Essential Information for New Jersey FamilyCare Providers

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NJ Department of Human Services
Division of Medical Assistance and Health Services

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Presentation Topics

- **Overview of New Jersey Medicaid/NJ FamilyCare**
- **Confirmation of Member Eligibility**
- **Provider Relations Overview- DMAHS /OMHC**
- Balance Billing
- Authorization and Claims Processing
- Continuity of Care
- Utilization Appeals
- **Provider /Stakeholder Resources**

What is Medicaid?

- Medicaid is a joint Federal and State program that helps pay medical costs if individuals have limited income and resources or meet other requirements.

- Medicaid is a voluntary program. If you want to participate, you must know, accept and abide by the rules and regulations

- New Jersey Medicaid is referred to as NJ FamilyCare in member and provider communication

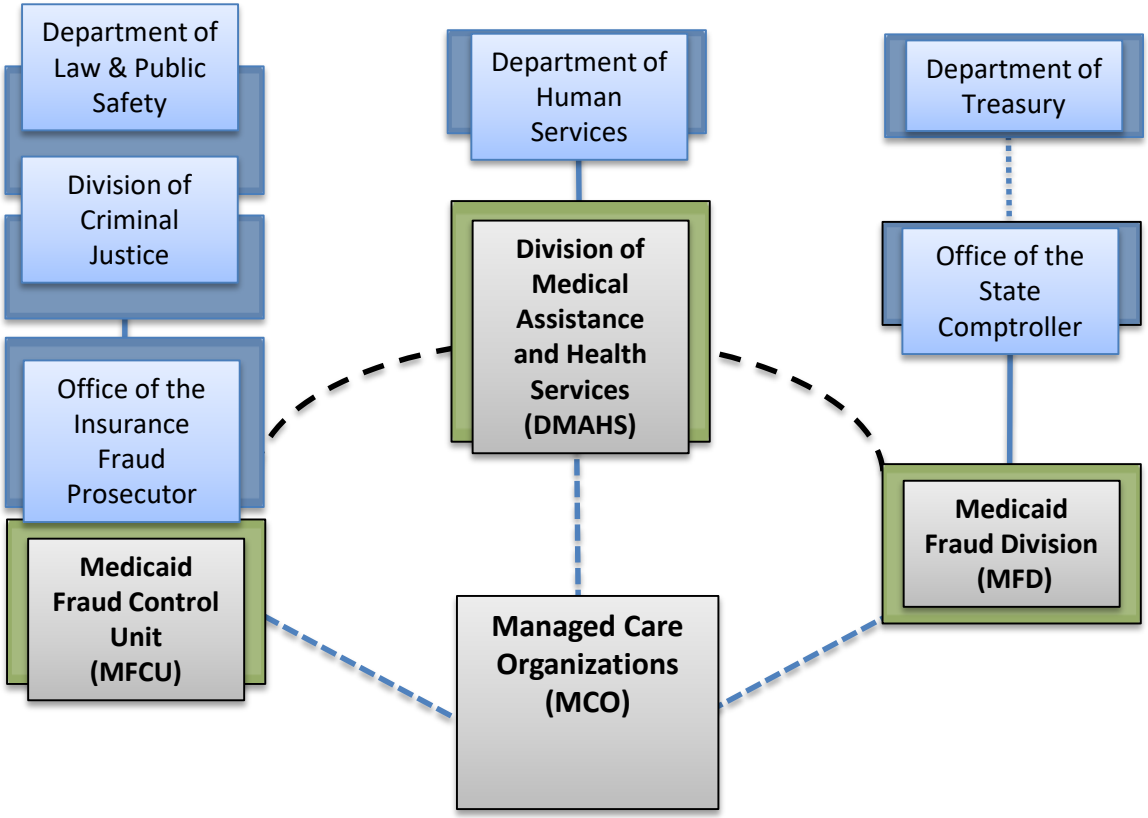
New Jersey Medicaid Managed Care Contracts

The New Jersey Department of Human Services, DMAHS, has a contract with the following Managed Care Organizations:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare Health Plans of NJ, Inc.

Administration & Oversight

The Medicaid program in New Jersey is administered and/or overseen by



CONFIRMATION OF MEMBERS NJ FAMILYCARE ELIGIBILITY

Provider's Requirement to Confirm NJ FamilyCare Eligibility

- Providers must confirm NJ FamilyCare Eligibility each month to ensure that member is currently enrolled
- Provider must confirm that member is enrolled in Health Plan and that they have an active authorization
- If Member has changed MCO, provider must contact existing Health Plan regarding authorization update

Medicaid Eligibility Verification System (**MEVS**)
E-Mevs

- Medicaid Eligibility Verification System (**MEVS**) is an electronic system used to verify recipient Medicaid eligibility. This electronic verification process will provide date specific eligibility which will help reduce claim denials related to eligibility. It can help to eliminate Medicaid fraud.
- NJ Providers access eMEVS through "**Login**" on the NJMMIS website www.njmmis.com
- In order to login, individual *must* have a secure username and password
- Users ids and passwords are requested through Provider Registration link on the NJMMIS navigational bar on main screen.

NJMMIS

Search: Go

- Home
- Site Requirements
- Help Index by Topic
- State Web Sites
- HIPAA Claims
- Login

Communication

- Contact Provider Services
- Contact Webmaster
- Fed & State Stats & Regs
- Forgot My Password
- Provider Directory
- Provider Enrollment Application
- Provider Registration

Information

- Approved Vendor List
- Billing Supplements
- Current Newsletter
- Edit Codes
- FAQ
- Forms & Documents
- Hospital Information
- Newsletters & Alerts
- NJMMIS Website Tutorial

Users access eMEVS by selecting Login

ANNOUNCEMENTS

Click here for more announcements

- **New** Click here to access and search for New Jersey health care professional information (including physician's medical license number).
- **New** Click here for information on the new CMS 1500

Providers will be notified via future newsletters regarding when the only provider identifier that will be accepted is the NPI. Providers still must register their NPI with New Jersey Medicaid and can email their NPI information to New Jersey Medicaid by clicking here.

Click her dlines

- **Temporary ovider Numbers:** The Division of Medica lth Services will no longer assign temp to pharmacy applicants.
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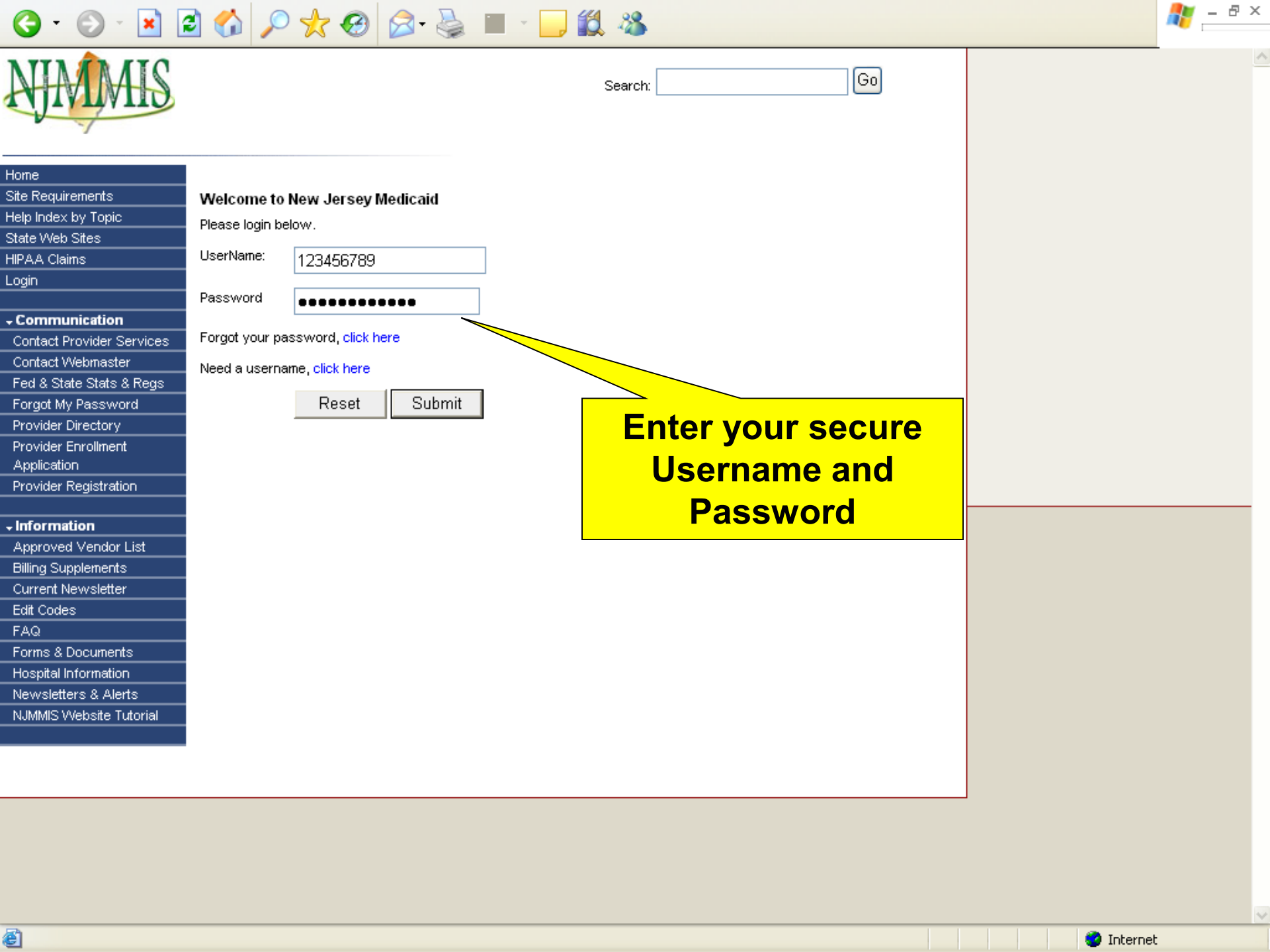
The State will continue to accept pharmacy applications to provide services to beneficiaries enrolled in Pharmaceutical Assistance for the Aged and Disable (PAAD), Senior Gold, AIDS Drug Distribution Program (ADDP) and Cystic Fibrosis.

For additional information please call Unisys Provider Enrollment at 609-588-6036.

- **HBID Card Program Kicks Off!** The Health Benefits Identification (HBID) Card program implementation continues. All New Jersey beneficiaries will have plastic HBID cards by February 2007.
  - Please click here for the newsletter and details on the program.
  - Click here for Frequently Asked Questions concerning the HBID cards

Internet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Provider Directory
Provider Enrollment Application
Provider Registration
Information
Approved Vendor List
Billing Supplements
Current Newsletter
Edit Codes
FAQ
Forms & Documents
Hospital Information
Newsletters & Alerts
NJMMIS Website Tutorial
Welcome to New Jersey Medicaid
Please login below.
UserName:
123456789
Password
Forgot your password, click here
Need a username, click here
Reset
Submit
Enter your secure Username and Password
Internet

Balance Billing

A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against a beneficiary, a beneficiary's family member, any legal representative of the beneficiary, or anyone else acting on the beneficiary's behalf unless service does not meet criteria referenced in NJAC 10:74-8.7(a).

Balance Billing details are also outlined in NJ Family Care Newsletter:

Volume 23 No. 15 **September 2013**

Limitations Regarding the Billing of NJ Family Care (NJFC) Beneficiaries

All Medicaid/NJ Family Care newsletters posted on http://www.njmmis.com

Managed Care Organization
Provider Relations Unit Requirements

- creating an annual provider manual and preparing updates as necessary;
- offering provider education and outreach, and
- provide a call center for claims troubleshooting for providers
- establish process for claims and utilization appeals
- assign Provider representative or contact to address Provider contract

Prior Authorization Parameters

Prior authorization decisions for non-emergency services shall be made within 14 calendar days

Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

Source: Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

Prior Authorization Guidelines for NJ Family Care Services

New Member No Existing Plan of Care	Member Transitions to MCO with existing Plan of Care for LTCE
MCO must prior-authorize service	MCO must honor continuity of care parameter of contract
Provider must be in Network with MCO and/or have a single case agreement to serve member	MCO and Provider must set up SCA or join network. Approved services as per existing plan will be reimbursed until new plan of care established

Managed Care Organization Claim Submission Requirements

- Capture and adjudicate all claims submitted by providers
- Support NJs NJ Family Care's encounter data reporting requirements
- Comply with "Health Claims Authorization, Processing and Payment Act" (HCAPPA) for all Medical Services
- Ensure Coordination of Benefits (exhaust all other sources of payment before NJ Family Care pays)

Claim Processing Compliance with Federal and State Laws and Regulations

- 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.

Claim Dispute

Adjudicate--the point in the claims/encounter processing at which a final decision is reached to pay or deny a claim, or accept or deny an encounter.

Contested Claim--a claim that is denied because the claim is an ineligible claim, the claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the claim requires special treatment.

Continuity of Care

Continuity of Care

Definition: The plan of care for an enrollee that should assure progress without unreasonable interruption

- The Contractor shall ensure continuity of care and full access to primary, behavioral, specialty, MLTSS and ancillary care as required under this contract and access to full administrative programs and support services offered by the Contractor for all its lines of business and/or otherwise required under this Contract.

Source: Article 2.B of the July 2017 NJ FamilyCare Managed Care Contract

Utilization Appeals

UM Appeal Process: Definitions

UM Appeal: An appeal of an adverse Utilization Management determination, initiated by the Member (or a provider acting on behalf of a Member with the Member's written consent)

Utilization Management Determination: A decision made by a Managed Care Organization (MCO) to deny, reduce, suspend or terminate a service based on medical necessity

Utilization Appeals Guidelines for NJ Family Care Services

	IURO (External Appeal) Time Frame	Medicaid Fair Hearing	Continuation of Benefits
NJ FamilyCare A and ABP Members	Yes*	Yes	Member and/or Provider on behalf of member must request within appeal timelines
Appeal Process for NJFC B, C, and D Members	Yes	Not Available	Member and /or Provider on Behalf of member must request within appeal timelines
(Select services are not eligible for IURO: Adult Family Care, Assisted Living Program, Assisted Living Services, Caregiver Participant Training, Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, PCA, Respite, Social Day Care, Structured Day Program)			

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Resources for Providers and Stakeholders

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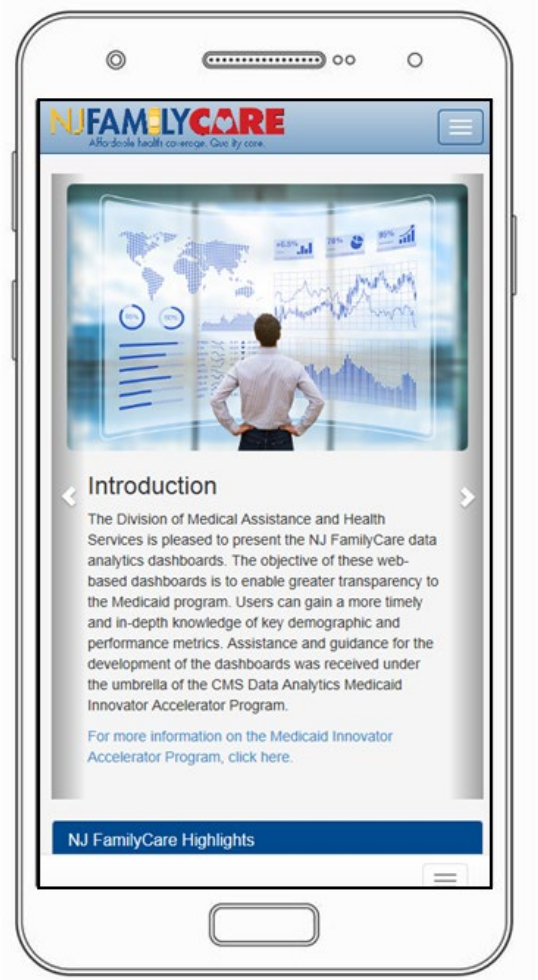
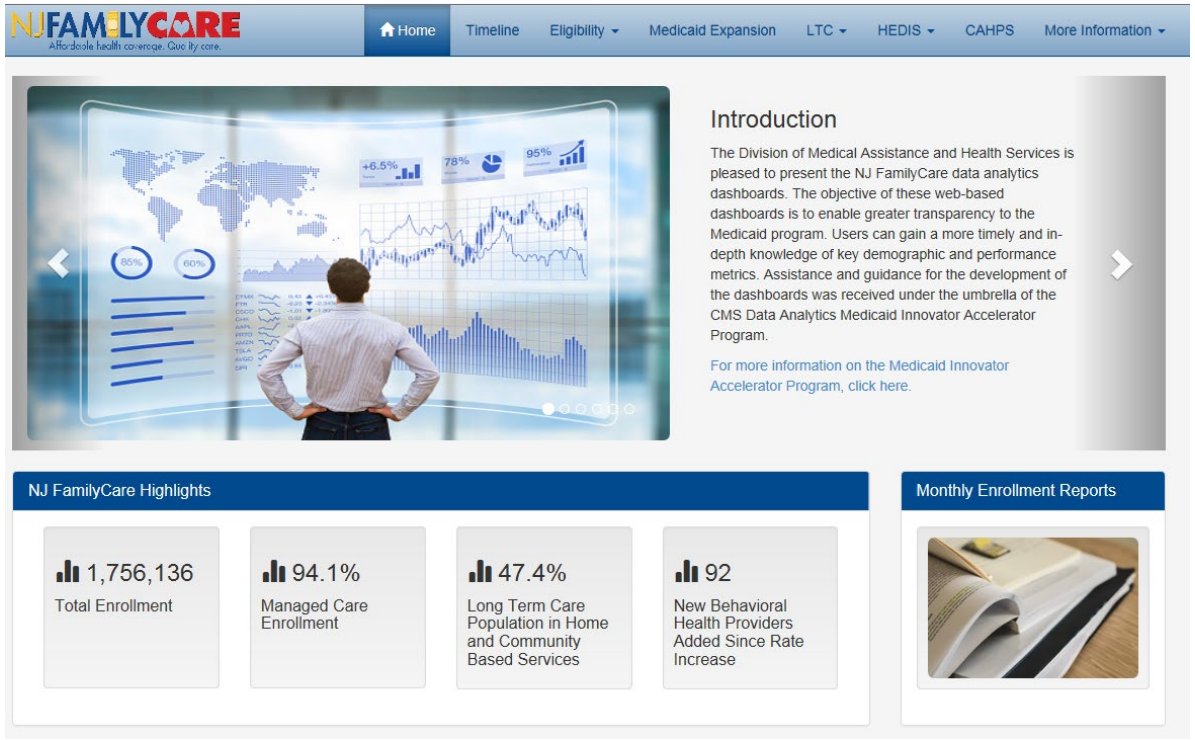
Mobile Friendly & Browser Independent





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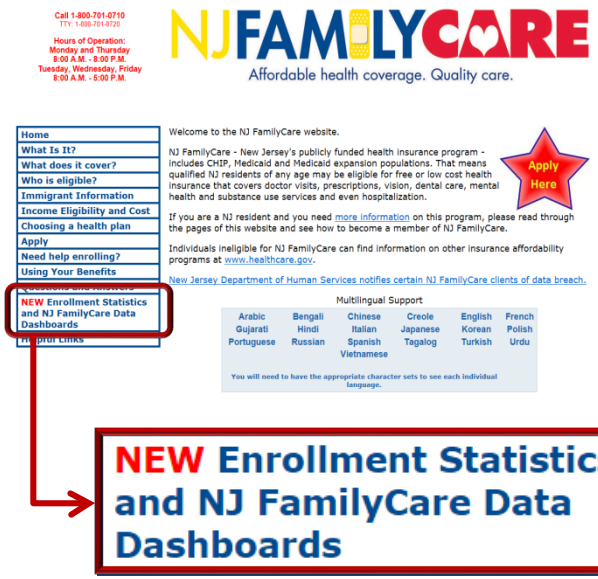
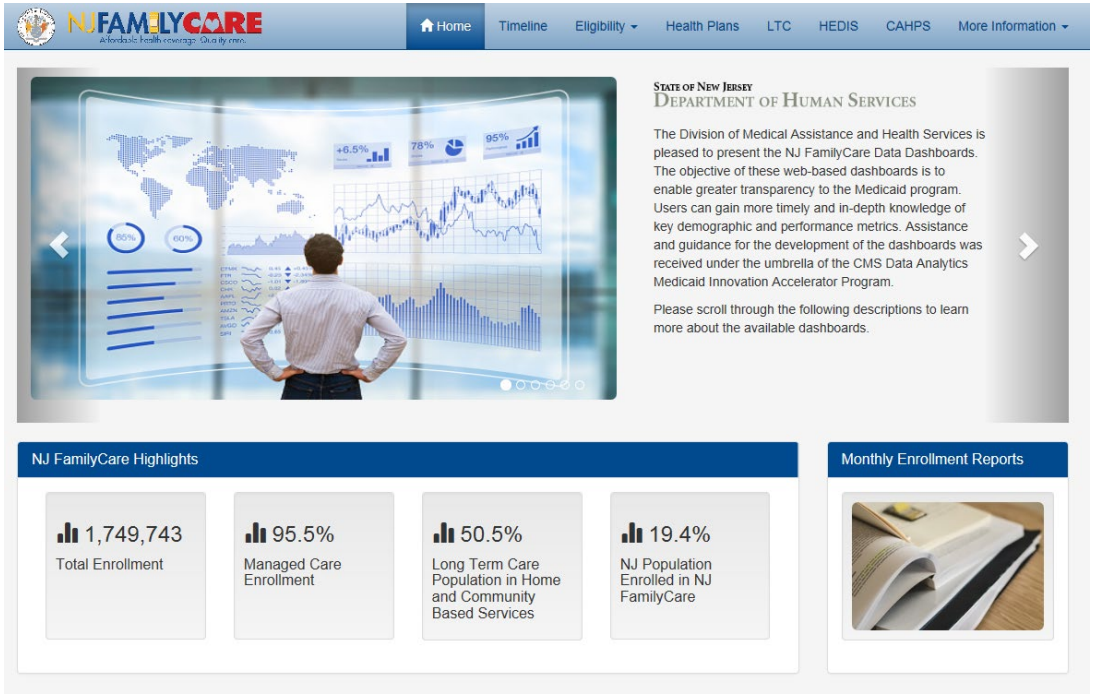
Link to Website with Enrollment informtion

http://www.njfamilycare.org



NEW Enrollment Statistics and NJ FamilyCare Data Dashboards

http://www.njfamilycare.org/analytics/home.html



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DMAHS Office of Managed Health Care (OMHC) Provider Relations Inquiry Process

Provider and/or Member contact DMAHS:

- Provider must submit claim detail to DMAHS: Providers must submit detail indicating that Medicaid guidelines were followed and MCO was contacted prior to outreach to OMHC
  - check eligibility
  - request prior authorization,
  - timely claim submission
  - Submission of appeal timely

Member: Submits copy of balance bill
DMAHS will contact the MCO

Submit to mahs.provider-inquiries@dhs.nj.gov

DMAHS Office of Managed Health Care (OMHC)
Provider Relations Inquiry Process

- OMHC completes inquiry upon receipt of detail indicating that MCO contract guidelines were followed

- OMHC will review and follow-up with MCO on behalf of the Provider if initial response does not meet contract guidelines. All inquiries sent to MCO are logged into a SharePoint database

Example: Claim inquiries are closed upon receipt of claim number and amount and /or letter to Provider.

MCO Provider Relations Reporting

- MCO Contracted Quarterly Report (Table 3C) includes all inquires submitted to MCO on behalf of Provider by the Office of Managed Health Care (OMHC)

- DMAHS prepares a Quarterly Provider Inquires Report (Feb 15th, May 15th, Aug 15th and Nov 15th)

- Quarterly Report documents all reported inquiries and identify inquiries that remain open beyond a designated quarterly period

DMAHS Follow-up

- Based on trends across plans and /or service types
  - Develop Provider Education
  - Develop policy guidance
  - Develop contract changes / updates
  - Present MCO Notices of Deficiencies or Corrective Action Plans if necessary

NJ FamilyCare MCO Resources

- NJ FamilyCare Health Plans Currently Under Contract and Providing Medicaid Managed Care Services in New Jersey

https://www.state.nj.us/humanservices/dmahs/clients/medicaid/hmo/index.html

- Member Relations- Access Member Manual

- Provider Relations -Provider Quick Reference Guide

State Resource for Managed Care Providers: Office of Managed Health Care (OMHC) Managed Provider Relations Unit

- MLTSS Resources

http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

- Behavioral Health Resources

https://www.state.nj.us/humanservices/dmahs/news/ebhb.html

- Form to submit inquiry is located by clicking on highlight
- DMAHS Provider Relations Inquiry Information
- Provider Relations Inquiry Request form – single case
- Provider Relations Inquiry Request form – multiple cases

Email detail via secure email to mahs.provider-inquiries@dhs.nj.gov

Separate emails should be sent for individual MCOs.
Multiple cases must include excel summary of information.

Questions