# MANAGED LONG TERM SERVICES AND SUPPORTS

## Essential Elements for Providers Participating in MLTSS

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

## June 2014

# Presentation Topics

- Confirming Members/NJ Family Care Eligibility
- Provider Enrollment Information
  - MCO Network Requirements
  - Application Process for Provider Enrollment
  - MCO Provider Relation Resources
- MCO Contract Parameters—Re: HCAPPA
  - Prior Authorization
  - Claims Submission
  - Utilization Appeals
- State Resources for Providers

How to check an individual's NJ Family Care/Family Care Eligibility

and/or Enrollment in MCO

# CONFIRMING MEMBERS NJ FAMILY CARE ELIGIBILITY

# Provider's Requirement to Confirm NJ Family Care Eligibility

- Providers must confirm NJ Family Care 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

# Options to Confirm Beneficiaries NJ Family Care Eligibility

- NJ Family Care FFS Service Enrolled Providers
  - NJMMIS
  - REVS
- Providers not enrolled as FFS NJ Family Care Provider must access individual Health Plan site for confirmation

# Beneficiary Eligibility Verification-Option 1

- Visit the NJMMIS website at www.njmmis.com and select the link on the left side of the page called "Contact Webmaster." You will complete a screen to request a username and password and access eMEVS.
- The State has a method to verify eligibility using the internet, which is referred to as eMEVS or electronic NJ Family Care Eligibility Verification System. eMEVS is supported on the secured area of the New Jersey NJ Family Care website, located at www.njmmis.com.
- When using eMEVS, a provider has the option to enter a Card Control Number from the HBID card, the client's Social Security Number or name. eMEVS displays a formatted eligibility response on the computer, which a provider can view quickly and print for their client records.

# Beneficiary Eligibility Verification-Option 2

Recipient Eligibility Verification System (REVS): Provider must be a NJ Family Care Provider to access REVS.

Call 800-676-6562 to verify NJ Family Care eligibility. This will also confirm if a member has Medicare Parts A and B. This telephone line will also provide MCO membership information.

# Provider Enrollment Information

# Provider Enrollment Information

- MCO Network Requirements
- Application Process for Provider Enrollment
- Provider Relations Resources

# MCO Network Requirements

- Establish network of providers to serve needs of enrolled members
- Certify that provider network meets standards of the MCO contract
- Establish network of MLTSS service providers, which plans are currently doing

# Process for Provider Enrollment

- offer an application for providers
- complete credential/re-credential process;
- contract with the network providers and subcontractors;

# Steps for Non-Residential Providers to be a Provider with the Individual MCOs

1. Submit Application

2. Complete Credentialing Requirements

3. Secure contract when plan and provider reach agreement

*Note: Residential Providers-AL, CRS, NF SCNP any willing provider clause in MCO Contract till July 2016*

# Any Willing Provider Any Willing Plan Provision for Residential and Pharmacy Providers

- July 2014 MCO contract has an Any Willing Provider and Any Willing Plan (AWP) Provision for two years including:
  1. Assisted Living
  2. Community Residential Services
  3. Nursing Facility
  4. Special Care Nursing Facilities
- Any NJ-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 and is willing to accept the terms and conditions of the MCO's provider contract, or terms for network participation.
- If an MCO wishes to have any New Jersey-based NF, SCNF, AL or CRS join its network, those providers will be instructed to complete the application form.

# MCO Provider Relations Requirements

- creating an annual provider manual and preparing updates as necessary;
- offering provider education and outreach, and
- providing a call center for claims troubleshooting for providers
- offering a process for claims and utilization appeals

# Health Plan
# Provider Contact Telephone Numbers

| Heath Plan | Provider Relations | MLTSS Contact Number |
|---|---|---|
| • Amerigroup New Jersey: | 1-800-454-3730 | 800-454-3730 |
| • Healthfirst Health Plan of NJ, Inc.: | 1-866-889-2523 | 888-464-4365 |
| • Horizon NJ Health: | 1-800-682-9091 | 877-765-4325 |
| • UnitedHealthcare Community Plan: | 1-800-362-3368 | 888-362-3368 |
| • WellCare: | 1-888-588-9769 | 888-453-2534 |

# MCO Contract Parameters


Prior Authorization parameters must comply with "Health Claims Authorization, Processing and Payment Act“ (HCAPPA) P.L. 2005, c.352

# PRIOR AUTHORIZATION PARAMETERS

# 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.

Claims Processing Comply with "Health Claims Authorization, Processing and Payment Act“ (HCAPPA) P.L. 2005, c.352 for all Medical Services

# CLAIMS PROCESSING

# MCO Claim Submission Requirements

- Capture and adjudicate all claims submitted by providers
- Support NJ FamilyCare'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)

# Universal Billing Format for MLTSS Services Paper Submission

- Providers need to use the 1500 for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
- Providers need to use the “UB-04” lite for NFs and SCNFs.

# Universal Billing Format for MLTSS Services Electronic Submission

- Providers need to use the 837 P for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.

- Providers need to use the 837 I for NFs and SCNFs.

# Claim Submission Requirements

- MCO claims are considered timely when submitted by providers within 180 days of the date of service as per (HCAPPA) P.L. 2005, c.352

# Claim Submission Requirements with Explanation of Benefits

- Providers are to 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.

# MCO Claims Processing

- MCO contract specifies that MLTSS service claim should be processed by MCO within 15 days of clean submission

- MCO contract specifies that claims for non-MLTSS services should be processed by MCO within 30 days of clean submission

# Claim Submission Categories

- Initial Claim
- Claim Resubmission
- Claim Denial
- Claim Appeal Information

# Claim Resubmission

- Claims may get denied for a variety of reasons and it is important to supply the plan with as much information as possible when resubmitting a claim.
- Common reasons for a claim resubmission would be:
  - ***Resubmission of a "Corrected Claim"***
  - ***Resubmission of "Prior Notification/Prior Authorization Information"***
  - ***Resubmission of a "Bundled Claim"***

# Claim Denials

- Claims may get denied for a variety of reasons and it is important to supply the plan with as much information as possible when appealing a decision.

# Claims Appeal Process

- Stage 1- Individual Health Plan

- Stage 2- Alternative Dispute Resolution

# Stage 1- Claims Appeal

- Submit claim appeal form created by DOBI to MCO within 90 calendar days following receipt of payer's claim determination.
- MCO staff review and provide determination within 30 days of receipt of claim appeal

# Stage 2-Alternative Dispute Resolution

- Submit claim to independent arbitration organization designated by DOBI. Aggregate of claims must total $1000 or more.
- Administrative fee is charged for processing
- Written Appeal must be submitted within 90 days of initial determination.

# External Appeal Information

- External appeals must be initiated through MAXIMUS,Inc.,

Additional information can be found at:

- MAXIMUS' website at ww.njpicpa.maximus.com or
- DOBI website at www.state.nj.us/dobi/index.html.

# Coordination of Benefits

- If a NJ Family Care beneficiary has another health or casualty insurer the MCO is responsible for coordinating benefits to maximize the utilization of third party coverage.
- The contractor is responsible for payment of the enrollee's coinsurance, deductibles copayments, and other cost-sharing expenses, but the contractor's total liability cannot exceed what it would have paid in the absence of Third Party Liability (TPL).
- The MCO is responsible for the costs incurred by the beneficiary with respect to care and services which are included in the contractor's capitation rate, but which are not covered or payable under the TPL.

# MCO will confirm Provider Claims Submission Processing

- If the beneficiary is dually eligible
  - Medicare must be billed prior to NJ Family Care if the service is covered by Medicare
  - Medicare balances may be billed to the NJ Family Care MCO if Medicare benefit is exhausted
- If the beneficiary has coverage with private insurance (TPL)
  - Private insurance must be billed prior to MCO

# 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


Utilization Appeal for Medical Services must comply with NJAC 11:24

# UTILIZATION APPEAL

# Appeal –Adverse Benefit Determination

- An appeal or adverse decision is included as part of MCO contract for any member and/or provider that is not satisfied with the MCO's policies and procedures, or with a decision made by the MCO, or disagrees with the MCO as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting.

# MCO Function: Complaints, Grievance and Appeals

- Members have 3 stages to appeal an adverse benefit determination by an MCO for medical services + the option to request a Medicaid Fair Hearing

(Providers can appeal on behalf of beneficiaries with written consent)

- Non-medical Services have 2 stages of appeal and option to request a Medicaid Fair Hearing

- Member can file complaint/grievance or a representative can file on their behalf (e.g., family member, provider)

# Continuation of Benefits

- During all stages of the appeal process or the Medicaid/ Fair Hearing process (for members eligible for a Fair Hearing), services will continue while appeal is being reviewed, if all of the following statements apply:
  - The appeal is filed on time
  - The appeal involves a previously authorized course of treatment
  - The services were ordered by an authorized provider
- For those who requested a Medicaid Fair Hearing, continuation of benefits must be requested in writing within 20 days of the date of the denial letter.

# NJ Family Care Fair Hearing

- A beneficiary or a provider on behalf of a beneficiary (with the beneficiaries written consent) can request a Medicaid Fair Hearing at any time during the appeals process.
- The NJ Family Care Fair Hearing Department can be reached at:

  609-588-2655

- You must mail the adverse decision letter to the Medicaid Fair Hearing Department

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

# NJ FAMILY CARE MANAGED CARE PROVIDER RESOURCES

# NJ Family Care Managed Care Reference Information

- Below is the link where MCO contract is posted on line:

http://www.state.nj.us/humanservices/dmahs/info/resources/care/

**The link below will provide connection to individual MCO sites. The phone number for Member and Provider Relations for MCO's are listed as well**

http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

# MCO Provider Resources

| | | |
|---|---|---|
| **Plan ABC Inc.** | | Atlantic |
| 123 Main Street | | Bergen |
| Any town, New Jersey 01111 | | Burlington |
| | | Camden |
| Provider Relations Phone Number | 1-800-123-4567 | Cape May |
| Member Services Phone Number | 1-800-321-4567 | Cumberland |
| | | Essex |
| | | Gloucester |
| | | Hudson |
| | | Hunterdon |
| | | Mercer |
| | | Middlesex |
| | | Monmouth |
| | | Morris |
| | | Ocean |
| | | Passaic |
| | | Somerset |
| | | Sussex |
| http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/ | | Union |
| | | Warren |