New Jersey | Medicaid

Wellpoint
MLTSS provider webinar

Wellpoint

Introductions

Speakers:

[Susanne Ardito, Mgr. Provider Relationship Acct Mgmt
Ebony Washington, Dir GBD Special Programs Svcs (case management)
Lynelle Steele, Program Administrator (PPP and EVV)
Keisha Woodson, Manager I GBD Special Programs (authorizations)

Panelists:

[Jennifer Iskandar, Dir GBD Special Programs

Please submit questions in the chat. These will be reviewed at the end of the presentation.

Agenda

- Wellpoint overview & NJ FamilyCare
- Medicare Advantage
- MLTSS level of care
- Our approach
- Institutional and home and community-based services
- PPP
- Options counseling
- Care management
- Continuity of care
- Service coordination
- Critical incident reporting
- Utilization management
- Service authorizations
- Cost share/patient payment liability
- Community resources and training
- EVV
- Fraud/waste/abuse
- Claims submission process
- Payment disputes
- Wellpoint/Availity Essentials* digital tools
- Join our network
- Contact us
- Q&A

Wellpoint overview

- Through its affiliated companies, we serve approximately [118 million people, including nearly 47 million within its family of health plans.
- Wellpoint:
  - Wellpoint in New Jersey currently covers over a quarter of a million Medicaid enrollees.
  - Over [30,000 members are covered by our Medicare Advantage plans.

NJ FamilyCare

- The New Jersey Division of Medical Assistance and Health Services (DMAHS) administers the NJ FamilyCare program. You can help identify potential recipients who may qualify for coverage by calling:
  - The State of New Jersey Health Benefits Coordinator at [**800-701-0710 (TTY 800-701-0720).**
  - Wellpoint at [**877-453-4080 (TTY 711)**.
- Medicaid recipients include NJ FamilyCare members (including **MLTSS**, Supplemental Security Income [SSI members, and clients of the DDD.)
- Some Medicare beneficiaries are eligible for the **fully integrated dual eligible special needs plan** (FIDE SNP) that has integrated Medicare and Medicaid coverage.
- Members can select a PCP at the time of enrollment or will be auto-assigned to a PCP. Members may change their PCP at any time. Members can change their MCO once every [12 months during annual enrollment [October 1 to November 15.
- No copayment or deductible is required or may be collected for medically necessary covered services for NJ FamilyCare A, B, ABP, and MLTSS members.
- MLTSS members receiving nursing facility or assisted living services may have patient pay liability (PPL). NJ FamilyCare C and D members may be responsible for a copayment or personal contribution to care (PCC) for services.
- Refer to the benefit guide in the *Provider Manual* for benefit information.

Medicare Advantage

Who is eligible?

•Age [65 or older, under age [65 with permanent disabilities, and all ages with end-stage renal disease (ESRD)

•Beneficiaries must be enrolled in Medicare Parts A and B and must live in the plan service area (New Jersey counties except for Hunterdon or Warren).

Dual special needs plans are fully integrated dual eligible SNP (FIDE SNP) plans that focus on beneficiaries who would benefit from enhanced coordination of care due to certain medical conditions. Our integrated Medicare and Medicaid care management model Medicaid coverage is consistent with state policy for MLTSS, behavioral health, and nursing facility services.

Dental, hearing, transportation, and vision are covered under plan's integrated Medicaid benefit:

- Amerivantage Dual Coordination (HMO D-SNP) H3240-013
- Amerivantage Dual Secure (HMO-POS D-SNP) H3240-024
- Amerivantage ESRD Care (HMO-POS C-SNP) H3240-014

We also offer these Medicare Advantage plans:

- Amerivantage Choice (PPO) H8343-007
- Amerivantage Classic (HMO) H3240-022
- Amerivantage Balance (HMO) H3240-021

Beneficiaries receive a Flex Card (MasterCard debit card) that can be used at any dentist, optometrist, or audiologist.

Healthy Groceries (grocery card) covers grocery items. Some exclusions apply.

MLTSS level of care

Help us connect members to MLTSS services!

A Member meets clinical criteria for MLTSS in one of three ways:

1. Hands-on assistance (or more) in at least three eligible assistance with daily living (ADL) areas:

2. Cognitive deficits in decision-making and short-term memory and needs supervision or greater assistance in three areas of ADLs.

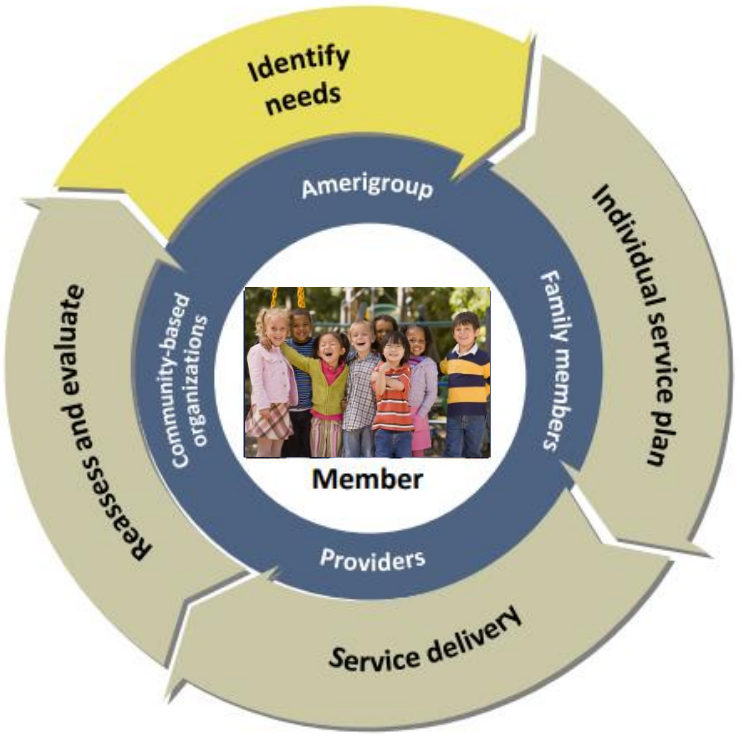
3. Cognitive deficits in decision-making and making self understood

and needs supervision or greater assistance in three areas of eligible ADLs.

Needs are identified:

A face-to-face visit is scheduled within 30 days of initial enrollment to conduct a comprehensive assessment of medical, behavioral, social, and long-term care needs and functional capabilities.

The care manager works with the member's PCP, care team, and MLTSS service providers to develop and implement a service plan and will continually evaluate and revise the service plan as needed.



Our approach

Our team of professionals helps individuals in need of LTSS to live independently in their home or a community-based setting of their choice. We help coordinate services and supports, increase access to self-directed options and provide members with a single point of contact to navigate complex systems of care.

- Person-centered care coordination: Wellpoint brings together the right combination of healthcare, services and supports while taking members' preferences and priorities into account. Our full-spectrum care and service coordination approach emphasizes an individualized, member-centric focus that supports self-direction, personal preference, and individual goal-setting.
- Guiding members through complex systems: Services and supports for members with LTSS needs can be confusing, so we are here to help guide members. Our offerings go beyond healthcare to connect members with the resources that are right for them.
- Helping members thrive in the community: We provide members and families with resources to build, maintain, or rebuild their lives with their families and friends. These supports include access to housing and transportation. By coordinating LTSS, we improve the quality of care and services, eliminate barriers, and support members to live independently at home and participate fully in their communities.
- Community partnerships: Wellpoint has a long history of working effectively with members, advocates, families, stakeholders, service providers, and faith- and community-based organizations. Our grassroots community collaboration is the cornerstone of our innovative and individualized approach to healthcare and service delivery.

Institutional and home and community-based services

Medicaid Waiver Program - managed long-term service and supports/program of all-inclusive care for the elderly.

- Adult Family Care**
- Assisted living services**
  1. Assisted living residence (ALR)
  2. Comprehensive personal care home (CPCH)
  3. Assisted living program (ALP)
- Behavioral management (TBI)
- Caregiver/participant training
- Chore services
- Cognitive therapy
- Community residential services
- Community transition services
- Home based supportive care
- Home delivered meals
- Medication dispensing device (set up and monthly monitoring)
- Personal care assistant (PCA)
- Non-medical transportation
- Nursing facility and special care nursing facility services (custodial)**
- Occupational therapy (group and individual)
- Personal emergency response system (PERS) (set up and monthly monitoring)
- Physical therapy (group and individual)
- Private duty nursing
- Residential modifications
- Respite (daily and hourly)
- Social adult day care
- Speech, language & hearing therapy structured day program
- Supported day services
- Vehicle modifications

* Services provided as appropriate per the individual's plan of care.
** Patient pay liability (cost share) may apply for participants in ALR, CPCH, AFC, NF or SCNF.

Participant direction and Personal Preference Program

Participant direction and Personal Preference Program (PPP)

Participant direction is a service delivery mechanism that emphasizes autonomy and empowerment by expanding the participant's/representative's degree of choice and control over their long-term services and supports. It allows participants/representatives to serve as the common law employer, responsible for directly hiring, training, supervising, and firing their paid caregivers. Participants/representatives are given the proper training and guidance to make informed decisions about their own care.

- The PPP offers an alternative way for NJ FamilyCare enrollees who qualify for the personal care assistant (PCA) benefit to remain in their home and active in their community by hiring a friend or family member to provide their care.
- The PPP allows NJ FamilyCare enrollees to direct and manage their activities of daily living (ADLs) as well as instrumental activities of daily living (IADLs).
- Clinical staff with Wellpoint will inform the individual about specific differences between PPP and agency delivered PCA in order to help make an informed choice and assist with beginning the enrollment process if PPP is chosen.

Options Counseling

Options Counseling is provided to eligible and interested NJ FamilyCare A enrollees and NJ FamilyCare B, C, and D eligible enrollees through EPSDT, and details the requirements and responsibilities of selecting self-direction.

- **Medicaid managed care plan members** receive Options Counseling through the NJ Choice assessment process by MCO clinical staff. Members residing in the community are counseled on nursing facility options. Similarly, members residing in the facility are counseled on their housing options in the community.
- **Nursing facility residents** who are not enrolled in a managed care plan will receive Options Counseling from Office of Community Choice Options (OCCO) directly. OCCO also works directly with the NJ FamilyCare enrollment unit, which inputs the resident's MCO selection into the system.
- **Options Counseling includes:**
  - **A dialogue** using the NJ Choice assessment tool to discuss the individual's level of independence and need for long-term services and supports, and
  - **Information about the individual's Medicaid service options** — MLTSS or the PACE program, and how to select a NJ FamilyCare MCO if MLTSS is chosen.

Care management

Our care management program is designed to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. We encourage providers to refer members that may be appropriate for comprehensive care management.

The care manager will:

- Determine the level of care management services needed.
- Work with the member, the member's representatives, and provider to develop and implement an individualized plan of care.
- Coordinate medical and nonmedical services, including social, educational, and therapeutic services and other nonmedical support services, such as personal care, women, infants, and children (WIC), and transportation.

Call [**855-661-1993**. Care managers are available during normal business hours from [8 a.m. to 5 p.m. ET.

For urgent issues, assistance is available after normal business hours, on weekends, and on holidays through Provider Services at [**800-454-3730**.

Our disease management (DM)/Population Health Program (PHP) is designed to help physicians and other healthcare professionals manage members with chronic conditions:

- [DM-PHP-ProviderReferrals@Wellpoint.com
- **[888-830-4300,** from 8:30 a.m. to 5:30 p.m.

Continuity of care

- Members receiving LTSS will be permitted to see all current providers on their approved service plan, including any non-network providers, until an assessment and service plan is completed and either agreed upon by the member or resolved through the appeals or fair hearing process.
- LTSS services will not be reduced, modified, or terminated in the absence of a new/up-to-date assessment of needs that would support any service reduction, modification or termination.

Source:
[http://www.state.nj.us/humanservices/dmahs/home/MLTSS_Provider_FAQs.pdf

Service coordination

Service coordination provides the member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the member’s well-being, independence, integration in the community, and potential for productivity.

Specialized care management services that are performed by a licensed service coordinator that provides:

- A holistic evaluation of the member's individual dynamics, needs, and preferences.
- Education and help providing health-related information to the member, the member's legally authorized representative (LAR), and others in the member's support network.
- Help to identify the member's physical, behavioral, functional, and psychosocial needs.
- Engagement with the member, the member's LAR and other caregivers in the design of the member's individual service plan.
- A connection for the member to covered and noncovered services necessary to meet the member's identified needs
- Monitoring to ensure the member's access to covered services is timely and appropriate

Critical incident reporting

New Jersey requires:

The maximum time frame for reporting an incident to Amerigroup is [**one** business day.

Initial report may be submitted verbally within [**one** business day accompanied by a follow-up written report within [**two** business days.

Suspected abuse, neglect, and exploitation shall be reported [**immediately.**

Response to any member emergency or future harm shall occur [**immediately** but not longer than [**one** business day.

Internal critical incident investigation shall be submitted by the provider no more than [**14** calendar days after the date of the incident.

Critical incidents include the following:

Unexpected death of a member; media involvement or the potential for media involvement; physical abuse (including seclusion and restraints both physical and chemical); psychological/verbal abuse; sexual abuse and/or suspected sexual abuse; fall resulting in the need of medical treatment; medical emergency resulting in need for medical treatment; medication error resulting in serious consequences; psychiatric emergency resulting in need for medical treatment; severe injury resulting in the need of medical treatment; suicide attempt resulting in the need for medical attention; 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; failure of member's back-up plan; elopement/wandering from home or facility; inaccessible for initial/on-site meeting; unable to contact; inappropriate or unprofessional conduct by a provider involving member; cancellation of utilities; eviction/loss of home; facility closure, with direct impact to member's health and welfare; natural disaster, with direct impact to member's health and welfare; operational breakdown; other

Adult Protective Services

If someone you know is [18 years of age or older, living in the community and is the subject of abuse, neglect and/or exploitation, contact the County Adult Protective Services (APS) office: **Department of Human Services | New Jersey Adult Protective Service Providers (state.nj.us)**.

An APS investigation is a thorough assessment of a potential at-risk adult. Within [72 hours of a referral's receipt, a face-to-face meeting with the adult by a trained APS social worker is required. All information generated by the investigation is confidential.

Utilization management

Utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. **Inpatient services and non-emergent services by non-participating providers always require prior authorization:**

- **First, use the Prior Authorization Look-up** tool to verify if a service requires prior authorization:
  - Please note that radiology and diagnostic procedures may be authorized through Carelon Medical Benefits Management, Inc.* via [www.providerportal.com or [**833-419-1491.**
  - To access UM criteria online, go to [https://provider.Wellpoint.com/new-jersey-provider/home > Resources > *Medical Policies and Clinical UM Guidelines*.
- Wellpoint will notify providers of approved prior authorization determinations for non-urgent services by telephone or in writing within [**14 calendar days or sooner** as required by the needs of the enrollee.
- If the request is a **stat/urgent** request (expedited service authorizations), the decision will be made [**within 24 hours,** but no later than three business days after receipt of the request for services.
- Prior authorization denials and limitations will be provided in writing in accordance with the *Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352*.
- A medical necessity reviewer is available at [**800-454-3730** to discuss any denial decision with the practitioner.
- Refer to the *Provider Manual* for detailed information about utilization management

Service authorizations

MLTSS services require prior authorization.***

To request authorization:

- Fax the appropriate *Precertification Request Form* at [https://provider.Wellpoint.com/new-jersey-provider/resources/forms to:
  - [**888-240-4716** — personal care assistant (PCA)
  - [**888-240-4717** — adult medical day care (AMDC)
  - [**888-826-9762** — all other MLTSS services including *EVV Provider Notification Form*
- Call [**855-661-1996**, [**option 1**

Reminders:

- Be sure to check member eligibility prior to each service.
- Know the end date of the authorization. (Request extension if necessary.)
- Per non-notification policy, Wellpoint will retroactively authorize services up to [72 hours.

Interactive care reviewer

Interactive care reviewer (ICR) is a secure, online provider UM tool — accessed via Availity Essentials — that offers a streamlined process to request authorization of inpatient and outpatient procedures/services.

With this tool, your practice can initiate online medical and behavioral health preauthorization requests for members with Wellpoint more efficiently and conveniently, as well as locate information on previously submitted requests regardless of how the original prior authorization was submitted.

Prior Authorization Lookup Tool:

- This tool within Availity Essentials is the quickest way to check if an outpatient service requires prior authorization.

NJ 211 — social drivers of health

- NJ 211 provides a vital connection to community services and resources that are essential to good health. Healthcare providers who are working to improve the health of patients struggling with life's basic needs can add NJ 211 to their healthcare team. Together, we can make a difference.
- NJ 211 is free, confidential, multilingual, and always open. New Jersey residents who need help finding affordable housing, food, utility assistance, and other basic needs, can [**dial 211** or text their zip code to [**898-211** and we will put them in touch with community resources that can help.
- NJ residents with special needs are encouraged to add their personal information to the Special Needs Registry at [Special Needs Registry (state.nj.us) or call **211**.

Community resources and training

- [Cultural competency resources
  https://mydiversepatients.com
- NJ Department of Human Services: MLTSS:
  https://www.state.nj.us/humanservices/dmahs/home/mltss_training.html
- NJ Department of Human Services: EVV:
  https://www.state.nj.us/humanservices/dmahs/info/evv.html

Provider Pathways eLearning
https://attend.webex.com/webappng/sites/attend/webinar/webinarSeries/register/e7a9cd723eb54e97b7561b1d898c6ffa

What is EVV?

EVV is the process in which a service performed for a member at home or in the community gets verified electronically:

- *Section 12006* of the *Federal 21st Century Cures Act* mandates the use of EVV to verify type of service provided, member receiving the service, caregiver providing the service, date of the service, location of the service delivery, and time the service begins and ends.
- EVV allows providers to confirm that services were actually delivered using a variety of electronic methods like a phone call, smartphone application, or a free EVV device in the home.
- EVV requirements also apply to self-directed services provided through the PPP and the Division of Developmental Disabilities (DDD) Self-Directed Options.

State resources:

- [DMAHS: **nj.gov/humanservices/dmahs/info/evv.html**
- EVV mailbox: **mahs.evv@dhs.state.nj.us**

State aggregator:

- HHAeXchange: **https://hhaexchange.com/nj-home-health/**

Wellpoint EVV Aggregator:

- CareBridge: njevv@carebridgehealth.com

How does EVV work as a provider with Wellpoint?

Effective [April 1, 2023, all claims must be supported by EVV visit data:

- Providers may use CareBridge, HHAeXchange, or their own third-party system (as long as it is integrated with either one).
- Provider submits visit data directly into CareBridge or HHAX or submits third party EVV vendor visit file interface to CareBridge. HHAX will submit visit file interface to CareBridge with confirmed visits.
- CareBridge generates and submits 837 for confirmed visits to Wellpoint.
- If using a third-party EVV vendor, please make sure the vendor is integrated with CareBridge:
  - Visit [http://evvintegrationeform.carebridgehealth.com/ and select **Resources for Integrated Agencies**
  - Providers and vendors can also visit [http://evvintegration.carebridgehealth.com/ or call [**844-924-1755** for CareBridge technical requirements and other integration-related questions.

CareBridge

Administrator and caregiver trainings:

- [Live webinars: http://carebridgehealth.com/trainingnjevv
- Training: https://www.carebridgehealth.com/nj-evv-hh-provider
- Resource library: http://resources.carebridgehealth.com/evv

- Provider support: **844-924-1755**
- CareBridge users: njevv@carebridgehealth.com
- Third-party EVV vendor users: evvintegration@carebridgehealth.com
- Integration specifications: http://evvintegration.carebridgehealth.com

EVV service codes

Services provided in the home require prior authorization.

Providers are required to submit EVV data.

Phase 1 code set

Personal Care Assistant Services:

- T1019 - PERSONAL CARE ASSISTANCE; PER 15 MINUTES
- T1019_HQ - PERSONAL CARE ASSISTANCE GROUP; PER 15 MINUTES
- T1019_SE - PERSONAL CARE ASSISTANCE (SELF DIRECTED) INDIVIDUAL; PER 15 MINS
- T1019_SE_UI - PERSSONAL CARE ASSISTANCE (SELF DIRECTED) INDIVIDUAL-AGENCY; PER 15 MINS
- T1020 - PERSONAL CARE SERVICES PER DIEM
- T1005 - MLTSS IN HOME RESPITE
- S5125_SE_HQ - PERSONAL CARE ASSISTANCE GROUP (SELF DIRECTED) GROUP; PER 15 MINUTES
- S5125_SE_U3 - PERSONAL CARE ASSISTANCE GROUP (SELF DIRECTED) GROUP-AGENCY; PER 15 MINUTES

MLTSS Home Based Supportive Care Services:

- S5130 - MLTSS HOME BASED SUPPORTIVE CARE
- S5130_HQ - MLTSS HOME BASED SUPPORTIVE CARE - SELF DIRECTED
- H2016HI - DDD INDIVIDUAL SUPPORTS; PER 15 MINS

DDD Individual Supports Services:

- H2016HI22 - DDD INDIVIDUAL SUPPORTS; PER 15 MINS
- H2016HIU8 - DDD INDIVIDUAL SUPPORTS; PER 15 MINS

DDD In Home Respite Services:

- T1005HI - DDD IN HOME RESPITE; PER 15 MINS
- T1005HIU8 - DDD IN HOME RESPITE; PER 15 MINS

DDD Community Based Supports:

- H2021HI - DDD COMMUNITY BASED SUPPORTS; PER 15 MINS
- H2021HI22 - DDD COMMUNITY BASED SUPPORTS; PER 15 MINS
- H2021HI52 - DDD COMMUNITY BASED SUPPORTS; PER 15 MINS

Effective 10/1/2021, claims submitted with these codes must be submitted using EVV or will be denied.

EVV service codes (cont.)

Phase 2 Codes: Services provided in the home require prior authorization. Providers are required to submit EVV data.
Phase 2 EVV code set

COHORT 1 Skilled Nursing / Private Duty Nursing / Home Health				
Codes	Procedure Name	Unit of Measure	Service Requirements	Requirements for EVV for FIDE SNP and MLTSS Dual Eligible Members
97597	Debridement, open wound, wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less	Per visit	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process services to by authorized Medicare/SNP
99601	Infusion- Skilled Nursing	Up to 2 hours	Prior Authorization – REQUIRED Place of Service -12/Home	
99602	Infusion- Skilled Nursing - additional hour(s)	Each additional hour	Prior Authorization – REQUIRED Place of Service -12/Home	
G0299*	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	EVV Data required when Medicaid authorizes
S9122	Home Health Aide/Certified Nurse Assistant	Per hour	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
S9123	Nursing care, in the home by registered nurse	Per hour	Prior Authorization – REQUIRED Place of Service -12/Home	
S9124	Nursing care, in the home by licensed practical nurse	Per hour	Prior Authorization – REQUIRED Place of Service -12/Home	
S9127	Social work visit, in the home	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	
T1000	Private duty/independent nursing service(s)	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
T1002	Private duty/independent nursing service(s)/RN	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
T1003	LPN/LVN SERVICES	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
T1030	Nursing care, in the home, by registered nurse	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	
T1031	Nursing care, in the home, by licensed practical nurse	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	
G0300*	Direct skilled nursing services of a licensed practical nurse (LPN) in the home or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
G0153*	Services performed by a qualified speech language pathologist in the home health or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
G0155*	Services performed by clinical social worker in home health or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	

EVV service codes (cont.)

Phase 2 Codes: Services provided in the home require prior authorization. Providers are required to submit EVV data.
Phase 2 EVV code set

COHORT 2 Therapies				
Codes	Procedure Name	Unit of Measure	Service Requirements	Requirements for EVV for FIDE SNP and MLTSS Dual Eligible Members
92507	Speech, Language and Hearing Therapy Individual	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	
97110	Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
97129	Cognitive Therapy, Individual	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact (List separately in addition to code for primary procedure)	Each additional 15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
97535	Occupational Therapy, Individual - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
G0151 *	Services performed by a qualified physical therapist in the home health or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
G0152 *	Services performed by a qualified occupational therapistin the home health or hospice setting	15 mins	Prior Authorization – REQUIRED Place of Service -12/Home	
S9128	Speech therapy, in the home	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	
S9129	Occupational therapy, in the home	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	Providers are required to submit EVV data. MCOs are not required to link billing process to services authorized by Medicare/SNP
S9131	Physical therapy; in the home	Per diem	Prior Authorization – REQUIRED Place of Service -12/Home	

Effective 7/1/2023, claims submitted with Phase 2 codes must be submitted using EVV based on state guidance or will be denied. Please refer to Phase 2 Provider Training link for additional details.
[https://provider.Wellpoint.com/new-jersey-provider/home -> Resources -> Training Academy

EVV phase 2 – authorization notification process

- The codes below currently do not require an authorization. However, in an effort to administer EVV, the following codes will now require notification in order to capture visit data. Please note, this notification process does not include medical necessity review. Notification process is only used to obtain an authorization number that will connect to CareBridge system. The notification process can be completed in two ways:
  - Submit through Availity Essentials using ICR (Interactive Care Reviewer). Details and instructions on provider training slides. **Provider will receive a confirmation of completion via Availity Essentials. There are no letters currently being generated as these notifications are auto approved.**
  - Send a request via fax: **800-964-3627**, form to use for fax can be found here: **NJ_CAID_ProviderNotificationRequest.pdf (Wellpoint.com)**

CPT/HCPC	Service Description	Required
97597	Debridement, open wound, wound assessment, use of whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less	Notification
99601	Infusion-Skilled Nursing	Notification
99602	Infusion-Skilled Nursing-additional hour(s)	Notification
S9127	Social work visit, in the home	Notification
G0155	Services performed by clinical social worker in home health or hospice setting	Notification

Fraud, waste, and abuse

Develop a robust compliance plan and ensure oversight

Conduct self audits on timesheets, signatures, medical records

Verify patient's identity

Ensure services are medically necessary

Document medical records completely

Claims

A clean claim:
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form (*CMS-1500, CMS-1450* or successor forms).
- Requires no further information, adjustment, or alteration to be processed and paid.
- Is not a claim under review for medical necessity.
- Includes the appropriate taxonomy code.
- Is not from a provider who is under investigation for fraud or abuse.

Rejected versus denied claims:
- Rejected claims don't enter the system due to missing or incorrect information and require a correction or change on the claim (claim form or electronic data interchange [EDI claim).
- Alterations to billing information
- Missing required information
- Mixed or altered format
- Claims that are denied go through the adjudication process, but payment is denied

If filing electronically, check the confirmation reports for acceptance of the claim that you receive from EDI.
If we do not have the claim on file, resubmit your claim within the timely filing requirements.

Cost share/patient payment liability

The patient payment liability (PPL) for cost of care is that portion of the cost of care that nursing facility, assisted living services residents, adult foster care (AFC) residents, and community residential services (CRS) residents must pay based on their available income as determined and communicated by the County Welfare Agency:

- PPL is deducted from CRS, assisted living services, AFC and nursing facility reimbursement.
- Nursing facility and assisted living providers are responsible for the collection of PPL and room and board.
- PPL data is shared with Wellpoint via the Department of Human Services.

Timely filing

Claim type	Medicaid	Medicare Advantage
Claim submission	Within [180 days from date of service (DOS) (or discharge date)	[90 days for participating providers (12 months for non-par providers)
Corrected claim	[365 days from DOS (or discharge date) (Use applicable frequency code: 1 – Original claim, 7 – Replacement of Prior Claim, 8 – Void/Cancel Prior Claim)	
Secondary carrier	Within [60 days from date of primary carrier's *EOP*	

The practice of balance billing Medicaid-beneficiaries with NJ FamilyCare, whether eligible for fee-for-service (FFS) benefits or enrolled in managed care, is prohibited under both federal and state law. All costs related to the delivery of healthcare 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). NJAC 10:74-8.7(a).

Furthermore, federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the *Social Security Act* [the *Act*).

Electronic data interchange

Electronic data interchange (EDI) is the computer-to-computer exchange of business documents in a structured format. EDI provides a faster and cleaner method for delivering time-dependent data, saving you time compared to filing paper claims.

Electronic fund transfer

The EnrollSafe electronic funds transfer (EFT) enrollment hub enables you to enroll in EFT processing for all participating plans in one simple and easy-to-use website [(https://enrollsafe.payeehub.org) at no cost to providers.

Q. How would a provider know if their registration and enrollment was successful?

A. The provider's request for registration must be verified prior to enrolling their bank account. Once verified, the provider will be sent an email with instructions on how to create their login credentials for EnrollSafe. Providers should allow [5 to 7 business days for this process to be completed:

- All enrollments are subject to a two-step verification process. Provider should allow [5 to 7 business days for this process to be completed. After the provider has submitted their enrollment, the EnrollSafe homepage will display the status of any enrollments associated with the account.
- Providers can check the status of their bank account(s) via EnrollSafe. After a provider has submitted their bank account enrollment, EnrollSafe will display the status of their enrollment.

Q. What if I need further assistance?

A. The provider can contact the support team by calling [**877-882-0384,** Monday through Friday 9 a.m. to 8 p.m. ET for questions related to registration and enrollment:

- **Note:** EnrollSafe does not support registration or enrollment from third-party billing agencies at this time. The provider must register and submit their enrollment requests directly through the website for greater security.

Claim payment disputes

You have the right to request an appeal of a claim decision. You may request this appeal on your own behalf or on behalf of a covered person.

Claim payment disputes can be submitted through availity.com. Benefits of submission through the secure provider website include:

- Instant receipt of acknowledgement for submissions.
- Online review for open payment dispute submissions and statuses.
- Email notification of finalized reconsiderations:
  - **Note:** Providers must log in to the secure website to receive the outcome.

Providers still have the option to submit claim payment disputes by mail. Refer to the *Provider Manual* or *Quick Reference Guide* for mailing information.

Claims requiring additional documentation:

- We may request additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, we may:
  - Deny the claim as the provider failed to provide required prepayment documentation.
  - Recover and/or recoup monies previously paid on the claim as the provider failed to provide required documentation for post-payment review.

Availity Essentials

Access to all Wellpoint digital tools and capabilities is available at Availity Essentials [availity.com

- Acceptance of **digital ID cards**
- **Eligibility and benefit inquiry** and response: Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- **ICR:** Prior authorization submissions including updates, attachments, and authorization status. Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- **Claim submission:** Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
- Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- **Integration with participating vendors' practice management software,** revenue cycle management software, and some electronic medical records software (B2B APIs).
- **Claim status, remittances, and payments**
- **Electronic remittance advice (ERA)**
- **Disputes**
- **Grievances and appeals**
- Demographic updates (coming soon)
- Precertification lookup tool
- Pharmacy prior authorization drug requests
- Services through Wellpoint affiliates, Carelon Medical Benefits Management and Carelon Behavioral Health, Inc.* (coming soon)
- **Chat** with Payer
- Provider online reporting
- **Patient360**
- **Provider enrollment** (New – October 2022)

Availity Essentials (cont.)

Access [Availity Essentials > **Payer Spaces** > **Wellpoint [New Jersey**

- Applications:
  - Custom learning center
  - Chat with payer
  - Claims status listing
  - Clear claim connection
  - Precertification Look-Up Tool
  - Provider online reporting
  - Remittance inquiry
  - Digital provider enrollment
- Resources
- EnrollSafe electronic funds transfer (EFT)
- News and announcements

Placeholder for Wellpoint screenshot

Availity Essentials (cont.)

- Registering for Availity Essentials:
  - Identify an Availity Essentials administrator for your organization:
    - The Availity Essentials administrator is the person responsible for entering information such as tax IDs and NPIs and identifying which employees need system IDs and passwords.
      - To register, the administrator should visit [availity.com, and select the **Register** button located in the upper right.

Wellpoint in New Jersey provider website

Resources:
- *Provider Manual* and *Quick Reference Guide*
- *Medical Policies* and *Clinical UM Guidelines*
- Prior Authorization Lookup Tool (see also Availity Essentials* > Payer Spaces)
- Referrals (online provider directory)
- Training Academy

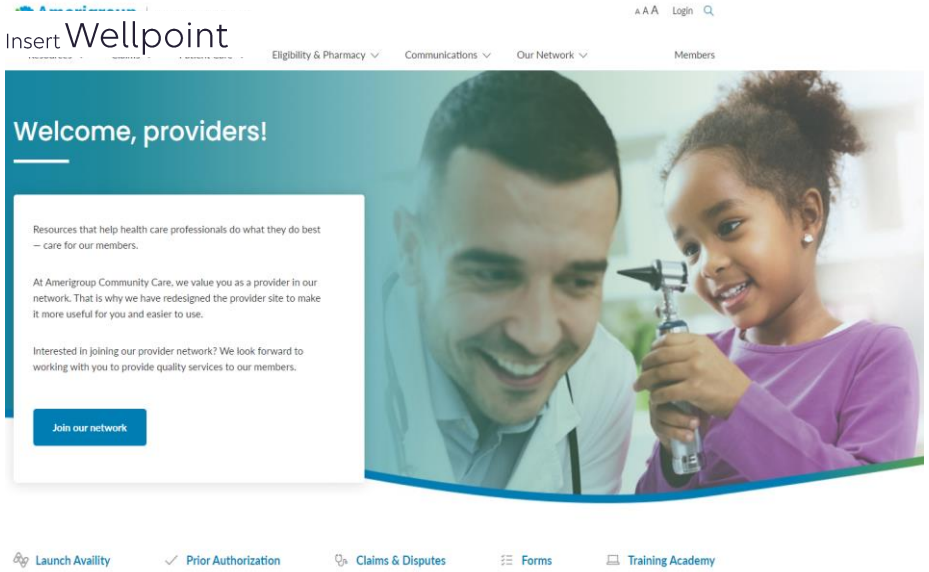
Claims:
- *Reimbursement Policies*

Patient care:
- Behavioral health
- Care management
- Dental
- Early and periodic screening, diagnosis, and treatment (EPSDT)
- Maternal child services
- Disease management/whole health

Eligibility & pharmacy:
- Pharmacy tools

Benefits partners:
- Carelon Medical Benefits Management
- Superior Vision*
- Liberty Dental*

Communications:
- Newsletters



[https://provider.wellpoint.com/NJ/

Join our network

Visit our website [https://provider.Wellpoint.com/new-jersey-provider/home or

Call Provider Services at **[800-454-3730** or **732-452-6000** to be directed to the MLTSS contracting team and for MLTSS-specific credentialing requirements.

Contact us

Did you know that most questions and issues can be resolved by using the provider self-service tools? Please use **Availity Essentials** for inquiries like payment disputes, claims status, member eligibility, etc. You can also live chat with an associate from Wellpoint within Availity Essentials.

Provider Services:

- **[800-454-3730** (Medicaid) or **866-805-4589** (Medicare Advantage)
- Demographic updates: NJProviderData@Anthem.com
- Credentialing – application submissions: Availity Essentials > Payer Spaces > Enrollment

Availity Essentials support:

- **[800-AVAILITY (800-282-4548)**

Electronic visit verification (EVV) support:

- **[844-924-1755** or njevv@carebridgehealth.com

Questions and answers

Thank you for your participation.

provider.wellpoint.com/nj/

Services provided by Wellpoint New Jersey, Inc. or Wellpoint Insurance Company.

NJWP-CD-042524-23 | December 2023