the Independent Health Care Appeals Program form. The request should be accompanied by the specified fee and general release, executed by the member, for all medical records pertinent to the appeal, as indicated on the form.

Upon receipt of the request to review an appeal from DOBI, the IURO will conduct a preliminary review of the appeal and accept for processing if it determines that:

1. The individual was a covered person of Horizon NJ Health at the time of the action on which the appeal is based.
2. The service, which is subject to the appeal, reasonably appears to be a covered service under the terms of the contract between the covered person and Horizon NJ Health.
3. The member, or provider acting on behalf of the member with the member’s consent, has provided all information required by the IURO and DOBI to make the preliminary determination. This information includes the IURO appeal form and a copy of any information provided by Horizon NJ Health regarding the decision to deny, reduce or terminate the covered service and a fully executed release to obtain any necessary medical records from Horizon NJ Health and any other relevant health care provider.

Upon completion of the preliminary review, the IURO notifies the covered person and/or provider in writing if the appeal has been accepted for processing and if not, the reason(s) why, within five business days of receipt of the request. The External appeal process is administered by DOBI and is utilized for the review of the appropriate utilization and medical necessity of covered health care services. The services below may not be eligible for the DOBI External appeal process.

1. Adult Family Care
2. Assisted Living Program
3. Assisted Living Services – when the denial is not based on medical necessity
4. Caregiver/Participant Training
5. Chore Services
6. Community Transition Services
7. Home-Based Supportive Care
8. Home-Delivered Meals
9. PCA
10. Respite (Daily and Hourly)
11. Social Day Care
12. Structured Day Program – when the denial is not based on medical necessity
13. Supported Day Services – when the denial is not based on the diagnosis of TBI

Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of Horizon NJ Health’s utilization management determination, the covered person was deprived of medically necessary covered services. In reaching this determination, the IURO will take into consideration all information submitted by the parties and information deemed appropriate in the opinion of the IURO, including pertinent medical records; consulting physician reports and other documents submitted by the parties; any applicable, generally accepted practice guidelines developed by the federal government; national or professional medical societies, boards and associations; and any applicable clinical protocols and/or practice guidelines developed by Horizon NJ Health.

The IURO shall refer all appeals to an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of appeal. All final decisions of the IURO shall be approved by a medical director of the IURO, who shall be a physician licensed to practice medicine in the state of New Jersey. The IURO does not have any direct financial interest in the organization or outcome of the independent review.

The IURO shall complete its review and issue a decision as soon as possible in accordance with medical exigencies of the case. Standard appeals must be completed within 45 calendar days and expedited appeals must be completed within 48 hours.

Once the IURO renders a determination, the decision is binding on Horizon NJ Health and the member, except to the extent that other remedies are available to either party under state or federal law. The IURO will send a written notification of the decision. The decision will be acknowledged in writing by Horizon NJ Health. If the IURO overturns an adverse determination resulting from an Internal appeal, Horizon NJ Health will reprocess the payment (if previously processed) within 10 business days.
Section 6 - Grievance and Appeals Process

External Appeal - Fair Hearing
Only NJ FamilyCare A and NJ FamilyCare ABP members have access to the Fair Hearing Process. Members or providers, acting on behalf of members with the members’ written consent, can request a Fair Hearing within 120 days from the date of the notice of action letter following an adverse determination resulting from an Internal appeal. The internal appeal must be completed prior to a request for a Fair Hearing.

A member has the right to pursue a Fair Hearing after the completion of, in lieu of, or concurrently with an External IURO Appeal. Members enrolled in NJ FamilyCare B, C or D do not have the right to request a Fair Hearing. Those members only have access to Internal and External IURO appeals. Members of these plans have up to 60 days after the adverse determination to file an Internal appeal and, if that is denied, up to 60 days to file an External appeal.

Continuation of Benefits during a Fair Hearing
Although a member has up to 120 days to request a Fair Hearing, he or she must request continuation of benefits during a Fair Hearing within the following timeframes:

- Within 10 calendar days of the notice of action letter following an adverse determination resulting from an Internal Appeal (if he or she wishes to pursue a Fair Hearing concurrently with or instead of an External/ IURO appeal)
- Within 10 calendar days of the notice of action letter following an adverse determination resulting from an External/IURO appeal, or on or before the final day of the previously approved authorization, whichever is later.

If the member did not qualify for a continuation of benefits during a UM Appeal or an IURO Appeal, then the member will not qualify for a continuation of benefits during a Fair Hearing. If the Fair Hearing results in an outcome that is not in favor of the member, he or she may be required to pay for the cost of the services that were provided during the continuation of benefits. If Horizon NJ Health does not cover the services while the Fair Hearing is pending, and the Fair Hearing results in a decision to reverse the adverse determination, Horizon NJ Health must cover the services that were not furnished. If the Fair Hearing results in a decision to uphold the adverse determination, Horizon NJ Health must still pay for the services that were provided during the continuation of benefits.

6.5 Claim Appeals Process
This section describes procedures through which participating and nonparticipating providers, facilities and health care professionals have a right to a written appeal of disputes relating to payment of claims, as defined below. As always, Horizon NJ Health’s procedures are intended to provide our providers, facilities and health care professionals with a prompt, fair and full investigation and resolution of claims issues. The procedure includes a Stage Two external Alternative Dispute Resolution (ADR) option for claim payments that providers, facilities and health care professionals can continue to dispute after pursuing their appeal through Horizon NJ Health’s Stage One internal claims appeal process.

Common Appeal Reasons
No Authorization: Authorization was provided by provider or Horizon NJ Health prior to providing the service to the member.

Untimely Filing: Claim was filed within the required 180 days from the date of service.

Payment Discrepancy: The amount paid was inconsistent with the contracted rate or the established Horizon NJ Health fee schedule.

Member Not Enrolled: The member was enrolled in the Medical Assistance program on the date of service, as evidenced by valid source documentation.

Lack of EOB: Third party liability information has been provided to show the member is not eligible for other coverage or has reached his or her benefit limit.

Claims Editing Discrepancy: Provider, facility or other health care practitioner disagrees with the edits applied to the claim.

Incorrect Denial: The denial code on the claim is not accurate.

No provider, facility or health care professional who exercises the right to file an appeal under this procedure shall be terminated or otherwise penalized for filing and pursuing such an appeal.

When a provider, facility or health care professional is dissatisfied with a claim payment, including payment 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 DOBI. The appeal must be received by Horizon NJ Health within 90 calendar days following receipt by the provider, facility or health care professional of the payer’s claim determination.
To file a claim appeal, a health care professional must mail the appeal application form and any supporting documentation to Horizon NJ Health at the following address:

**Claims Appeals Coordinator Horizon NJ Health**  
PO Box 63000  
Newark, NJ 07101-8064

**IMPORTANT** – Please do not send medical records with administrative claim appeals. Supporting documentation, i.e., proof of timely filing, may be submitted. Please follow all appropriate procedures as defined in this manual before submitting an appeal.

**Stage One**

A Horizon NJ Health employee who serves as an appeals resolution analyst shall review all claim appeals. Appeals resolution analysts are personnel of Horizon NJ Health who are not responsible on a day-to-day basis for the payment of claims. The appeals resolution analyst shall review all submitted documentation and confer with all necessary Horizon NJ Health departments, given the nature of the claim appeal. Upon review by the appeals resolution analyst, a decision will be rendered. The appeals resolution analyst will render a final determination with written notification that will be sent to the facility or health care professional within 30 calendar days of the date of Horizon NJ Health’s receipt of the claim appeal request. The appeal decision will be sent to the contact information that is documented on DOBI’s Claim Appeal Application Form.

Horizon NJ Health has established a binding and non-appealable external alternative dispute resolution (ADR) mechanism that involves arbitration and, in some cases, mediation, for facilities or health care professionals who remain dissatisfied following their pursuit of an appeal through the Stage One internal claim appeal process. These mechanisms are described below.

**Stage Two**

**Alternative Dispute Resolution (ADR)**

All adverse decisions made by a claim appeal reviewer may be appealed by the health care professional through an independent, binding ADR process. Arbitration must be initiated on or before the 90th calendar day following receipt of the determination of an internal appeal.

Disputes must be in the amount of $1,000 or more. Health care professionals may aggregate claims to reach the $1,000 minimum under circumstances in which the same claim issue is involved.

DOBI awarded the independent arbitration organization contract to MAXIMUS, Inc. Parties with claims eligible for arbitration may complete an application at [njpicpa.maximus.com](http://njpicpa.maximus.com) and submit the application, together with required review and arbitration fees, to the Program for Independent Claims Payment Arbitration (PICPA).

Participating and nonparticipating health care professionals may initiate the above binding and non-appealable external ADR review of an adverse decision of a physician or health care professional claim appeal review after the Stage One internal appeal by filing a request for external ADR review with the written findings from the Stage One determination within 90 calendar days from the date of the claim appeals reviewer’s written decision to the following address:

**MAXIMUS, Inc.**  
Attn: New Jersey PICPA 3750 Monroe Ave.  
Suite 705  
Pittsford, NY 14534  
Fax: 1-585-869-3388

External appeals must be initiated through MAXIMUS, Inc., and not through Horizon NJ Health. Further information regarding the Program for Independent Claims Payment Arbitration (PICPA) can be found on MAXIMUS’s website at [njpicpa.maximus.com](http://njpicpa.maximus.com) or on the DOBI website at [www.state.nj.us/dobi/index.html](http://www.state.nj.us/dobi/index.html).

**Additional Review**

Notwithstanding of the above, providers have the right, at any time and regarding any issue, to seek assistance from the following:

**New Jersey Department of Health**  
and Senior Services Office of Managed Care  
PO Box 367  
Trenton, NJ 08625-0367

Or

**New Jersey Department of Banking and Insurance**  
Division of Enforcement and Consumer Protection  
PO Box 329  
Trenton, NJ 08625-0329
Section 7 - Service Departments

Horizon NJ Health has several departments that provide services to our members. Each department performs an important role in helping you provide the highest level of care and professional help to our membership.

7.1 Professional Contracting & Servicing
A Provider Contracting & Strategy Department representative is available to visit your office and/or facility to provide orientation and training on Horizon NJ Health policies and administrative procedures.

Please forward documentation to us regarding changes in your practice, such as:
- Office relocation address
- Changing the name of your practice
- Changing your phone number
- Changing your fax number
- Changing your tax ID number
- Adding or removing a physician to or from your practice
- Changing your hospital affiliation
- Receiving new or updated documents related to your credentialing or recredentialing process
- Changing the open or closed status of your panel (this applies to PCPs only and has a 90 day waiting period)
- Requesting inservice/orientation for yourself, staff or facility
- Changing your address, including your billing address

Please mail or email your notification to our Provider Contracting & Strategy Department at:

**Horizon BCBSNJ**
3 Penn Plaza East
Mail Station PP-14C
Newark, NJ 07105
Email: EnterprisePDM@horizonblue.com

To assist you with the provider update process, a reference guide to the required documentation is noted below. This information can also be found on horizonblue.com/providers/policies-procedures/demographic-updates.

7.2 MLTSS Provider Services
MLTSS Provider Services is available to provide general information about policies, administrative procedures, eligibility, member benefits, member care, billing, claims and capitation inquiries, coordination of benefits and other services available for members.

MLTSS Provider Services is available at 1-855-777-0123, 24 hours a day, seven days a week.

Translation services are available by calling 1-800-682-9094 x89469

7.3 MLTSS Member Services
Horizon NJ Health cares about making sure that members in the MLTSS program have the information they need to make informed decisions and have someone they can speak to if they have any issues or questions. Member Services is available to MLTSS members 24 hours a day, seven days a week. Member Services will:
- Internally represent the interests of MLTSS members and assist them in understanding the MLTSS Services versus Plan Benefit
- Provide education to members, families and providers on issues related to the MLTSS program
- Assist members in navigating Horizon NJ Health’s system
- Be a resource for members by providing information, making referrals to other staff members and resolving issues

MLTSS Member Services can be reached at 1-844-444-4410 (TTY 711), 24 hours a day, seven days a week.

7.4 Utilization Management Department
The Utilization Management (UM) Department coordinates hospital admissions, precertification, discharge planning and home care services. This department also assists physicians in managing the services provided to members. Horizon NJ Health’s UM program oversees the prompt, efficient delivery of quality health care services and evaluates the appropriateness of medical resources utilized by our members.

Prior authorization, concurrent review, discharge planners and care managers are available to coordinate care for members with complex medical and/or social problems, as well as to educate members about covered services and the utilization management process.

**Utilization Management Department**
1-800-682-9094
Monday through Friday, 8 a.m. to 5 p.m.
Saturday and Sunday, 9 a.m. to 5 p.m.

Or

**Provider Services** 1-800-682-9091
Monday through Friday, 8 a.m. to 5 p.m.
7.4.1 UM Ethical Standards

Horizon NJ Health adheres to the following principles in the conduct of the UM program:

- UM decisions made are based solely on the necessity and appropriateness of care and service within the parameter of the member’s Medicaid benefit.
- Horizon NJ Health does not compensate those responsible for making UM decisions in a manner that provides incentive to deny or approve coverage for medically necessary and appropriate covered services.
- Horizon NJ Health does not offer its employees performing UM review incentives to encourage denials of coverage or service that are medically necessary and does not provide financial incentives to hospitals, physicians and other health care professionals to withhold covered health care services that are medically necessary and appropriate.
8.1 Member Rights and Responsibilities

All members have the following rights:

1. To have access to a PCP or a backup doctor, 24 hours a day, 365 days a year, for urgent care
2. To obtain a current directory of doctors within the network
3. To have a choice of specialists
4. To have a second opinion
5. To receive care from an out-of-network provider when a participating Horizon NJ Health provider is not available
6. If a member has a chronic disability, to be referred to specialists who are experienced in treating his or her disability
7. To have a doctor make the decision to deny or limit a member’s coverage
8. To have no “gag rules” in Horizon NJ Health. That means doctors are free to discuss all medical treatment options even if the services are not covered
9. To know how Horizon NJ Health pays its doctors, so a member will know if there are financial incentives or disincentives tied to medical decisions
10. To be free from inappropriate balance billing
11. To be treated with respect and with recognition of their dignity and right to privacy at all times
12. To receive care without regard to race, color, religion, sex, age or national origin
13. To participate with their doctor in making decisions about their health care
14. To information and open discussion about the member’s own medical condition, and the right to choose from different ways of treating his or her condition, regardless of cost or benefit coverage
15. To have the member’s medical condition explained to a family member or guardian if the member is unable to understand, and have it documented in the member’s medical records
16. To refuse medical treatment with an understanding of the results of refusal
17. To call 911 in a potential life-threatening situation – without prior approval from Horizon NJ Health
18. To have Horizon NJ Health pay for a medical screening exam in the ER to determine whether an emergency medical condition exists
19. To postpartum stays in the hospital no less than 48 hours for a normal vaginal delivery and no less than 96 hours following a cesarean section
20. To receive up to 120 days of continued coverage, if medically necessary, from a doctor who has been terminated by Horizon NJ Health including:
   • Up to six months after surgery
   • Six weeks after childbirth
   • One year of psychological or oncologic treatment
No coverage may be continued if the doctor is terminated for cause
21. To timely notification of changes to the member’s benefits or the status of his or her provider
22. To make an advance directive about medical care; Federal law requires providers to ask about a member’s advance directive
23. To receive information about Horizon NJ Health, its services, doctors and providers and the member’s rights and responsibilities
24. To offer suggestions for changes in policy and procedure, including the member’s rights and responsibilities
25. To have access to a member’s own medical records at no charge to the member
26. To privacy of the member’s medical information and records
27. To refuse the release of personal information (except when required or permitted by law)
28. To be informed in writing if Horizon NJ Health decides to end a member’s membership
29. To tell Horizon NJ Health when a member no longer wishes to be a member
30. To appeal a decision to deny or limit coverage, first within Horizon NJ Health and then through an independent organization
31. To appeal any Horizon NJ Health decision, the care it provides, benefits or membership
32. To file a grievance about the organization or the care provided in the member’s primary language
33. To know that a member or his or her doctor cannot be penalized for filing a complaint or appeal
34. To contact the Department of Banking and Insurance or the Department of Human Services whenever the member is not satisfied with Horizon NJ Health’s resolution of a grievance or appeal
35. To give consent and make informed decisions about treatment of a member’s minor dependents
36. Horizon NJ Health will provide care for members younger than 18 years old following all laws and treatment and will be at the request of the minor’s parent(s) or other person(s) who have legal responsibility for the minor’s medical care. Under certain circumstances, New Jersey law allows minors to make health care decisions for themselves
Horizon NJ Health will allow treatment without parental consent in the following cases:

- Minors who go to an ER for treatment and that treatment is determined to be medically necessary
- Minors who want family planning services, maternity care or sexually transmitted diseases (STD) services

All members have the following responsibilities:

1. To treat health care providers with same respect and kindness in which the member expects to be treated
2. To talk openly and honestly, and seek care regularly from a doctor
3. To abide by Horizon NJ Health’s rules for medical care
4. To give information to a doctor and Horizon NJ Health in order for them to provide care
5. To ask questions of their doctor(s) so that members can understand their health problems and the care they are receiving and participate in developing mutually agreed-upon treatment goals
6. To follow their doctor’s advice that was agreed upon, or to consider the results if they choose not to
7. To keep appointments and call in advance if an appointment must be cancelled
8. To read all the Horizon NJ Health materials and follow the rules of membership
9. To follow the proper steps when making complaints about care
10. To take advantage of educational opportunities to learn about health issues
11. To pay any copayments and/or premiums, when applicable
12. To inform the Health Benefits coordinator and Horizon NJ Health about any doctors the member is currently seeing at the time of enrollment

8.1.1 MLTSS Member Rights and Responsibilities

In addition to the rights a traditional Horizon NJ Health member has, an MLTSS member has the right to:

1. Ask for and receive information on the choice of services and providers available.
2. Have access to and choice of qualified service providers.
3. Be told about all of their rights before receiving chosen and approved services.
4. Get services no matter what their race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability.
5. Have access to all services that are best for their health and welfare.
6. Make the right decisions after being made to understand the risks and possible effects of the decisions made.
7. Make decisions about their own care needs.
8. Help develop and change their own Plan of Care.
9. Ask for changes in services at any time, including to add, increase, decrease or discontinue them.
10. Ask for and receive from their Care Manager a list of names and duties of any providers assigned to provide services to them under the Plan of Care.
11. Receive support and direction from their Care Manager to resolve concerns about their care needs and/or complaints about services or providers.
12. Be told about a list of resident rights, and receive a copy in writing, upon admission to an institution or community residential setting.
13. Be told of all the covered/required services they are entitled to, required by and/or offered by the institutional or residential setting, and of any charges not covered by Horizon NJ Health while in the facility.
14. Not to be discharged or transferred out of a facility unless it is medically necessary; to protect their welfare and safety as well as the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice, to pay the facility from available income as reported on the statement of available income for Medicaid payment.
15. Have Horizon NJ Health protect and promote all their rights.
16. Have all rights and responsibilities outlined here shared with their authorized representative or court-appointed legal guardian.

Along with rights come responsibilities, here are some of the key responsibilities for MLTSS members:

1. Provide all health- and treatment-related information, including but not limited to, medication, circumstances, living arrangements, and informal and formal supports, to the Care Manager to identify care needs and develop a Plan of Care.
2. Understand their health care needs and work with their Care Manager to develop or change goals and services.
3. Work with their Care Manager to develop and/or revise their Plan of Care to facilitate timely authorization and delivery of services.
4. Ask questions when they need more information.
5. Understand the risks that come with their decisions about care.
6. Understand that Horizon NJ Health does not provide 24/7 care management services and that they will need to work with family and friends to safeguard against potential risks.

7. Develop an emergency back-up plan for care and services with their Care Manager.

8. Report any major changes about their health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager.

9. Notify their Care Manager should any problems occur or if they are not pleased with the services being provided.

10. Pay their room and board in a nursing facility or community residential setting and their cost share on time each month (if applicable).

11. Treat service workers and care providers with dignity and respect.

12. Keep all Horizon NJ Health documents, such as their Plan of Care, emergency back-up plan, etc., for their personal records and future reference.

13. Follow Horizon NJ Health’s rules and/or those rules of institutional or community residential settings.

14. Comply with care management activities and allow visits per the contract.

8.2 Member Non-Compliance

Please call the Member Services Department when a member does not abide by the member responsibilities, continues with disruptive behavior or refuses to comply with the recommended treatment program. MLTSS Member Services will contact the member to discuss his or her responsibilities as a Horizon NJ Health member and seek to find a resolution to the situation.

Member Services 1-844-444-4410
24 hours, seven days a week

A healthy relationship between a provider and a member is important. If the provider believes that he/she cannot have this with a member, the provider may ask that the member receive services from another provider. Other circumstances in which a provider may request that a member be changed to another provider include:

- Inability to solve conflicts between the member and his or her provider
- If a member fails to comply with health care instructions, where such non-compliance prevents the physician from safely or ethically proceeding with the member’s health care services
- If a member has taken legal action against the provider

8.3 Horizon NJ Health Policies and Procedures

Because Horizon NJ Health’s policies and procedures are intended to comply with federal and state requirements for the Medical Assistance program, providers are responsible for abiding by federal and state laws, regulations and program requirements, including the provisions of the contract between Horizon NJ Health and the New Jersey Department of Human Services.

8.4 Medically Necessary Services

The Division of Medical Assistance and Health Services (DMAHS), through regulation NJAC 10:74-1.4, defines medically necessary services as set forth below:

Medically necessary services are services or supplies necessary to prevent, 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 enrollee. 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 enrollee and not solely for the convenience of the enrollee 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, when appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion and medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services,
including 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 enrollees) 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.

The Health Claims Authorization, Processing and Payment Act (HCAPPA) defines medical necessity or medically necessary as follows:

“Medical necessity” or “medically necessary” means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance with the “generally accepted standards of medical practice;” clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the covered person’s illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person’s illness, injury or disease.

Horizon NJ Health believes that the DMAHS definition, which we are mandated to use by the State Contract and NJAC 10:74-1.4, incorporates the language and principles of the HCAPP definition. Therefore, Horizon NJ Health’s Utilization Management (UM) program will function under the definitions in the same way as it has previously, utilizing the language from DMAHS found at NJAC 10:74-1.4. Furthermore, our medical policies and UM criteria used to help Horizon NJ Health reach decisions about medical necessity for coverage purposes reflect compliance with both definitions.

8.5 Clinical Practice Guidelines

Clinical practice guidelines are initiated and then re-evaluated biannually by Horizon NJ Health or more frequently in the event that new scientific evidence or national standards are published or such national guidelines change during the time period between biannual reviews. References to these guidelines are available on the Horizon NJ Health website, horizonNJhealth.com, or Appendix A of this manual.

8.6 Referrals

Primary Care Providers do not need to provide referrals for in-network specialist services. As a reminder, Horizon NJ Health members must:
- Use in-network doctors and health care providers for all services.
- Request authorization for out-of-network specialist services.

Out-of-Network Referrals

Occasionally, a member’s needs cannot be provided through the Horizon NJ Health network of physicians and health care professionals. When the need for out-of-network services occurs, the physician must contact the Utilization Management department. The Utilization Management department, in collaboration with the recommendations of the PCP, will arrange for the member to receive the necessary medical services with a specialty care physician. Every effort will be made to locate an in-network specialty care physician. Members who seek self-initiated care from a nonparticipating physician or a non-covered service will be responsible for the cost of the care.

Utilization Management Department
1-800-682-9094

8.7 Confidentiality Statement

The provider agrees and understands that all information, records, data and data elements collected and maintained for the operation of the provider, Horizon NJ Health and the Department of Human Services of the State of New Jersey and pertaining to Horizon NJ Health members, shall be protected from unauthorized disclosure, in accordance with the provisions of 42 CFR Part 1396 (a) (7) (Section 1902 (a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, N.J.S.A. 30:4D-7 (g) and N.J.A.C 10:49-9.7, and any and all applicable state and federal laws and regulations. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of the your Agreement with Horizon NJ Health including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For Horizon NJ Health members who are eligible through the Division of Child Protection and Permanency, records must be kept in accordance with the provision under N.J.S.A 9:6-8.10a and 9:6-8.40 and any and all applicable state and federal laws and regulations, consistent with the need to protect the members’ confidentiality.
8.7.1 Enrollee-Specific Information

With respect to any identifiable information concerning Horizon NJ Health members that is obtained by the provider, it: (a) shall not use any such information for any purpose other than carrying out the express terms of your Agreement with Horizon NJ Health; (b) shall promptly transmit to Horizon NJ Health and DMAHS all requests for disclosure of such information; (c) shall not disclose, except as otherwise specifically permitted by Horizon NJ Health, any such information to any party other than DMAHS without Horizon NJ Health or DMAHS’s prior written authorization specifying that the information is releasable under Title 42 CFR, Section 431, 300et seq.; and (d) shall, at the expiration or termination of your Agreement with Horizon NJ Health, return all such information to Horizon NJ Health and/or DMAHS or maintain such information according to written procedures set by DMAHS for this purpose.

8.7.2 Employees

The provider shall instruct his or her employees to keep confidential information concerning the business of Horizon NJ Health or DMAHS, its financial affairs, its relations with members and its employees, as well as any other information that may be specifically classified as confidential by law.

Medical records and management of information data concerning Medicaid beneficiaries enrolled pursuant to your Agreement with Horizon NJ Health shall be confidential and disclosed to other persons within the provider’s organization only as necessary to provide medical care and quality peer or grievance review of medical care under the terms of your Agreement with Horizon NJ Health.

The provisions of this section shall survive the termination of your Agreement with Horizon NJ Health and shall bind the provider, so long as the physician and health care professional maintain any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

8.8 Affirmative Statement

The provider is encouraged to freely communicate with members regarding available treatment options, including medication treatment that may or may not be a covered benefit under Horizon NJ Health.

Horizon NJ Health distributes a statement to providers and employees who make UM decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage
- Horizon NJ Health does not specifically reward providers or other individuals for issuing denials of coverage or care
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization

8.9 Non-Discrimination Statement

The provider shall comply with the following requirements regarding non-discrimination:

- The provider shall accept assignment of a Horizon NJ Health member and not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental handicap, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

- ADA Compliance. In providing health care services, the provider shall not directly or indirectly, through contractual, licensing or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are “qualified individuals with a disability” covered by the provisions of the ADA.

- A “qualified individual with a disability” is defined as an individual with a disability who, with or without reasonable modifications to rules, policies or practices; the removal of architectural, communication or transportation barriers; or the provision of auxiliary aids and services, meets the essential eligibility requirements for the recipient of services or the participation in programs or activities provided by a public entity.
• Horizon NJ Health shall submit a written certification to DMAHS that it is conversant with the requirements of the ADA, is in compliance with the law and has assessed its provider network and certifies that the providers meet ADA requirements to the best of the provider's knowledge. The provider warrants that he or she will hold the state harmless and indemnify the state from any liability, which may be imposed upon the state as a result of any failure of the provider to be in compliance with the Act. Where applicable, the provider must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

• The provider shall not discriminate against eligible persons or members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider, or the eligible person's actuarial class or pre-existing medical/health conditions.

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

• The provider shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations or orders that prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion or national origin or ancestry. There shall be no discrimination against any employee engaged in the work required to produce the services covered by your Agreement, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

• Horizon NJ Health and the provider shall not discriminate with respect to participation, reimbursement or indemnification as to any provider, who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit Horizon NJ Health from including the provider, only to the extent necessary to meet the needs of the organization's members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

• Scope. This non-discrimination provision shall apply to, but not be limited to, the following: recruitment, hiring, employment upgrading, demotion, transfer, layoff or termination, rates of pay or other forms of compensation and selection for training, including apprenticeship included in PL 1975, Chapter 127.

• Grievances. The provider agrees that copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation or physical or mental handicap shall be forwarded to DMAHS for review and appropriate action within three business days of receipt by the provider.

8.10 Indemnification and Hold Harmless

As required by the New Jersey Medicaid program, at all times during the term of your Agreement, the provider shall indemnify, defend and hold the State of New Jersey and members harmless from and against all claims, damages, causes of action, cost or expense, including reasonable attorney’s fees, to the extent such actions were caused by any negligent act or other wrongful conduct by the provider or provider’s employee(s) arising with respect to the provider’s services to members.

Billing Members

The provider agrees that under no circumstances (including, but not limited to, nonpayment by Horizon NJ Health, insolvency of the managed care plan or breach of agreement) will the provider bill, charge or seek compensation, remuneration or reimbursement from or have recourse against enrollees, or persons acting on their behalf, for covered services, except for applicable copayments as designated by Horizon NJ Health. However, a provider may charge DMAHS for Medicaid services not included in Horizon NJ Health’s benefits package under this contract on a New Jersey Medicaid fee-for-service basis.

The provider may charge members when they seek care on their own for non-covered services. The provider is required to notify the member in writing before the service is rendered and receive the member’s agreement to pay for all or part of the provider’s charges.
The provider agrees that this provision shall survive the termination of your Agreement with Horizon NJ Health regardless of the reason for termination, including insolvency of Horizon HMO or Horizon NJ Health, and shall be construed to be for the benefit of Horizon HMO and the members. The provider agrees that this obligation supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider and the members, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services, provided under the terms and conditions of this continuation of benefits provision.

8.11 Credentialing

The use of thorough screening of credentialing criteria is an important step in maintaining the quality of the Horizon NJ Health provider network.

Horizon NJ Health also uses strict standards for the credentialing of its provider network following guidelines of an external accrediting organization. Evaluation of a credentialing application includes review of the following:

- Accreditation
- Current state licensure
- Medicare/Medicaid certification
- Medicare/Medicaid sanction activity
- Professional liability coverage (malpractice)
- Satisfactory history of malpractice claims and settlements

In addition, site visits may be conducted to ensure that our members are receiving treatment in an appropriate, clean and safe environment that adheres to Occupational Safety and Health Administration and Clinical Laboratory Improvement Amendments standards and respects member privacy.

Updates to all credentialing information must be reported as changes occur. Copies of provider credentialing information are kept on file and must be updated every three years at recredentialing. Please send copies of these documents, since they are required.

8.12 Recredentialing

Recredentialing of providers will be conducted by Horizon NJ Health every three years. This process will include an update of all credentialing information, as well as the following:

- Correspondence between the medical management program and the provider
- Actions of the utilization and quality improvement committees
- Economic and medical utilization data
- Compliance with Horizon NJ Health policies and procedures
- Patient satisfaction or complaint response information
- Other pertinent data recommendations will be made to the medical director if any change in participation status is deemed necessary

8.13 Subrogation

Subrogation by Horizon NJ Health operates in compliance with the requirements of Department of Health and Senior Services Bulletin No. 01-11 and the New Jersey Supreme Court ruling Perreira v. Rediger et al., A-145-99.

To help control health care costs, Horizon NJ Health is obligated to attempt to recover payments made for medical services that result from injuries caused by the negligence or wrongful acts of another person.

Subrogation clauses in the State Contract permit the State of New Jersey to recover benefit payments from a third party who is determined to be liable.

Since subrogation cases are often not settled until months after an accident, Horizon NJ Health will not delay claim payment until litigation is final or a settlement is reached. Payment will be made and recovery will be pursued by the State of New Jersey.

If a member is injured or becomes ill through the act of a third party, Horizon NJ Health is responsible for providing care to that individual and then identifying that individual to the New Jersey Department of Human Services.

In cases where there is a legal cause of action for damages, the Department of Human Services has the sole and exclusive right to pursue and collect payments when a legal cause of action for damages is instituted on behalf of a Medicaid enrollee against a third party or when the state receives notice that legal counsel has been retained by or on behalf of any enrollee.

If services are provided to a member who is ill or injured as the result of a third party action, the provider must notify Horizon NJ Health. Even after a claim has been made, the provider should notify Horizon NJ Health of any lawsuits or legal action for which they are aware and that are related to the injury or condition treated. For questions, contact MLTSS Provider Services at 1-855-777-0123.
8.14 Treatment of Minors Policy

Provider agrees to provide medical treatment to minors in accordance with applicable law; and, to the extent required, treatment will be in accordance with the wishes of parent(s) or other person(s) having legal responsibility for the minor’s medical care.

Under certain circumstances, New Jersey law authorizes minors to make health care decisions on their own behalf. Horizon NJ Health will not deny access to medical care in the following situations:

- Minors presenting themselves for family planning services, maternity care or sexually transmitted diseases (STD) services
- Minors 14 years or older presenting themselves for drug/alcohol or mental health treatment

8.15 Americans with Disabilities Act

All physicians and health care professionals agree to comply with the Americans with Disabilities Act of 1990 (ADA), all amendments to that act and all regulations promulgated thereunder. Horizon NJ Health is required by the State of New Jersey to conduct a formal ADA physician survey. Horizon NJ Health also conducts a special needs survey. If you have not completed either survey, please do so at your earliest convenience.

The surveys will provide handicap accessibility information regarding your practice facility or business location and information regarding your experience in treating members with special facility or business needs. Your responses will provide helpful information to special needs members, their families and caretakers, including other physicians who might require this information.

You will find ADA survey and special needs survey forms on the Horizon NJ Health website. Please follow the directions below to complete the surveys. The surveys will take approximately 10 minutes to complete.

ADA Provider Survey

- Read the survey thoroughly
- Answer each question appropriately
- Sign and date the survey
- Please use black or blue ink

Note: If you have 15 or fewer employees at your location, please complete only questions 1-4 (a-g) and sign Statement II on page 6 of the survey.

Special Needs Survey

- Read the survey thoroughly
- Answer each question appropriately

8.16 Domestic Violence Reporting

The health care provider is a primary source in identifying members who may have been subjected to domestic violence. Domestic violence includes both abuse and battery. Abuse is a pattern of coercive control that one person exercises over another. Battery is a behavior that physically harms, arouses fear, prevents a partner from doing what they wish or forces them to behave in ways they do not want.

State law requires the reporting of child abuse. Reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Immediately report any suspected child abuse or neglect to the Division of Child Protection and Permanency at 1-877-NJABUSE (1-877-652-2873). Calls can be received 24 hours a day, seven days a week.

The provider is responsible to report suspected cases of elder or partner abuse, neglect or exploitation that occurs in the community. Immediately report any suspected elder or partner abuse to the state’s Department of Adult Protective Services at 1-609-588-6501.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report
suspected abuse or neglect may be subject to a fine up
to $1,000 or imprisonment up to six months.

To help identify domestic violence, the below questions
have been developed by the Family Violence Prevention
Fund.

Domestic Violence Screening Tools

Framing Statements:
• Because violence is so common in many people’s
  lives, I’ve begun to ask all my patients about it.
• I’m concerned that your symptoms may have been
  caused by someone hurting you.
• I don’t know if this is a problem for you, but many of
  the women I see as patients are dealing with abusive
  relationships. Some are too afraid or uncomfortable
  to bring it up themselves, so I’ve started asking about
  it routinely.

Direct Verbal Questions:
• Are you in a relationship with a person who physically
  hurts or threatens you?
• Did someone cause these injuries? Was it your
  partner/husband?
• Has your partner or ex-partner ever hit you or
  physically hurt you? Has he ever threatened to hurt
  you or someone close to you?
• Do you feel controlled or isolated by your partner?
• Do you ever feel afraid of your partner? Do you feel
  you are in danger? Is it safe for you to go home?
• Has your partner ever forced you to have sex when
  you didn’t want to? Has your partner ever refused to
  practice safe sex?

8.17 Change in Address

A Horizon NJ Health for change of information form
must be completed and request in advance when a
participating physician or provider changes phone
numbers, practice locations, billing address, tax ID or any
operational changes, such as business hours.

The guide for updating information can be found at
horizonNJhealth.com/demographicupdates. Requests
may be submitted to EnterprisePDM@horizonblue.com,
or mailed to Horizon BCBSNJ, 3 Penn Plaza East, Mail
Station PP 14 C, Newark, NJ 07105. Please allow 30 days
for processing time.

8.18 Workers’ Compensation

Workers’ compensation covers any injury or illness that is
the result of a work-related accident. Employers purchase
the insurance. You should always bill the workers’
compensation carrier for work-related illnesses or injuries.

Payment will not be made for services provided to a
member for any injury, condition or disease if payment
is available under workers’ compensation laws.

8.19 Financial Disclosure

If you have annual revenues from Horizon NJ Health in
excess of $25,000, you agree to cooperate with Horizon
NJ Health in the disclosure of significant business
transactions between you and Horizon NJ Health.
Transactions to be reported include any sale, exchange
or leasing of property, any furnishing for consideration of
goods, services or facilities (but not employee salaries)
and any loans or extensions of credit.

8.20 Corrective Action

Horizon NJ Health is committed to working cooperatively
with participating physicians to resolve any identified
areas of noncompliance with administrative or
quality standards. In order to prevent and avoid such
noncompliance, all attempts will be made to educate our
physicians on our policies and procedures.

Steps in the corrective action process include, but are not
limited to, the following:
• Provider notification of Horizon NJ Health standards
  and clinical practice guidelines. (See Appendix A
  Preventive and Clinical Guidelines.)
• Provider is monitored against these guidelines.
• Administrative or quality-of-care issues are identified
  by Horizon NJ Health staff and reviewed by the
  medical director.
• Medical director identifies deficiencies that need
  to be reviewed by the Peer Review Committee
  (hereafter identified as the “committee.”)
• If the committee or medical director identifies a
  concern, the provider is notified and given the
  opportunity to respond before a final determination
  is made.

The Corrective Action Program contains important
safeguards for the provider to ensure that all decisions are
made fairly with the goal of improving quality of care and
service to our members.
8.21 Sanctions and Appeals of Sanctions

It is the goal of Horizon NJ Health to resolve identified provider deficiencies in a fair manner, which allows an opportunity for provider education and fair due process, where indicated. When non-compliance significantly affects the quality of care provided to the member, Horizon NJ Health may impose sanctions through the Corrective Action Program. Sanctions will only be imposed after a thorough review of the issue.

Severity Levels of Sanctions

Level Zero: No quality-of-care or service issue and/or no evidence of failure to comply with documented administrative policies and procedures.

Level One: Includes failure to comply with documented administrative policies and procedures of, and contractual obligations with, Horizon NJ Health (i.e., EPSDT, Case Management, Quality Management, Claims, Recipient Restriction, Pharmacy, Provider Services and Grievances). Examples include but are not limited to:
- Failed site evaluation
- Failed medical record review
- Failure to precertify procedures
- Failure to comply with complaint protocol

Level Two: Will be imposed upon providers who have greater than five occurrences of Level One sanctions or for activities that are documented quality-of-care concerns. Examples include but are not limited to:
- Documented pattern of member complaints
- Grossly negligent professional behavior
- Quality-of-care and/or service concerns

Sanctions and Appeal Process

1. The Quality Peer Review Committee (QPRC) will send the provider a letter outlining the decision and committee recommendations, including an action plan, if applicable. Actions that can be taken related to identified deficiencies include, but are not limited to:
   - Individual provider education
   - Educational seminars
   - Request for a corrective action plan
   - Site visit
   - Freezing of patient panel and/or incentive payment
   - Termination from the provider network

2. Following the QPRC determination, the file is forwarded to the Quality Management Department and a copy of the resolution letter is placed in the file. If the provider does not respond within 30 days from the initial QPRC determination, a copy of the resolution letter is forwarded to Horizon Blue Cross Blue Shield of New Jersey’s Credentialing Department to place in the provider’s credentialing file. The requested corrective action plan(s) are tracked for receipt.

3. A corrective action plan, if requested, is due within 30 days of receipt of our letter. When the plan is received, it will be reviewed by a medical director and forwarded to the next QPRC meeting. The QPRC determines if the plan is accepted. If it is accepted, the plan will be placed in the file and the case closed. If the plan is not accepted, a committee member will contact the provider, either by telephone or mail, to identify the areas of concern and await a response, which is due within 10 days. If no plan is received within 10 days, the case will be brought back to the QPRC for further action.

4. If the provider does not agree with the determination of the QPRC regarding a Level One or Level Two Sanction, the provider may appeal the decision in writing to the Quality Management Department within 30 days of receipt of the determination to request a hearing.

5. A Hearing Committee shall be established to preside over the hearing, which shall take place within 30 days. The committee shall consist of at least three people, at least one of whom must be a clinical peer in the same or substantially similar discipline and specialty as the health care professional. This peer may not be an employee of Horizon NJ Health, but shall be a participating provider who is not otherwise involved in the plan management. If the health care professional consents, the hearing may be conducted by conference telephone or any means of communication by which all persons participating in the hearing are able to hear each other. The decision of the committee shall be by majority vote.

6. If applicable, after the close of the First Level Hearing, the provider is notified of the Hearing Committee’s decision within 30 days. If the provider does not respond within 10 days to the First Level Hearing determination, a copy of the resolution letter is forwarded to Horizon Blue Cross Blue Shield of New Jersey’s Credentialing Department to place in the provider’s credentialing file.
Section 8 - Policies and Procedures

7. If the provider does not agree with the First Level Hearing decision, the provider has the right to submit a second level appeal request in writing, within 10 days, directly to either the chief medical officer if appealing a professional competency action, or the president/chief operating officer or designee if appealing an administrative action. The chief medical officer or the president/chief operating officer or designee shall then convene a Second Level Appeal Hearing Committee, which shall consist of at least three people who were not involved with the First Level Appeal. Furthermore, the Second Level Appeal Hearing Committee shall include at least one provider who is a clinical peer in the same or substantially similar discipline and specialty as the health care professional. This peer, as in the case of the First Level Hearing Committee, may not be an employee of Horizon NJ Health, but still may be a participating provider who is not otherwise involved in the plan management. The Second Level Appeal Hearing Committee shall conduct a hearing, as described in Section 6, and issue its decision with the exception that no further appeal rights following the Second Level Appeal shall be available, as described. As such, the decision reached through this Second Level Appeal process shall be final.

8. At the conclusion of the Second Level Hearing, the provider is notified of the Second Level Hearing committee's decision within 30 days and a copy of the resolution letter is forwarded to Horizon Blue Cross Blue Shield of New Jersey's Credentialing Department to place in the provider's credentialing file.

If formal sanctioning proceedings are implemented and the outcome is not in favor of the provider, the National Practitioner Data Bank may need to be notified depending on the severity of the deficiency and the associated sanction and corrective action.

8.22 Termination

Providers must notify Horizon NJ Health 90 days prior to their intent to terminate their contract.

Written notifications must be sent by certified mail to:

Horizon NJ Health
Professional Contracting & Servicing Department
1700 American Blvd.
Pennington, NJ 08534

Horizon NJ Health will notify members of the provider termination at least 30 days prior to the termination date.
Appendix A – Glossary of Terms

The following glossary of terms is used in conjunction with this manual and in Horizon NJ Health provider contracts.

1.0 Provider

“Affiliate” means any entity, as previously identified or as identified in the future by HMO as an affiliate, which owns or is owned by HMO, directly or indirectly, and any entity, as previously identified or as identified in the future by HMO as an affiliate, which is under common ownership, directly or indirectly, with HMO.

“Capitation” means the prospective payment for primary care services (as defined herein) made at a predetermined, monthly rate reflecting the number of persons in a Primary Care Provider (PCP)’s panel (as defined herein).

“Claim” means a request for payment of charges for services rendered or supplied, provided by a provider to a member.

“Clean claim” means a claim that has no defect or impropriety, including any lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment being made on the claim. A “clean claim” is a claim, or part of a claim, which can be paid exactly as submitted without the need for further documentation or explanation.

“CMS” means the Centers for Medicare & Medicaid Services of the United States government.

“Coinsurance” means a percent of the payment (as defined herein) that a member is responsible to pay for covered services.

“Contested claim” means a claim, or part of a claim, that has not been adjudicated because it has a material defect or impropriety. A “contested claim” is a claim, or part of a claim, which cannot be paid because further documentation or explanation is necessary before the claim can be considered a clean claim.

“Copayment” means a specified dollar amount that a member is responsible to pay for covered services.

“Covered service” means those medically necessary health care services, as set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which members are entitled under the New Jersey Medicaid program unless expressly provided in the Medicaid/NJ FamilyCare contract or set forth in the Provider Manual.

“Declined claim” means a claim that is not covered because the member is not a covered member, the member has not used a Horizon NJ Health network provider, the particular service is not a covered service under the member’s contract or requested information or documentation has not been submitted in a timely manner.

“Emergency services” shall mean health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 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 a bodily organ or party. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

“Health benefit plan” means the contract describing the benefits partially or wholly insured, underwritten by the State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services and administered by Horizon NJ Health of which you have received or will receive written notice that this agreement applies.

“Medical emergency” means health care services required to treat a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 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 a bodily organ or party. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to affect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

“Member” means an enrolled participant in the HMO relating to the managed Medicaid and NJ FamilyCare programs.

“Network hospital” means a hospital that has a contractual arrangement with Horizon NJ Health to provide covered services for certain inpatient and outpatient hospital services.

“Panel” means the group of members who have notified Horizon NJ Health that they have selected you to be their PCP or who may be assigned to you.
Appendix A – Glossary of Terms

“Participating physician” means a physician who has a contractual arrangement with HMO relating to the managed Medicaid and NJ FamilyCare programs.

“Participating provider” means a participating physician, network hospital or other health care professional or entity who has a contractual arrangement with HMO relating to the managed Medicaid and NJ FamilyCare programs.

“Payment” means the amount payable to you for covered services, which shall be either of the following types: (i) provider’s billed charges or Horizon NJ Health’s applicable fee, whichever is less; or (ii) capitation. You acknowledge that the type of payment generally and the type of payment for any particular covered service is determined by Horizon NJ Health and is subject to revision from time to time.

“Primary Care Provider” means any duly licensed medical doctor (MD) or doctor of osteopathy (DO) who has entered into a physician agreement with the HMO relating to the managed Medicaid and NJ FamilyCare programs, and who is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnoses and treatment of illness or injury, coordination of overall medical care, record maintenance and for maintaining continuity of patient care.

“Primary care services” means the following medically necessary basic health care services:

- All primary ambulatory care visits and routine office procedures; periodic physical examinations
- Appropriate referrals to specialty physicians and other health care providers, who have an agreement with HMO relating to the managed Medicaid and NJ FamilyCare programs to provide services to members. In the case of a medical emergency, no prior authorization or approval is required for referral to a non-affiliated provider. Horizon NJ Health shall periodically supply to the physician a list of primary care and specialty physicians affiliated with the managed Medicaid and NJ FamilyCare programs
- Provision or arrangement for primary care services 24 hours a day, seven days per week
- Obtaining of lab specimens for lab studies, including Pap tests and phlebotomy services
- Supervision, coordination and management of the member’s care

“Specialty physician” means a duly licensed medical doctor (MD) or doctor of osteopathy (DO), other than a PCP, who has entered into a physician agreement with the HMO relating to the managed Medicaid and NJ FamilyCare programs, and who is responsible for providing health care services that are ordered and approved by the PCP or Horizon NJ Health.

“Specialty physician services” means those medically necessary covered services provided by participating physicians, which are not primary care services.

“You,” “provider,” “provider/subcontractor” means the provider bound by this agreement.
Appendix B – Contract Compliance

The State of New Jersey requires that any provider/subcontractor who agrees to serve Medicaid/NJ FamilyCare members comply with all the following provisions. Any changes made to the required verbatim language by the State of New Jersey shall be deemed to be incorporated herein by reference without amendment, and provider/subcontractor shall remain apprised of, and comply with, any such changes.

The provider/subcontractor agrees to serve enrollees in New Jersey’s managed care program and, in doing so, to comply with all of the following provisions:

A. Subjection of provider contract/subcontract

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor’s provider network requirements shall be included in the Contractor’s provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based NF, SCNF, AL and CRS join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.


3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

4. Any Willing and Qualified Provider (AWQP): MLTSS. AWQP refers to any New Jersey Based nursing facility (NF) provider that meets the criteria defined below in Section N. In order to be an AWQP and in the Contractor’s network, the New Jersey-Based NF must meet any four of the following seven quality performance measures in what is herein known as the NF Quality Improvement Initiative. The first five measures are part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified NFs as part of the Minimum Data Set (MDS):

a. The NF shall be at or above the statewide average of the percentage of long stay residents who are immunized against influenza. This measure is calculated annually during the influenza season.

b. The NF shall be at or below the statewide average of the percentage of long stay residents who receive an antipsychotic medication. The measure could be met with any four of the most recent six quarters examined.

c. The NF shall be at or below the statewide average of the percentage of long-stay, high risk residents with a pressure ulcer. The measure could be met with any four of the most recent six quarters examined.

d. The NF shall be at or below the statewide average of the percentage of long stay residents who are physically restrained. The measure could be met with any four of the most recent six quarters examined.

e. The NF shall be at or below the statewide average of the percentage of long stay residents who experience one or more falls with a major injury. The measure could be met with any four of the most recent six quarters examined.

f. These two additional measures are also included in the NF Quality Improvement Initiative:
Appendix B – Contract Compliance

i. The CoreQ Long-Stay Resident Experience Questionnaire and the CoreQ Long-Stay Family Questionnaire will measure NF resident and family satisfaction across all NFs. It will provide the average CoreQ satisfaction rating for each NF, which combines the satisfaction scores of both the long-stay residents and their family members. There will be benchmarks of the average resident score and the CoreQ satisfaction rating that the NF shall meet or exceed.

ii. This performance measure will ask the NF whether the facility is using INTERACT, Advancing Excellence Tools, TrendTracker or another validated tool to measure 30-day re-hospitalizations and overall hospital utilization. The NF shall directly provide a response of yes or no.

5. While the following are general provisions in the AWQP policy, they will be outlined in guidance and procedures and issued by the State prior to the implementation of the NF Quality Improvement Initiative:

• In cooperation with the State, the Contractor shall be responsible for notifying NFs, which fail to meet any four out of seven performance quality measures, that no new MLTSS enrollments for their members will be forthcoming; and for MLTSS members currently residing in the NF, the Contractor will enter into single case agreements.

• The Contractor may not contract with a NF for new MLTSS admissions that does not meet any four out of seven performance quality measures.

• The Contractor shall focus their NF care management on working with the NFs to improve their performance quality measures.

• The NF shall be able to appeal to the State for reconsideration of network exclusion. Exceptions may be made by the State for NFs that have a population with disproportionate needs, etc.

The NF shall be able to enter into a corrective action plan with the State if it doesn’t meet any four of the seven measures.

Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;
2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. Compliance with federal and state laws and regulations

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.
2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.
3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer’s Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. Approval of provider contracts/subcontracts and amendments

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. Effective date

This provider contract/subcontract shall become effective only when the Contractor’s agreement with the State takes effect.

E. Non-renewal/termination of provider/subcontract

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor’s network. If the termination was “for cause,” as related to fraud, waste, and abuse, the
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Contractor’s notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute “cause” unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. Enrollee-provider communications

1. The Contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider/subcontractor’s patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider/subcontractor’s patient. Providers/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractor shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:
   a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or
   b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontract or to otherwise require the Contractor to reimburse providers/subcontractors for benefits not covered.

G. Restriction on termination of provider contract/subcontract by contractor

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor’s decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor’s decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient’s medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of the Contractor, or the provider/subcontractor’s personal recommendation regarding selection of a health plan based on the provider/subcontractor’s personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. Termination of provider contract/subcontract by state

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;
2. Takes any action that threatens the fiscal integrity of the Medicaid program;
3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;
5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;
6. Materially breaches the provider contract/subcontract; or
7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. Non-discrimination

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are “qualified individuals with a disability” covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A “qualified individual with a disability” as defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to Horizon a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor’s knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person’s actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to Horizon copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.
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J. Obligation to provide services after the period of the contractor's insolvency and to hold enrollees and former enrollees harmless

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.


K. Inspection

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b)(1).

L. Medical record administration

M. Records maintenance

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

N. Record retention and provider/subcontractor documentation requirements

Provider/Subcontractor Documentation Requirements

- The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8.

The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A 30:4D-12(e) and N.J.A.C. 10:49-5.5(a)(13)(i) through (iv) may apply to these documentation requirements.
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Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10(a) and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Contractor, the Provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

Compliance with Specific Requirements - Providers/subcontractors must comply with the following requirements:

1. Medical supplies and DME:
   a. Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:
   i. The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;
   ii. A detailed description of the specific supplies and/or equipment prescribed;
      (1) For example, the phrase “wheelchair” or “patient needs wheelchair” is insufficient. The order shall describe the type and style of the wheelchair;
   iii. The length of time the medical equipment items or supplies are required;
   iv. A diagnosis and summary of the patient’s physical condition to support the need for the item(s) prescribed; and
   v. The prescriber's printed name, address and signature.

2. Orders for laboratory tests:
   a. All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.
   b. If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:
      i. In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;
      ii. A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or
      iii. Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.
   c. Standing orders shall be:
      i. Patient specific, and not blanket requests from the physician or licensed practitioner;
      ii. Medically necessary and related to the diagnosis of the recipient; and
      iii. Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.
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d. The laboratory must ensure that all orders described in (a) through (c) above contain the following information:
   i. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;
   ii. The patient’s name or unique patient identifier;
   iii. The sex (if known) and date of birth of the patient;
   iv. The specific test(s) to be performed;
   v. The source of the specimen, when appropriate;
   vi. The date and, if appropriate, time of specimen collection;
   vii. For Pap smears, the patient’s last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;
   viii. For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;
   ix. Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

e. All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

f. The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

g. All laboratory test orders shall be supported by documentation in the referring physician’s/ practitioner’s medical records.

h. If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

3. Services Provided by a Psychologist

   a. Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).

   b. For the initial examination, the record shall include, as a minimum, the following:
      i. Date(s) of service rendered;
      ii. Signature of the psychologist;
      iii. Chief complaint(s);
      iv. Pertinent historical, social, emotional, and additional data;
      v. Reports of evaluation procedures undertaken or ordered;
      vi. Diagnosis; and
      vii. The intended course of treatment and tentative prognosis.

   c. For subsequent progress notes made for each Medicaid/ NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:
      i. Date(s) and duration of service (for example, hour, half-hour);
      ii. Signature of the psychologist;
      iii. Name(s) of modality used, such as individual, group, or family therapy;
      iv. Notations of progress, impediments, or treatment complications; and
      v. Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

   vi. One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):
      (1) Symptoms and complaints;
      (2) Affect;
      (3) Behavior;
      (4) Focus topics; and
      (5) Significant incidents or historical events.
4. Mental Health Services Provided by an Independent Clinic
   a. An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:
      i. Evaluates the beneficiary’s mental condition;
      ii. Determines whether treatment in the program is appropriate, based on the beneficiary’s diagnosis;
      iii. Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary’s treatment needs; and
      iv. Is made part of the beneficiary’s records.
   b. A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary’s condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary’s records and shall consist of:
      i. A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.
      (1) Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;
      ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
      iii. The type of personnel that will be furnishing the services; and
      iv. A projected schedule for completing reevaluations of the beneficiary’s condition and updating the plan of care.
   c. The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.
      i. This documentation, at a minimum, shall consist of:
         (1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;
         (2) the date and time that services were rendered;
         (3) The duration of services provided;
         (4) The signature of the practitioner or provider who rendered the services;
         (5) The setting in which services were rendered; and
         (6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.
   d. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary’s medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.
   e. The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.
   f. Periodic review of the beneficiary’s plan of care shall take place at least every 90 days during the first year and every six months thereafter.
      i. The periodic review shall determine:
         (1) The beneficiary’s progress toward the treatment objectives;
         (2) The appropriateness of the services being furnished; and
         (3) The need for the beneficiary’s continued participation in the program
      ii. Periodic reviews shall be documented in detail in the beneficiary’s records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.
5. APN Services:

a. The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

b. Documentation of services performed by the APN shall include, as a minimum:
   i. The date of service;
   ii. The name of the beneficiary;
   iii. The beneficiary’s chief complaint(s), reason for visit;
   iv. Review of systems;
   v. Physical examination;
   vi. Diagnosis;
   vii. A plan of care, including diagnostic testing and treatment(s);
   viii. The signature of the APN rendering the service; and
   ix. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

c. In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:
   i. Chief complaint(s);
   ii. A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;
   iii. Pertinent medical history;
   iv. Pertinent family and social history;
   v. A complete physical examination;
   vi. Diagnosis; and
   vii. Plan of care, including diagnostic testing and treatment.

d. In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:
   i. In an office or residential health care facility:
      (1) The beneficiary’s chief complaint(s), reason for visit;
      (2) Pertinent medical, family and social history obtained;
      (3) Pertinent physical findings;
      (4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and
      (5) A diagnosis.
   ii. In a hospital or nursing facility setting:
      (1) An update of symptoms;
      (2) An update of physical symptoms;
      (3) A resume of findings of procedures, if any done;
      (4) Pertinent positive and negative findings of lab, X-ray or any other test;
      (5) Additional planned studies, if any, and the reason for the studies; and
      (6) Treatment changes, if any.

e. To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN’s notes indicating that the APN personally:
   i. Reviewed the beneficiary’s medical history with the beneficiary and/or his or her family, depending upon the medical situation;
   ii. Performed a physical examination, as appropriate;
   iii. Confirmed or revised the diagnosis; and
   iv. Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

f. The APN’s involvement shall be clearly demonstrated in notes reflecting the APN’s personal involvement with, or participation in, the service rendered.

g. For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary’s medical record and shall include:
   i. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.
   ii. A developmental and nutritional assessment.
   iii. A complete, unclothed, physical examination to also include the following:
      (1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and
      (2) Vision, dental and hearing screening;
   iv. The assessment and administration of immunizations appropriate for age and need;
   v. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;
   vi. Mandatory referral to a dentist for children age twelve months or older;
   vii. The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines;
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viii. Health education and anticipatory guidance; and
ix. An offer of social service assistance; and, if requested, referral to a county welfare agency.
h. The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:
i. The beneficiary's chief complaint(s), reason for visit;
ii. Pertinent medical, family and social history obtained;
iii. Pertinent physical findings;
iv. The procedures, if any performed, with results;
v. Lab, X-ray, ECG, etc., ordered with results; and
vi. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

6. Physician Services
a. Physician Recordkeeping; general
i. All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.
ii. The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.
iii. The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.
iv. Records of Residential Health Care Facility patients shall be maintained in the physician's office.
v. The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b. Minimum documentation; initial visit; new patient
i. The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit — New patient:
   (1) Chief complaint(s);
   (2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;
   (3) Pertinent past medical history;
   (4) Pertinent family and social history;
   (5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;
   (6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;
   (7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and
   (8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

b. Minimum documentation; initial visit; new patient
i. The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:
   (1) In an office or Residential Health Care Facility:
      (a) The purpose of the visit;
      (b) The pertinent physical, family and social history obtained;
      (c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;
      (d) Procedures performed, if any, with results;
      (e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and
      (f) Prognosis and diagnosis.

c. Minimum documentation; established patient
i. The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:
   (1) In an office or Residential Health Care Facility:
      (a) The purpose of the visit;
      (b) The pertinent physical, family and social history obtained;
      (c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;
      (d) Procedures performed, if any, with results;
      (e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and
      (f) Prognosis and diagnosis.

d. Minimum documentation; home visits and house calls
i. For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

e. Minimum documentation; hospital or nursing facility
i. In a hospital or nursing facility, documentation shall include:
   (1) An update of symptoms;
   (2) An update of physical findings;
   (3) A resume of findings of procedures, if any are applicable;
   (4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;
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(5) Any additional planned studies, if any, including the reasons for any studies; and
(6) Treatment changes, if any.

f. Minimum documentation; hospital discharge medical summary
   i. When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.
   ii. The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.

g. Minimum documentation; mental health services
   i. For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:
      (1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;
      (2) The date and the time services were rendered;
      (3) The duration of services provided, for example, one hour, or one- half hour;
      (4) The signature of the physician who rendered the service;
      (5) The setting in which services were rendered;
      (6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;
      (7) Notations of progress, impediments, treatment, or complications; and
      (8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.
   ii. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

7. Pharmaceutical services
   a. Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.
   b. Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABP- VAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.
   c. Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.
   d. Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must
submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.

e. Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non-legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer’s name, address and registration number.

O. Data reporting
The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

P. Disclosure
1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor’s agreement with the State.
3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

Q. Limitations on collection of cost-sharing
The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

R. Indemnification by Provider/subcontractor
1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.
2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.
3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.
4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.
5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.
S. Confidentiality

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor’s plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee’s confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department’s prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider’s/subcontractor’s organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U.S.C. 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

T. Clinical laboratory improvement

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

U. Fraud, waste and abuse

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.
Appendix B – Contract Compliance

3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney’s Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the Contractor’s agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor’s network for the audits and investigations the Contractor solely conducts.

V. Third party liability

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the Contractor.

3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.
   a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
   b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
   c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.
   d. The claim is for a child who is in a DCP&P supported out of home placement.
   e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.
   a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee’s health insurance coverage.
   b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee’s name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee’s legal representative, copies of pleadings, and any other documents related to the action in the provider’s/subcontractor’s possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee’s diagnosis and the nature of the service provided to the enrollee.
   c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the “Combined Notification of Death and Estate Referral Form” located in subsection B.5.1 of the Appendix.
   d. The provider/subcontractor agrees to cooperate with the Contractor’s and the State’s efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.
W. Enrollee protections against liability for payment

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider’s sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and/or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee’s family Member, any legal representative of the enrollee, or anyone else acting on the enrollee’s behalf unless subsections (a) through and including (f) or subsection (g) below apply:

a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider’s charges; and

c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a).i; and

e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d).9, and/or NJAC 11:24-15.2(b).7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or the Contractor for the service; or

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party’s payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor’s network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

X. Off-shore

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

Y. Further delegation of any delegated activity is not permissible.