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1.1 Welcome to Horizon NJ Health

We are pleased you are a participating provider and part of Horizon NJ Health. Horizon NJ Health is a health care management company that administers a managed care program for Medicaid recipients and those enrolled in NJ FamilyCare, 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 all members and for yourself. Horizon NJ Health regards your efforts as indispensable in making this program successful and for providing the highest quality medical care and 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 Physician and Health Care Professional Manual (“Manual”) is a guide to the policies and administrative procedures of Horizon NJ Health. The Manual should be kept in your office or facility for easy access and referral. Use it as a guide to answer questions about referral and 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 the Participating Physician, Hospital or Ancillary Provider 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 the Horizon NJ Health 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’s Professional Contracting and Servicing department at 1-800-682-9091.

1.3 Medicaid/NJ FamilyCare Program

As a managed care organization, our participation in the Medicaid and NJ FamilyCare program enables us to provide or arrange for the provision of services covered under the Medicaid/NJ FamilyCare program. These include comprehensive, preventive, diagnostic and therapeutic health care services.

NJ FamilyCare is a federal- and state-funded health insurance program created to help New Jersey’s uninsured have affordable health coverage. It is not a welfare program.

NJ FamilyCare is for hard-working families who cannot afford to pay for health insurance privately. Eligibility is based on family size and monthly income. Coverage is provided for children and adults with dependent children as well as adults without children. Please refer to Sections 2 and 3 for more information regarding eligibility and benefits for Medicaid/NJ FamilyCare members.

The NJ FamilyCare program helps reduce reliance on the hospital charity care program among low- and moderate-income residents of the State, by placing these individuals into a regular system of primary and preventive care. Those persons who have health care coverage are more likely to not only address their health problems, but ensure that their children obtain necessary care, including immunizations and well-child visits with a primary care provider.

1.4 Managed Long Term Services and Supports (MLTSS)

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 facility, in community residential services, or in a nursing home.

Managed Long Term Services and Supports (MLTSS) includes:

- Personal Care
- Respite
- Care Management
- Home and Vehicle Modifications
- Home Delivered Meals
- Personal Emergency Response Systems
- Mental Health and Addiction Services
- Assisted Living
- Community Residential Services
- Nursing Home Care
1.5 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, health care professionals 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 guides.

If you have any questions or would like a printed copy of any of these items, please contact your Professional Relations representative.

NaviNet.net

Horizon NJ Health offers multiple online services via NaviNet that can greatly benefit providers. This free, secure website offers a single sign-on where providers can access transactions and services for multiple health plans. With its efficient electronic transactions and multi-payer database, NaviNet helps providers reduce their administrative costs and greatly reduces administrative time.

By joining NaviNet, Horizon NJ Health providers get access to:

• On-Line Referral Submission
• Referral Inquiries
• Searchable Eligibility and Benefit Information
• Claim Status Inquiries
• Administrative Reports
• Care Gap Reports
• CareAffiliate
• Claim Appeals

The online Administrative Reports that are available include:

• Authorization Status Summary
• Claim Appeal Status
• Claim Status Summary
• Panel Rosters

The online Care Gap reporting feature allows better access to patients’ medical information and helps ensure that patients are receiving their required screenings. The online Care Gap reports that are available include:

• Comprehensive Diabetes Care – Eye Exam
• Comprehensive Diabetes Care – HbA1C < 8%
• Adolescent Well-Care Visits
• Annual Dental Visits
• Well-Child Visits (First 15 months of life)
• Well-Child Visits (3rd – 6th year of life)
• Childhood Influenza Immunizations
• Childhood Pneumococcal Immunizations
• Childhood Immunization – Combo 2
• Lead Testing
• Adult Access to Preventive/Ambulatory Health Services
• Breast Cancer Screening
• Cervical Cancer Screening
• Child and Adolescent Access to Primary Care Physician (PCP)
• Colorectal Cancer Screening
• Use of Imaging Studies for Low Back Pain
• Appropriate Treatment for Children with Upper Respiratory Infection
• Avoidance of Antibiotic Treatment in Adults in Acute Bronchitis
• Emergency Room Visits

To enroll with NaviNet:

• Visit HorizonNJHealth.com and select the “For Providers” tab and click on the NaviNet link in the Resources column
• Complete the NaviNet Enrollment Request Form
• Your NaviNet username and temporary password will be sent via email once your registration is completed.

If you need more information, call the Physician & Health Care Hotline at 1-800-682-9091.

1.5.1 CareAffiliate

Providers who use NaviNet can access the CareAffiliate Internet portal to submit authorization requests easily and securely. CareAffiliate allows providers to communicate
directly with Horizon NJ Health by checking the status of all requests in real time. It also sends providers notifications when requests are completed. The main features in CareAffiliate include authorization requests and the ability to view status of authorization requests. It can also be used for authorizations for home care, DME purchase/rental, surgical procedures and inpatient admissions.

Providers can use CareAffiliate to easily change dates of service while the authorization request is pending for review and to upload attachments in Excel, Word or PDF. CareAffiliate is a single submission process and also includes printable approvals. For medically urgent requests, providers can still contact Provider Services at 1-800-682-9091. http://www.horizonnjhealth.com/for-providers/resources.

1.6 Provider Enrollment

To enroll as a network provider with Horizon NJ Health, a PCP, Specialist, Ancillary or MLTSS provider must fill out a Credentialing Application Packet, sign two contracts and submit them to Horizon NJ Health’s Department of Provider Contracting and Servicing (PC&S). The Credentialing Department will, within two weeks, review the provider’s application and contact the prospective provider if any discrepancies arise or if more information is required from the provider. It will take up to 90 days for the credentialing process to be completed. Upon acceptance, the provider will be notified of the credentialing committee’s decision and, if approved, be added to the Horizon NJ Health Provider Network.

All PCPs or Specialists seeking applications or more information on the credentialing process should contact the Senior Manager of Network Relations, at 1-800-682-9094, extension 89489. All MLTSS providers seeking applications or credentialing information should contact the Manager of MLTSS Network Relations, at 1-800-682-9094, extension 89887.

Credentialing applications should be submitted to:
Horizon NJ Health Provider Credentialing
Department of Professional Contracting and Servicing
210 Silvia Street
West Trenton, NJ 08628
Fax: 1-609-538-3004

1.6.1 Provider Inquiries, Complaints, Grievances and Appeals

Providers can check the status of appeals by going to NaviNet.net and can check the status of complaints and grievances by contacting Provider Contracting and Servicing at 1-800-682-9091.

1.6.2 Professional Relations Representatives

Horizon NJ Health’s list of Professional Relations Representatives that serve physicians, can be found listed by counties served at horizonNJhealth.com/for-providers/professional-relations-representatives or by calling Provider Contracting and Servicing at 1-800-682-9091.

1.7 Provider Directory

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

Printed copies of the Provider Directory are available by calling the Physician & Health Care Hotline at 1-800-682-9091.

Newly enrolled members are sent a Provider Directory that is limited to include only the primary care providers, dentists, OB-GYNs, vision providers, hospitals, health centers, and pharmacy locations specific to their county. These county directories are updated monthly.

If your office information is not correctly shown in these publications, please complete a Request for Change of Information form and fax it to the Horizon NJ Health Professional Contracting and Servicing department at 1-609-538-3004. A copy of the form can be printed from the Horizon NJ Health website at horizonNJhealth.com.

1.8 Health Literacy

Health literacy is defined in Healthy People 2010 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 the Horizon NJ Health website for additional health literacy resources.
2.0 ELIGIBILITY

2.1 Individuals Eligible to Enroll

New Jersey residents who belong to one of the following categories are eligible for enrollment with Horizon NJ Health:

- Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF)
- AFDC/TANF-related New Jersey Care: Special Medicaid Program for Pregnant Women and Children
- SSI – Aged, Blind, Disabled
- New Jersey Care: Special Medicaid program for Aged, Blind and Disabled
- New Jersey Care: Special Medicaid program for Breast and Cervical Cancers
- Division of Developmental Disabilities clients, including the Division of Developmental Disabilities Community Care Waiver
- Medicaid only or SSI-related Aged, Blind and Disabled
- Medicaid/NJ FamilyCare for Parents or caretakers
- Medicaid/NJ FamilyCare for Adults without Children
- Children who qualify for NJ FamilyCare programs
- Individuals eligible through the Division of Child Protection & Permanency (DCPP)
- Individuals who are enrolled in both Medicare and Medicaid (dual eligibles)

- Meet clinical eligibility, which is determined by a state or county professional as needing nursing facility level of care.
- Want to participate in the program.

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

2.1.1 Eligibility Requirements for MLTSS Membership

To be eligible to enroll with Horizon NJ Health's MLTSS program, a person must:

- Be a resident of New Jersey
- Be determined by the Division of Medical Assistance and Health Services to meet clinical eligibility.
- Qualify for Medicaid financial eligibility by:
  - Qualifying for SSI in the community, or
  - Qualifying for Medicaid Only - Institutional Level, or
  - Qualifying for New Jersey Care (with income at or below 100% of the Federal Poverty Level and resources at or below $4,000).

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 conduct 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 NF LoC, the person is informed by OCCO by letter of their right to request a Fair Hearing to appeal the determination.
2.0 ELIGIBILITY

2.2 Medicaid/NJ FamilyCare Program

The Medicaid/NJ FamilyCare programs are the New Jersey programs that provide managed care coverage to eligible adults and children. Medicaid/NJ FamilyCare eligibility is based on income level.

Medicaid/NJ FamilyCare A provides comprehensive managed care coverage to:

- Children under the age of 19 with family incomes up to and including 133 percent of the Federal Poverty Level
- Children under the age of 1 year and pregnant women eligible under New Jersey Care Special Medicaid Programs
- Pregnant women with an income up to 200 percent of the Federal Poverty Level
- AFDC eligibles with incomes up to and including 133 percent of the Federal Poverty Level
- Non-institutionalized aged, blind and disabled individuals enrolled under Medicaid, SSI or New Jersey Care Special Medicaid Programs

In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid Fee-for-Service.

Medicaid/NJ FamilyCare ABP provides comprehensive managed care coverage to:

- Parents/Caretakers with family incomes up to and including 133 percent of the Federal Poverty Level
- Adults without Children under the age of 65 with income up to and including 133 percent of the Federal Poverty Level

In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid Fee-for-Service.

NJ FamilyCare B provides comprehensive managed care coverage, including all benefits provided through New Jersey Care Special Medicaid Programs, to uninsured children under the age of 19 with family incomes above 133 percent and up to and including 150 percent of the Federal Poverty Level. In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid Fee-for-Service.

NJ FamilyCare C provides comprehensive managed care coverage, including all benefits provided through New Jersey Care Special Medicaid Programs, to uninsured children under the age of 19 with family incomes above 150 percent and up to and including 200 percent of the Federal Poverty Level. In addition to covered managed care services, eligibles under this program may access certain other services, which are paid by Medicaid Fee-for-Service.

NJ FamilyCare D provides managed care coverage to uninsured:

- Children under the age of 19 with family incomes between 201 percent and up to and including 350 percent of the Federal Poverty Level

In addition to covered managed care services, eligibles under this program may access certain services, which are paid by Medicaid Fee-for-Service and are not covered under this contract.

Upon collection of a copayment, a physician is responsible for issuing a receipt to the member. This receipt should include the physician’s name, address and telephone number.

2.3 Special Needs Enrollees

Adult special needs enrollees under the NJ State Medicaid program are defined as adults with special needs that include complex/chronic medical conditions requiring specialized health care services. This includes persons with physical, mental, substance abuse and/or developmental disabilities, as well as such persons who are homeless. Children with special health care needs are those who have (or are at an increased risk for) a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond what is generally required by children.

2.4 Member Identification Cards

Medicaid/NJ FamilyCare Health Benefits Identification Card

Upon enrollment, Medicaid/NJ FamilyCare programs issue the member a Health Benefits Identification (HBID) card, which is a permanent, plastic magnetic-striped card. The HBID can be used by members to access services covered by Fee-for-Service and those benefits not covered by Horizon NJ Health.
NJ FamilyCare

Horizon NJ Health

NAME
MEMBER ID NO: YHZ
PCP
 PHONE
ISSUE DATE
 EFFECTIVE
 BCBS Plan Codes 280/780
 www.horizonNJhealth.com

NJ FamilyCare

Plan:
Dental Benefit:
Emergency $ 
PCP Copay $ 
Dental Copay $ 
Specialist Copay $ 
Rx Generic $ 
Rx Brand $ 
Pharmacies Group: HORIZON, BIN 610606, ProCtrl: HMC

MLTSS

Managed Long Term Services and Supports (MLTSS)

Horizon NJ Health

NAME
MEMBER ID NO: YHZ
PCP
 PHONE
ISSUE DATE
 EFFECTIVE
 BCBS Plan Codes 280/780
 www.horizonNJhealth.com

Horizon NJ Health

Primary care provider’s (PCP) name and phone number
Indication of dental benefits
Coverage effective date
Copayment amounts (NJ FamilyCare C and D)
Note that the phrase “BC/BS Plan Codes 280/780” as well as “YHZ” before the member ID number appear on the face of the member ID cards. Please disregard this information. Participating Horizon NJ Health physicians are not required to include the YHZ prefix when referring to a member ID number.

Both the Horizon NJ Health and the HBID cards are for identification purposes only. Eligibility must be verified before services are provided.
2.5 Determining Eligibility

The Horizon NJ Health member ID card cannot be accepted as the sole verification of a member’s eligibility to receive benefits. ID cards do not list an expiration date and are not always returned to Horizon NJ Health when a member’s coverage terminates. To confirm eligibility, visit NaviNet or call 1-800-682-9091 at the time of service. A member should present an HBID card in addition to a Horizon NJ Health ID card. Ask the member for all forms of insurance to facilitate claims processing. See Section 9.6.2 Other Third Party Medical Insurance for more information. Also see section 1.5 for more information on NaviNet and member eligibility.

2.5.1 Determining Newborn Eligibility

Horizon NJ Health provides health care coverage to newborns from birth up to 60 days through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point, through the mother’s Horizon NJ Health membership. Each newborn is issued an individual temporary ID number for billing purposes. Do not use the mother’s ID number when billing for services provided to the newborn. This will result in non-payment of the claim. Providers are required to verify a newborn’s eligibility prior to service.

To indicate that newborn children of Horizon NJ Health members have Horizon NJ Health coverage, mothers receive a letter for their newborn that serves as a temporary enrollment notification for their baby to receive health care services for the first 60 days after birth.

If a provider has a newborn present for care without a "proof of coverage" letter, he/she must take the following steps:

- Call the Horizon NJ Health Enrollment Department at 1-800-682-9094.

- Horizon NJ Health will request to speak with the newborn’s mother/legal guardian to verify demographic information. Note that the mother/legal guardian must be present at the provider’s office.

- The Enrollment Department will enroll the newborn and create an identification number.

- The provider’s office will be notified of the newborn identification number within one hour.

- The provider’s office cannot bill for services under the mother’s identification number.

- The newborn must have his/her own identification number.

**A mother can submit a request for newborn coverage on the same day as late as one hour before going to the doctor’s office. It will take one hour after the request is submitted to generate the ID for the newborn. Once the ID number is generated, Horizon NJ Health will make an outbound call to the requestor and mother.

The newborn coverage with Horizon NJ Health ends on the 61st day after the baby’s birth, unless the baby has been registered through the New Jersey State Board of Social Services or NJ FamilyCare and subsequently enrolled into Horizon NJ Health. Once the baby has been registered with the State or NJ FamilyCare and enrolled into Horizon NJ Health, a permanent Horizon NJ Health member ID card will be issued for the newborn. The newborn will receive an HBID card from the State.
### 3.1 Medicaid/NJ FamilyCare Benefit Matrix and Managed Care Protocols

This benefit matrix provides a comprehensive overview of the benefits for preventive and medically necessary services provided to Medicaid and NJ FamilyCare members enrolled in Horizon NJ Health. NJ FamilyCare members enrolled in Horizon NJ Health through NJ FamilyCare A, ABP and B do not incur a copayment. Members enrolled through NJ FamilyCare C and D are required to pay a copayment for certain services.

Notwithstanding, the following is the benefit matrix for the Medicaid contract and sets forth the services that are reimbursable to the physician by Horizon NJ Health.

Benefits are established by the State of New Jersey and are subject to change.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>NJ FamilyCare A</th>
<th>NJ FamilyCare ABP</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions and Related Services</td>
<td>Covered by Fee-for-Service</td>
<td></td>
<td>Coverage limited to acupuncture provided by a licensed physician when performed as a form of anesthesia in connection with covered surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Covered when provided by a licensed doctor</td>
<td></td>
<td>Coverage limited to acupuncture provided by a licensed physician when performed as a form of anesthesia in connection with covered surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology (see EPSDT for hearing screenings)</td>
<td>Covered</td>
<td></td>
<td>Coverage limited to children under the age of 16 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood and Blood Plasma</td>
<td>Covered</td>
<td></td>
<td>Coverage is limited to administration of blood, processing of blood, processing fees and fees related to autologous blood donations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Coverage is limited to spinal manipulation</td>
<td>Coverage is limited to spinal manipulation • $5 copay</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td>Covered</td>
<td>Coverage limited to 60 visits per therapy, per incident, per calendar year</td>
<td>Coverage is limited to treatment for non-chronic conditions and acute illnesses and injuries. Limited to 60 visits per therapy, per incident, per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Covered</td>
<td></td>
<td>Covered with a $5 copayment, except for diagnostic and preventive services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>NJ FamilyCare A</td>
<td>NJ FamilyCare ABP</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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</tr>
<tr>
<td>Cognitive Rehabilitation Therapy (see also Rehabilitation Services)</td>
<td>Covered</td>
<td>Coverage limited to 60 visits per therapy, per incident, per calendar year</td>
<td>Coverage limited to 60 visits per therapy, per incident, per calendar year</td>
<td>Coverage limited to treatment for non-chronic conditions and acute illnesses and injuries. Coverage also limited to 60 visits per therapy, per incident, per calendar year</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Covered</td>
<td>$5 copay except for preventive dentistry visits</td>
<td>$5 copay except for preventive dentistry visits</td>
<td>$5 copay except for preventive dentistry visits</td>
<td></td>
</tr>
<tr>
<td>Dental Orthodontics</td>
<td>Covered for members up to age 21 years old when medically necessary</td>
<td>$5 copay</td>
<td>$5 copay</td>
<td>Covered for members up to age 19 years old when medically necessary</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies &amp; Equipment</td>
<td>Covered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies</td>
<td>Covered</td>
<td></td>
<td></td>
<td>Coverage is limited to specific equipment. Talk to your doctor or call Member Services for more information.</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Care/Emergency Services</td>
<td>Covered</td>
<td></td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>EPSDT (Early &amp; Periodic Screening, Diagnosis &amp; Treatment)</td>
<td>Coverage includes: • Medical examinations; • Dental, vision, hearing and lead screening services; • Treatment services identified through the examination</td>
<td></td>
<td>$10 copay for emergency room visits</td>
<td>$35 copay for emergency room services except when referred by PCP for services that should have been provided in PCP’s office or when member is admitted to the hospital</td>
<td>Coverage is limited to well-child care, newborn hearing screenings, immunizations, and lead screening and treatment</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered when services provided by a participating Horizon NJ Health provider. Covered by Fee-for-Service when services are provided by a non-participating Horizon NJ Health provider.</td>
<td></td>
<td></td>
<td></td>
<td>Coverage includes medical history and physical exams (including pelvic and breast), diagnostic and lab tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling. Must use Horizon NJ Health participating network providers</td>
</tr>
</tbody>
</table>
### 3.0 BENEFIT OVERVIEW

<table>
<thead>
<tr>
<th>Benefit</th>
<th>NJ FamilyCare A</th>
<th>NJ FamilyCare ABP</th>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
</table>
| Group Homes and DCPP Residential Treatment Facilities | • Coverage limited to services provided by Horizon NJ Health participating providers  
• Horizon NJ Health shall cooperate with the medical, nursing and administrative staff to ensure members have timely and appropriate access to participating providers and to coordinate care between participating providers and those providers employed by facility/group home | Not Covered | Coverage limited to children under the age of 16 years |
| Hearing Aid Services | Covered | | | | |
| Home Health Agency Services | Coverage includes:  
• Nursing services by a registered nurse and/or licensed practical nurse;  
• Home health aide service;  
• Medical supplies and equipment;  
• Physical Therapy, Occupational Therapy and Speech Therapy services;  
• Pharmaceutical services;  
• Durable Medical Equipment | | | | |
| Hospice Services | • Covered in the community as well as in institutional settings. Room and board are included only when services are delivered in an institutional (non-private residence) setting.  
• Hospice care for children under age 21 shall cover both palliative and curative care. | | | | |
| Hospital Services  
(Inpatient) | Covered | | | | |
| Hospital Services  
(Outpatient) | Covered | Covered | Covered | Covered | $5 copay except for preventive services |
| Intermediate Care Facilities/Intellectual Disability | Covered by Fee-for-Service | | Not Covered | | |
| Laboratory Services | Covered | | Coverage includes routine testing related to the administration of atypical antipsychotic drugs | Covered | $5 copay when not part of office visit |
| Maternity Services and related newborn care and hearing screening | Covered | | | | |
### Benefit Overview

<table>
<thead>
<tr>
<th>Benefit</th>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Day Care</td>
<td>Covered</td>
<td></td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered</td>
<td></td>
<td></td>
<td></td>
<td>Limited coverage.</td>
</tr>
<tr>
<td>Mental Health Inpatient Hospital Services (Including Psychiatric Hospitals)</td>
<td>Covered for DDD and MLTSS members by Horizon NJ Health. Non-DDD members are covered by Fee-for-Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Outpatient Services (Excluding Partial Care Services)</td>
<td>Covered for DDD and MLTSS members by Horizon NJ Health. Non-DDD members are covered by Fee-for-Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health – Home Health</td>
<td>Covered for DDD and MLTSS members by Horizon NJ Health. Non-DDD members are covered by Fee-for-Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone (Maintenance and Administration)</td>
<td>Covered by Fee-for-Service</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>Covered</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Covered</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nursing Facility Services (Custodial Care, Rehabilitation, Post-acute Care, Skilled Nursing Care and Services in Special Nursing Facilities, Such as Ventilator Facilities, Pediatric Long-term Care and Treatment for AIDS)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered, No Custodial Care</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>NJ FamilyCare A</td>
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</tr>
</tbody>
</table>
| Optical Appliances          | Covered for select eyeglasses and contact lenses as follows:  
|                             | • Age 18 and under – Replacement eyeglasses or contact lenses annually if prescription changes  
|                             | • Age 19 to 59 – Replacement eyeglasses or contact lenses every two years if prescription changes  
|                             | • Age 60 and older – Replacement eyeglasses or contact lenses annually if prescription changes  
|                             | • Replacement eyeglasses or contact lenses may be dispensed more frequently if significant vision changes occur. |                   |                 |                 |                 |
| Optometrist Services        | Covered for one routine eye exam per year |                   | Covered for one routine eye exam per year $5 copay |                 |                 |
| Organ Transplants           | Covered for transplant-related medical costs for the donor and recipient. |                   |                 |                 |                 |
| Orthodontic Services        | Coverage is limited to members up to age 21 who require these services due to medical need, including developmental problems or jaw injury. Prior authorization required. |                   | Coverage is limited to members up to age 19 who require these services due to medical need, including developmental problems or jaw injury, with a $5 copayment. Prior authorization required. | Coverage is limited to members up to age 19 who require these services due to medical need, including developmental problems or jaw injury, with a $5 copayment. Prior authorization required. |                 |
| Orthotics                  | Covered |                   |                 |                 | Not Covered |
| Outpatient Diagnostic Testing| Covered |                   |                 |                 | Not Covered |
| Partial Care Program        | Covered by Fee-for-Service |                   | Not Covered |                   |                 |
| Partial Hospital Program    | Covered by Fee-for-Service |                   | Not Covered |                   |                 |
| Personal Care Assistant Services | Covered |                   | Not Covered |                   |                 |
| Personal Preference Program Services | Covered |                   | Not Covered |                   |                 |
| Podiatrist Services         | Covered. Routine hygienic care of feet, including the treatment of corns and calluses, trimming of nails and other hygienic care in the absence of a pathological condition, is not covered. |                   | Covered with a $5 copayment. Routine hygienic care of feet, including the treatment of corns and calluses, trimming of nails and other hygienic care in the absence of a pathological condition, is not covered. |                 |                 |
## 3.0 BENEFIT OVERVIEW

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<tr>
<th>Benefit</th>
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<th>NJ FamilyCare C</th>
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</tr>
</thead>
</table>
| **Prescription Drugs (Retail Pharmacy)** | Coverage includes:  
• atypical antipsychotics;  
• Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence; and | | Coverage includes:  
• atypical antipsychotics;  
• Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence; and | | • Coverage excludes over the counter drugs  
• $5 copay for brand name and generic drugs. If greater than a 34-day supply, $10 copay applies. |
|  | Coverage excludes:  
• erectile dysfunction drugs; and  
• drugs not covered by a third-party Medicare Part D formulary |  |  |  |  |
| **Prescription Drugs — Medicare Part B physician administered** | Covered | Covered | Covered | Covered | Covered |
|  |  |  |  |  |  |
| **Primary Care, Specialty Care & Women’s Health Services** | Covered | Covered | Covered | Covered | Limited Circumstances |
|  |  |  |  |  |  |
| **Private Duty Nursing** | Covered | Covered | Covered | Covered |  |
|  |  |  |  |  |  |
| **Prosthetics** | Covered | Covered |  |  |  |
|  |  |  |  |  |  |
| **Radiology Services - Diagnostic & Therapeutic** | Covered | Covered | Covered |  |  |
|  |  |  |  |  |  |
| **Rehabilitation Services (Outpatient Physical Therapy, Occupational Therapy & Speech Therapy)** | Covered |  | Coverage limited to 60 visits per therapy, per incident, per calendar year |  |  |
|  |  |  |  |  |  |

Coverage limited to 60 visits per therapy, per incident, per calendar year

• Coverage limited to 60 visits per therapy, per incident, per calendar year.
• $5 copay
• Speech pathology services rendered for treatment of delays in speech development are not covered unless resulting from disease, injury or congenital defects.
• Cognitive rehabilitation therapy services are also limited to treatment for non-chronic conditions and acute illnesses and injuries.
<table>
<thead>
<tr>
<th>Benefit</th>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Abuse Examinations &amp; Related Diagnostic Testing</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Social Necessity Days</td>
<td>Covered by Fee-for-Service; limited to no more than 12 inpatient hospital days</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty Foods (Medical Foods)</td>
<td>Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Substance Abuse (Inpatient and Outpatient)</td>
<td>Covered for DDD members by Horizon NJ Health. Medically managed detox in an acute care setting is covered by Horizon NJ Health</td>
<td>Covered for DDD members by Horizon NJ Health. Medically managed detox in an acute care setting is covered by Horizon NJ Health Non-DDD members are covered by Fee-for-Service.</td>
<td>Covered for DDD members by Horizon NJ Health. Medically managed detox in an acute care setting is covered by Horizon NJ Health</td>
<td>Covered for DDD members by Horizon NJ Health. Medically managed detox in an acute care setting is covered by Horizon NJ Health</td>
<td>Covered for DDD members by Horizon NJ Health. Medically managed detox in an acute care setting is covered by Horizon NJ Health</td>
</tr>
<tr>
<td>Substance Abuse (Day Treatment/Partial Hospitalization)</td>
<td>Not Covered</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Substance Abuse (Outpatient and Intensive Outpatient)</td>
<td>Not Covered</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Substance Abuse (Residential – Halfway House and Short-term Residential)</td>
<td>Not Covered</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sub-acute Medically Managed Detoxification and Enhanced Medically Managed Detoxification</td>
<td>Not Covered</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation Services – Emergency Ambulance (911)</td>
<td>Coverage is limited to ambulance for medical emergencies only</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sub-acute Enhanced Medically Managed Detoxification - for ABP enrollees</td>
<td>Not Covered</td>
<td>Covered by Fee-for-Service</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation Services – Emergency Ambulance Transportation to Medically Necessary Services –</td>
<td>Covered by Fee-for-Service through LogistiCare. To schedule, call LogistiCare at 1-866-527-9933 (TTY: 1-866-288-3133).</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation – Livery Services (Bus and Train Fare or Passes, Car Service, Mileage Reimbursement) to Medically Necessary Services</td>
<td>Covered by Fee-for-Service through LogistiCare. To schedule, call LogistiCare at 1-866-527-9933 (TTY: 1-866-288-3133).</td>
<td>Contact LogistiCare at 1-866-527-9933 (TTY: 1-866-288-3133).</td>
<td>No Covered</td>
<td>No Covered</td>
<td>No Covered</td>
</tr>
</tbody>
</table>
3.2 Exclusions for NJ FamilyCare A, ABP, B and C Without MLTSS

- All services not medically necessary, provided, approved or arranged by a Horizon NJ Health participating physician or other provider (within his/her scope of practice), except emergency services
- Any service or items for which the provider does not normally charge
- Any service covered under any other insurance policy or other private or governmental health benefit system or third-party liability
- Cosmetic surgery except when medically necessary and approved
- Experimental procedures, or procedures not accepted as being effective, including experimental organ transplants
- Infertility diagnoses and treatment services (including sterilization reversals and related medical and clinic office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures)
- Services provided by or in an institution run by the federal government, such as the Veterans Health Administration
- Respite care
- Rest cures, personal comfort, convenience items and services and supplies not directly related to the care of the patient. Examples include guest meals and telephone charges
- Services in which health care records do not reflect the requirements of the procedure described or procedure code utilized by the billing provider
- Services involving the use of equipment in facilities in which its purchase, rental or construction has not been approved by the State of New Jersey
- Services furnished by an immediate relative or member of the beneficiary’s household
- Services resulting from any work-related condition or accidental injury when benefits are available from any workers’ compensation law, temporary disability benefits law, occupational disease law, or similar law
- Services or items provided or started while the covered person is on active duty in the military
- Services or items reimbursed based on submission of a cost study in which there is no evidence to support the costs allegedly incurred or beneficiary income to make up for these costs. If financial records are not available, a provider may verify costs or available income using other evidence that the NJ FamilyCare program accepts.
- Services provided in an inpatient psychiatric institution that is not an acute care hospital, to individuals under 65 years of age and over 21 years of age
- Services provided outside the United States and territories
- Services provided to all persons without charge. Services and items provided without charge through programs of other public or voluntary agencies shall be utilized to the fullest extent possible

3.2.1 Exclusions for NJ FamilyCare D Members

The following services are not covered for NJ FamilyCare D participants either by Horizon NJ Health or Division of Medical Assistance and Health Services (DMAHS):

- Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery
- Audiologist services, except for children under 16 years
- Biofeedback
- Blood and blood plasma, except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered
- Chiropractic services
- Cosmetic services
- Court-ordered services
- Custodial care
- Early and periodic screening, diagnostic and treatment (EPSDT) services (except for well-child care, including immunizations and lead screening treatments)
- Experimental and investigational services
- Hearing aid services for members over the age of 16
- Infertility services
- Intermediate care facilities for individuals with intellectual disabilities
- Medical day care services
- Non-medically necessary services
- Nursing facility services
- Orthotic devices
- Personal care assistant services
- Private duty nursing unless authorized by the contractor
- Radial keratotomy
- Recreational therapy
- Rehabilitative services for substance abuse
- Religious non-medical institutional care and services
- Residential treatment center psychiatric programs
- Respite care
- Self-initiated care without referral/authorization
- Sleep therapy
- Special remedial and educational services
- Temporomandibular joint disorder treatment, including treatment performed by prosthesis placed directly in the teeth
- Thermograms and thermography
- Weight-reduction programs or dietary supplements, except surgical operations, procedures or treatment of obesity, when approved by Horizon NJ Health

3.2.2 MLTSS Services and Benefits

MLTSS services are provided by a network provider. The benefits provided, and the frequency and length of time they are provided depend on the medical, health and social needs of the member. A service is medically necessary if it is needed to prevent, diagnose, correct or cure conditions that may cause
acute suffering, endanger life, result in illness, interfere with a member’s capacity for normal activity, or may cause a serious handicap.

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
- Behavioral Health and Substance Abuse Services
- TBI Behavioral Management (Group and Individual)
- 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)
- TBI-Structured Day Program
- TBI-Supported Day Services
- Vehicle Modifications

3.3 Family Planning

Horizon NJ Health members are entitled to receive family planning services. Services that prevent or delay pregnancy are covered, including:

- Medical history and physical examination (including pelvic and breast)
- Diagnostic and laboratory tests
- Drugs and biologicals
- Medical supplies and devices
- Counseling
- Continuing medical supervision
- Continuing care and genetic counseling

Elective/induced abortions and related services are not covered under this contract, but will continue to be paid on a fee-for-service basis by Medicaid. Infertility diagnoses and treatment services, including sterilization reversals and related office (medical or clinical) drugs, laboratory, radiological and diagnostic and surgical procedures are not covered.

Hysterectomy is not a covered service if it is performed solely for the purpose of sterilization. Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. See Section 3.4 Obstetrical and Gynecological Care.

Horizon NJ Health is available to assist members in locating family planning services. Members can access services through Horizon NJ Health’s physician network or through participating Medicaid family planning providers.

(NJ FamilyCare D may only access services through participating Horizon NJ Health physicians). Members may self-refer and go directly to a family planning clinic or call Horizon NJ Health directly. No referral from a Horizon NJ Health primary care provider (PCP) is necessary. A Horizon NJ Health representative may coordinate family planning services for a member.

Horizon NJ Health is responsible for payment of all claims related to family planning services when rendered by a participating physician, including voluntary sterilization, tubal ligation, vasectomy, or similar procedures having the purpose of pregnancy prevention. An HHS-687 Consent for Sterilization Form must be completed and signed by the member in advance of the sterilization procedures being performed. A copy of the consent form must be attached to the claim prior to submission to Horizon NJ Health.

A copy of the form can be printed from the Horizon NJ Health website. The individual who has given voluntary consent for a sterilization procedure must be at least 21 years old at the time the consent is obtained and must not be a mentally incompetent person.

Medicaid Fee-for-Service is responsible for the payment of claims from non-participating physicians, and they should be submitted to the Medicaid fiscal agent. Family planning claims from participating providers should include the member’s Social Security Number and be submitted to:

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

3.4 Obstetrical and Gynecological Care

Horizon NJ Health provides a full range of obstetrical and gynecological (OB-GYN) services to members.
Obstetrical and Gynecological Care Policy
Members may self-refer to a participating physician for routine OB-GYN services. No referral from the PCP is required.

NJ FamilyCare C and D members are responsible for a $5 copayment for OB-GYN services unrelated to well visits, prenatal visits and Pap smears. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician’s name, address and telephone number.

The Obstetrician/Gynecologist will assume responsibility for referring the member to their PCP for medical services unrelated to the OB-GYN care.

Obstetrical and Gynecological Care Procedure
OB-GYN physicians should refer members and send specimens to the laboratory service center assigned to their office affiliated with Laboratory Corporation of America Holding (LabCorp), which is the exclusive contracted laboratory for Horizon NJ Health. Please refer to www.labcorp.com for the LabCorp Patient Service Center in your area.

CPT Codes for OB-GYN Services
For 1-3 Antepartum Care Visits, use E&M Codes.

All newly enrolled members must receive prenatal care within their first trimester or within 42 days of enrolling in Horizon NJ Health.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425</td>
<td>Antepartum Care Only: 4-6 visits</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum Care Only: 7 or more visits</td>
</tr>
</tbody>
</table>

A postpartum visit must be completed between 21 and 56 days after delivery.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Regular Vaginal Delivery</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum Care Visit Only</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean Section Delivery Only</td>
</tr>
<tr>
<td>59409, 59612</td>
<td>Vaginal After Cesarean Delivery (First Newborn)</td>
</tr>
<tr>
<td>59510, 59514, 59515, 59618, 59620, 59622</td>
<td>Vaginal After Cesarean Delivery (Subsequent Newborn)</td>
</tr>
</tbody>
</table>

The following codes are used when billing for maternity support services:

Maternity Support Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>HD</td>
<td>Initial antepartum maternity health support services</td>
</tr>
<tr>
<td>59425/</td>
<td>None</td>
<td>Subsequent antepartum</td>
</tr>
</tbody>
</table>

Non-Invasive Prenatal Testing
The informaSeqSM Prenatal Test, is available via LabCorp for all pregnant members. This test uses a blood sample from the pregnant woman to look for fetal DNA and detects trisomies of chromosomes 21, 18 and 13 with a high degree of accuracy. Prior authorization will not be required. However, testing will only be covered for members meeting medical criteria.

For more information about informaSeq, please call LabCorp at 800-631-5250.

Newborn Biochemical Screening Testing
New Jersey has expanded its statewide system of newborn biochemical testing to include disorders that, if not detected early, can cause severe health problems, mental retardation and even death. Hospitals submit newborn blood samples to the Department of Health and Senior Services’ Public Health and Environmental Laboratories, which perform the tests. Examples of disorders that are screened for in New Jersey are:

- Phenylketonuria (PKU)
- Congenital hypothyroidism
- Galactosemia
- Hemoglobinopathies
- Biotinidase deficiency
- Congenital adrenal hyperplasia (CAH)
- Cystic fibrosis
- Maple syrup urine disease (MSUD)
- Medium chain acyl-CoA dehydrogenase (MCAD) deficiency
- Short chain acyl-CoA dehydrogenase (SCAD) deficiency
- Long chain acyl-CoA dehydrogenase (LCAD) deficiency
- Very long chain acyl-CoA dehydrogenase (VLCAD) deficiency
- Citrullinemia
- Argininosuccinic aciduria

There is a critical need for timely medical evaluation, diagnostic laboratory testing, referral and treatment for these disorders. Appropriate diagnosis and management of infants with these disorders...
disorders requires specialized and timely care. A physician should contact the Utilization Management department when a newborn has a positive laboratory result. Horizon NJ Health will contact the member to coordinate care.

Utilization Management Department
1-800-682-9094

Hysterectomy

Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189). A copy of the form can be printed from the Horizon NJ Health website at horizonNJhealth.com.

Horizon NJ Health requires that a properly completed FD-189 form be submitted during the request for precertification for all non-emergent hysterectomies. Claim payment for a hysterectomy without a copy of the Hysterectomy Receipt of Information form will be made only if the physician performing the hysterectomy certifies that:

a. The woman was already sterile, stating the cause of that sterility; or
b. The hysterectomy was required because of a life-threatening emergency situation. The physician must also include a description of the nature of the emergency.

Colposcopies

- Fee-for-Service, if performed in a PCP office
- No referral required if done by a participating OB-GYN or a nonparticipating OB-GYN in a participating group
- UM authorization is required if done in an outpatient setting (other than the OB-GYN office) by calling Pre-Cert at 1-800-682-9094.

Check to verify member eligibility by calling the Physician & Health Care Hotline at 1-800-682-9091 or through the Horizon NJ Health Plan Central on NaviNet.

3.6 Chiropractic Care

Chiropractic care, when it meets medical necessity criteria, is limited to “manual manipulation of subluxation of the spine.” CPT Codes 98940, 98941, 98942 and 98943 are eligible for reimbursement.

Chiropractic services, including the initial visit and initial treatment, require a PCP referral. All subsequent treatments require prior authorization.

The following evaluation and management codes are only eligible for payment when billed during the initial office visit:

- 99201-99205

NJ FamilyCare C members are responsible for a $5 copayment for chiropractic visits. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician’s name, address and telephone number.

Chiropractic benefits are not covered for NJ FamilyCare D members.

3.7 Organ Transplants

Donor and recipient costs for non-investigational and non-experimental organ transplants are reimbursable by Horizon NJ Health. Eligible organ transplants include, but are not limited to:

- Heart
- Heart/lung
- Kidney
- Liver
- Bone marrow
- Intestine
- Cornea
- Lung
- Pancreas

- X-ray tibia AP & LAT: 73590
- X-ray ankle, complete: 73610
- X-ray foot AP & LAT views: 73620
- X-ray foot, complete, min 3 view: 73630
- Calcaneus, min 2 view: 73650

Routine foot care, including nail clipping, corn and callus removal and other hygienic care, such as cleaning or soaking feet, is covered only when medically necessary.

NJ FamilyCare C and D members are responsible for a $5 copayment for specialty care visits. Please issue a receipt to the member, upon collection of a copayment. This receipt should include the physician’s name, address and telephone number.
All costs associated with the procurement and transplantation of organs for eligible members are covered by Horizon NJ Health. The PCP will coordinate all transplant services with the specialty care physician. The specialty care physician must contact the Utilization Management department to obtain an authorization for services.

Utilization Management Department
1-800-682-9094

3.8 Hospice Care

The PCP must contact the Horizon NJ Health Utilization Management department to arrange for hospice care. The Utilization Management department will handle the coordination needs between the PCP and hospice care provider to ensure that the member receives the appropriate care.

Utilization Management Department
1-800-682-9094

A PCP who prescribes a hospice program for a member must discuss with the member and their family the status of an advance directive or “living will.” Review Section 12.21 for more information. Horizon NJ Health’s physicians are encouraged to review the guidelines published by the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care. The guidelines can be viewed at http://www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf

3.9 Durable Medical Equipment (DME) and Medical Supplies

Horizon NJ Health will provide benefits for DME and medical supplies when medically necessary and approved.

- If the billed charge of the non-rental item is less than $250, the participating provider may dispense the item without prior authorization from Horizon NJ Health. However, Horizon NJ Health recommends that the provider contact the Physician & Health Care Hotline at 1-800-682-9091 to verify eligibility prior to dispensing the item.

Provisions have been made for participating network pharmacies to dispense certain DME and medical supplies when written on a prescription.

- If the billed amount of the claim is equal to or greater than $250, authorization must be obtained from the Horizon NJ Health Utilization Management department before the item is dispensed. To receive authorization, the requesting provider must fax an authorization request to the Utilization Management department at 1-609-583-3011.
  - All rental items require authorization

Certain DME/medical supply items require the completion of a letter of medical necessity prior to authorization.

DME items may require a DME assessment by an independent contractor prior to authorization.

Utilization Management Department
1-800-682-9094

3.9.1 Durable Medical Equipment Available for NJ FamilyCare D Members

Coverage is limited to the following:

- Apnea Monitors
- Bathroom Equipment (Permanently Affixed Equipment Not Covered)
- Catheterization and Related Supplies
- Commodes
- DME Repairs
- Enteral Nutrition and Related Services/Supplies
- Hospital Beds (Manual, Semi-Electric and Full Electric) and Related Equipment
- Insulin Pumps and Related Supplies
- Manual Wheelchairs (Motorized Wheelchairs Not Covered)
- Nebulizers and Related Supplies
- Ostomy / Ileostomy / Jejunostomy Supplies
- Oxygen and Related Equipment/Supplies
- Pacemaker Monitors
- Parenteral Therapy and Related Services / Supplies
- Patient Lifts and Related Equipment
- Pressure Mattresses / Pads (Low Air Loss and Air Fluidized Beds Not Covered)
- Respiratory Assist Devices and Related Supplies
- Suction Machines and Related Supplies
- Total Parenteral Nutrition (TPN) Equipment and Related Supplies
- Tracheostomy Supplies
- Traction/Trapeze Apparatus
- Wheelchair Accessories
- Wound Care Supplies
- Wound Vac and Related Supplies
3.9.2 Adult and Pediatric Incontinence Management Products

Medline Industries Inc. is Horizon NJ Health's provider of adult and pediatric incontinence management products. These products include:

- Disposable Briefs (Adult, youth and diapers for children four years old and older)
- Disposable Protective Underwear (Adult and youth pull-ups)
- Disposable Bladder Control Pads (Bladder Pads/Male Guards)
- Disposable Underpads

Each member is approved for a maximum of 180 total items per month. This includes a combination of diapers, diaper liners, and pull-ups. For example, one can have a combination of 90 diapers and 90 pull-ups, or any other numerical split, but one cannot obtain 180 of each.

If a member requires more than 180 items per month, they will need to obtain a prior authorization (or approval). Participating providers should fax prescriptions for these products to Medline at 1-866-202-1563. The products are shipped to the member's home by Medline.

3.10 Prosthetics/Orthotics

Participating providers may dispense prosthetic/orthotic devices to members when medically necessary.

Prosthetics require a signed and dated prescription and a completed Medical Necessity Request form from the prescribing physician. All repair and replacement of parts for custom-made prosthetic devices require a signed and dated prescription and a complete Medical Necessity Request form.

Prosthetic devices are limited to the initial provision for NJ FamilyCare members. Repair and replacement services are covered when due to congenital growth.

Prosthetics are limited to the initial provision of a prosthetic device for NJ FamilyCare D members.

Orthotic Devices

Orthotic devices for members are pre-authorized by Horizon NJ Health. Orthotics require a signed and dated prescription and a completed Medical Necessity Request form from the prescribing physician. All repair and replacement of parts for custom-made orthotic devices require a signed and dated prescription from the physician.

If the billed charge for the purchase, repair or replacement of parts is under $500 and the provider is participating, no prior authorization from Horizon NJ Health is required. If the billed charge for the purchase, repair or replacement of parts is equal to or greater than $500, prior authorization is required.

Orthotics and orthotic devices are not a covered benefit for NJ FamilyCare D members.

3.11 Home Health Care

When medically appropriate, Horizon NJ Health encourages the use of home health care services as an alternative to hospitalization to allow early hospital discharge, avoid unnecessary admissions and allow the member to receive care in familiar surroundings. Among the home health care services covered are the following:

- Skilled nursing
- Physical therapy
- Speech therapy
- IV therapy
- Occupational therapy
- Home care visits for prenatal and postpartum needs
- Lead outreach
- Social work
- Private duty nursing for members under age 21

Horizon NJ Health’s Utilization Management department shall coordinate all medically necessary home care. The Utilization Management department will review each case to assess and authorize the length or type of service required. An authorization number will be assigned and should appear on all bills submitted for preauthorized services provided to the member.

Home care agencies receiving requests to provide care must contact the Utilization Management department to verify eligibility and benefit availability and obtain authorization for services prior to providing the service, except in emergency circumstances.

Payment of a maternity/postpartum or health management home visit is contingent upon receipt of the assessment by Health Services. If you need a copy of the assessment form, please call the Health Services department.

Health Services Department
1-800-682-9094
Fax Number: 1-609-538-1574

An authorization is given for each service type requested. However, the authorization number may be updated for continuance of any service, which will extend beyond the initial approval period. Contact should be made at least five days prior to the end date of the original authorization.

Physician orders and care plans need not be submitted
3.0 BENEFIT OVERVIEW

with claims for home care services; however, the physician must keep such information on file for presentation to Horizon NJ Health’s Utilization Management department, if requested. All claims submitted by the Home Care provider that include DME or pharmaceutical supplies must be accompanied by a physician-issued prescription. All claims submitted are subject to eligibility and benefit availability.

Private-duty nursing services require authorization in all instances. They are an EPSDT benefit and covered for children who meet the EPSDT age requirement. They are not a covered benefit for NJ Family Care D members, unless authorized by Horizon NJ Health. For more information, please call the Utilization Management department.

For NJ FamilyCare D members, home health services are limited to skilled nursing visits for homebound beneficiaries when provided or supervised by a registered nurse and home health aide, when the purpose of the treatment is skilled care and medical social services necessary for treatment of medical condition.

3.12 Personal Care Assistant Services

Personal care assistant service is available to members with Medicaid and NJ Family Care Plans A and ABP. This service provides hands-on personal care to members, including bathing, grooming and toileting.

A nurse completes an assessment to determine care needs based on the member's functional status, and members who qualify are authorized for a specific number of service hours per week.

3.13 Medical Day Care Services

Medical day care service is available to members with Medicaid and NJ FamilyCare A and ABP. This is a facility-based service for medical care for children and adults. Preauthorization is required following an assessment to determine medical needs.

3.14 Therapeutic Services

The following outpatient therapeutic services are covered by Horizon NJ Health:

- Physical therapy
- Speech/pathology services
- Occupational therapy
- Cognitive rehabilitation, limited to those with an identifiable event

For outpatient physical and occupational therapy, participating providers do not need an authorization for the initial evaluation, but they do need a referral. After the initial evaluation is completed, the provider needs to request authorization for initial visits either by going online and submitting a Utilization Management request through NaviNet/Care Affiliate or by faxing a copy of the Prior Authorization Form to 609-583-3042. The Utilization Management department will process the request based on the clinical information provided. Follow-up requests for additional authorizations will require proof, such as daily treatment notes or flow sheets, that all previously authorized visits have been completed.

Participating providers must be licensed by the state in their respective disciplines in order to provide these services. Referrals are required for all Therapeutic Services.

For NJ FamilyCare D members, further treatments must also be coordinated by the treating provider(s) and authorized by the Utilization Management department. There are limitations for speech and cognitive therapy

3.15 Vision Care

Davis Vision administers the vision care benefit for Horizon NJ Health members, including vision exams, eyeglasses, corrective lenses and contact lenses, if prescribed. Members may self-refer and go directly to a participating Davis Vision provider.

A referral from a Horizon NJ Health PCP is not necessary in order to receive routine services from a participating Davis Vision provider. If a condition that requires further treatment is detected during the annual exam, the PCP

Utilization Management Department
1-800-682-9094
must be contacted. A network optometrist or ophthalmologist may provide treatment for eye disorders that requires specialized attention beyond the routine services provided by a Davis Vision provider. A referral from the PCP is required for all follow-up treatment, including therapeutic services.

Davis Vision optometrists or ophthalmologists rendering therapeutic services as a result of a routine visit must contact Davis Vision to obtain an authorization.

If you are a Davis Vision provider, please contact Davis Vision at 1-800-933-9371 to verify eligibility and to obtain a comprehensive Davis Vision Physician Manual.

NJ FamilyCare C and D members are responsible for a $5 copayment for optometry visits. Please issue a receipt to the member upon collection of a copayment. This receipt should include the physician’s name, address and telephone number.

3.16 Dental Services

Horizon NJ Health offers a full range of dental services to certain members. These services include preventive and diagnostic, specialty and major restorative dental services. When necessary, orthodontics are also covered for members under 21 years of age or as allowed by EPSDT.

Scion Dental administers dental services for Horizon NJ Health members.

Referring a member to a dentist by 1 year of age and every year thereafter is recommended. Referral to a dentist is mandatory when a member reaches 3 years of age, and annually thereafter through age 20.

Dental services include an initial examination and any required dental services determined to be dentally necessary. Scion Dental coordinates all precertifications for the provision of inpatient dental care. Please contact Scion Dental at the telephone number below to obtain more information about covered benefits.

Scion Dental
1-855-878-5368

Dental claims should be mailed to:

Scion Dental
PO Box 299
Milwaukee, WI 53201

Except for preventive dentistry services, NJ FamilyCare C members are responsible for a $5 copayment for dental services.

Preventive dental benefits for NJ FamilyCare D members are limited to children under the age of 19 years, including oral examinations, oral prophylaxis, topical applications of fluorides, X-rays and sealants.

3.16.1 Medical Versus Dental Services

Horizon NJ Health recognizes that medical conditions may exist that can exhibit one or more dental components. These dental components/conditions may be 1) causative to the medical situation of the patient, 2) completely unrelated, or 3) the sequelae of the medical condition or its treatment.

A physician or oral surgeon may perform procedures that may be considered medical or dental (e.g., surgical procedures for fractured jaw or removal of cyst). Please see Section 8.2 Precertification Process to obtain the authorization process or you may call the Horizon NJ Health Utilization Management department.

A broad definition of dental services would be those procedures used to treat the dental structures, including primary and permanent dentition and supporting structures including the periodontium and alveolar bone.

Specific procedures that would fall under the category of dental treatment are:

- Restoration of tooth structure lost by decay, fracture, attrition or erosion using synthetic materials. This can include intra-coronal restorations, such as amalgam, gold or composite, full or partial coverage crowns and tooth strengthening and retention enhancement for endodontically treated teeth.
- Endodontic treatment of teeth, including re-treatment, if necessary, and any necessary periapical or sectioning surgical intervention
- Surgical services and post-op treatment performed on the dental supporting structures that include treatment of periodontal disease, osseous surgery and any other surgery to the periodontium
- Replacement of missing teeth using full dentures, removable partial dentures or fixed prostheses and related services
- Removal of teeth and re-implantation of teeth and associated services
- Orthodontic treatment, even if a component of an eligible medical condition or treatment

Obtain authorization by calling Horizon NJ Health’s Utilization Management department at least five business days prior to the inpatient or outpatient procedure if the procedure requires anesthesia or is performed in an inpatient setting or non-participating ambulatory surgical center.

Utilization Management Department
1-800-682-9094
3.16.2 Dental Director

Horizon NJ Health shall retain on staff at all times a Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD). The Dental Director must have practiced in New Jersey and is responsible for:

- The development, implementation and interpretation of dental policies and procedures to guide and support the provision of dental care
- Oversight or shared oversight of dental provider recruitment activities
- Reviewing all dental provider applications and making recommendations to those with provider contracting authority regarding credentialing and recredentialing of all dental providers
- Surveillance of the performance of providers in their provision of dental care to members
- Administration of all Horizon NJ Health dental activities
- Continuous assessment and improvement of the quality of dental care provided to members
- Serving on the Quality Management Committee
- Oversight of dental providers' orientation, education and in-service training
- Assuring that adequate staff and resources are available for the provision of dental care
- The review and approval of studies and responses to DMAHS concerning quality matters
- Representing Horizon NJ Health at meetings of the DMAHS Dental Advisory Council and at local dental societies and associations
- Monitoring performance of Scion Dental or that of any other dental contractor or vendor; providing direction to dental contractor or vendor; ensuring that any decisions are made in a timely and clinically important manner; addressing dental issues at the level of the contractor or vendor
- Verifying on a monthly basis that dental providers and subcontractors have not been suspended, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs

3.16.3 Fluoride Varnish Provider Incentive Program

In an effort to help quell the alarming rate of early childhood caries for Horizon NJ Health members under the age of 6, Horizon NJ Health has developed a pediatric fluoride varnish program. This program encourages pediatricians to apply fluoride varnish to children’s teeth, perform assessments, and promote routine dental visits for our young members.

Horizon NJ Health is offering reimbursement to trained pediatrician offices when their pediatricians, nurse practitioners or physician assistants apply fluoride varnish to the teeth of Horizon NJ Health members at well-child visits through age 5. Pediatricians will receive $15 for each fluoride varnish application up to every three months. Pediatricians are also encouraged to discuss with patients the importance of nutrition and oral hygiene and provide anticipatory guidance.

Providers will receive compensation for members under age 6 who visit a dentist within 60 days of the application of fluoride varnish. Providers receive $10 per child for dental visits within 30 days of their physician visit and $5 for dental visits within 31 to 60 days.

In order to receive CME training credit (in some cases) and collect the reimbursement, practitioners must complete the following online training and assessment:

- Go to www.smilesforlifeoralhealth.org and click Course 6 in the right column – Caries Risk Assessment, Fluoride Varnish & Counseling
- One provider per facility may complete the curriculum and agree to train their colleagues
- After completing the curriculum, that provider must sign the Fluoride Varnish Attestation Form attesting that they completed the training and agree to train the other providers in their office

Once the training is complete, the PCP should fax the attestation to 1-609-583-3024. All providers under the PCP’s TIN should be listed on the attestation form. Please use CPT code 99188 when billed with ICD-10 Z41.8 as the primary diagnosis code. A copy of the form is on the Horizon NJ Health website in the "For Providers" tab, select Resources and then Forms.

Note that providers who have not completed the training are not eligible for reimbursement.
3.17 Mental Health and Substance Abuse Services

Horizon NJ Health’s physicians will systematically identify and address behavioral health needs for all Horizon NJ Health members at the earliest possible time following initial enrollment with Horizon NJ Health or after the onset of the condition, through a behavioral health screening tool administered by the member’s PCP. PCPs and other physicians are to utilize mental health/substance abuse screening tools, as well as other mechanisms, to facilitate early identification of behavioral health needs for treatment. For your reference, the behavioral health screening tool has been posted to the website at www.horizonNJhealth.com.

The State retains a separate behavioral health system for members who are not clients of the Division of Developmental Disabilities (DDD) through the NJ Medicaid Fee-for-Service program. Horizon NJ Health PCPs refer non-DDD members to a NJ Medicaid Fee-for-Service behavioral health professional.

Horizon NJ Health provides behavioral health benefits to Horizon NJ Health members who are clients of the DDD through the Horizon Behavioral Health Network. Horizon NJ Health’s Care Management department will coordinate the behavioral health services for DDD members with the PCP, Horizon Behavioral Health and its professional network.

Horizon Behavioral Health can be contacted at 1-877-695-5612.

The PCP will perform a medical diagnostic work-up to formulate a diagnosis or effect the treatment of a behavioral health disorder and ongoing medical care for any member with a behavioral health diagnosis, as well as to coordinate the care with the behavioral health professional. This includes physical examinations, neurological evaluations, laboratory testing and radiologic examinations and any other diagnostic procedures necessary to make the diagnostic determination between a primary behavioral health disorder and an underlying physical disorder, as well as for medical work-ups required for medical clearances prior to the provision of psychiatric medication or electroconvulsive therapy (ECT), or for transfer to a psychiatric/substance abuse facility.

Behavioral health services include, but are not limited to, comprehensive intake evaluation, offsite crisis intervention, family therapy, family conference, psychological testing and medication management.

Any member may be referred to a behavioral health professional by the PCP and other physicians, family members, state agencies or Horizon NJ Health, or a member may self-refer. The PCP must notify the behavioral health professional of the medical examination and diagnostic testing results within 24 hours of receipt for urgent cases and five business days of receipt for non-urgent cases. The PCP should notify the behavioral health professional by telephone with followup in writing, when feasible. This notification is applicable to DDD and non-DDD members.

Diagnoses that are categorized as altering the mental status of an individual, but are of organic origin, will be eligible as a covered service under Horizon NJ Health. Horizon NJ Health will assume responsibility for the provision of medical care in these cases for all members. This includes, but is not limited to, the diagnoses in the following ICD-10-CM series:

- F03.90 Senile dementia, uncomplicated
- F03.90 Presenile dementia, uncomplicated
- F03.90 Presenile dementia with delirium
- F03.90 Presenile dementia with delusional features
- F03.90 Presenile dementia with depressive features
- F03.90 Senile dementia with delusional or depressive features
- F03.90 Senile dementia with delusional features
- F03.90 Senile dementia with depressive features
- F03.90 Senile dementia with delirium
- F01.50 Vascular dementia, uncomplicated
- F01.51 Vascular dementia with delirium
- F01.51 Vascular dementia with delusions
- F01.51 Vascular dementia with depressive mood
- F03.90 Other specific senile psychotic conditions
- F03.90 Unspecified senile psychotic condition
- F10.26 Alcohol-induced persisting amnestic disorder
- F10.27 Alcohol-induced persisting dementia
- F13.27 Drug-induced persisting dementia
- F13.26 Drug-induced persisting amnestic disorder
- F11.19 Unspecified drug-induced mental disorders
- F05 Acute delirium due to conditions classified elsewhere
- F05 Subacute delirium
- F06.2 Transient organic psychotic condition, paranoid type
- F06.0 Transient organic psychotic condition, hallucinatory type
- F06.30 Transient organic psychotic condition, depressive type
3.0 BENEFIT OVERVIEW

<table>
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<tr>
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<th>Description</th>
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<td>F04</td>
<td>Amnestic syndrome</td>
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<tr>
<td>F17.220</td>
<td>Tobacco use disorder</td>
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<tr>
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<td>Tobacco use disorder</td>
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<td>F07.0</td>
<td>Frontal lobe syndrome</td>
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<td>F07.81</td>
<td>Postconcussion syndrome</td>
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<td>F07.9</td>
<td>Unspecified, nonpsychotic mental disorder</td>
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<td>following organic brain damage</td>
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<td>F09</td>
<td>Unspecified, nonpsychotic mental disorder</td>
</tr>
<tr>
<td></td>
<td>following organic brain damage</td>
</tr>
</tbody>
</table>

Horizon Behavioral Health can be contacted at 1-877-695-5612.

3.17.1 Mental Health and Substance Abuse
Well-Being Screening Tool

PCPs are required to assess the behavioral health needs of enrolled members. To help facilitate your assessment, please use the Well-being Screening Tool as a screening tool to assess early identification of behavioral health needs for each Horizon NJ Health member prior to treatment. A copy of the form can be printed from the Horizon NJ-Health website at horizonNJhealth.com. A copy of the completed questionnaire should be placed in the member’s medical record. If a behavioral health need is identified, please refer the member for behavioral health services, as indicated below.

Horizon NJ Health members and clients of the DDD
- Physicians may call Horizon NJ Health’s Utilization Management department at 1-800-682-9094. Our DDD Care Management department will coordinate the behavioral health services for DDD members with medical providers.
- Physicians and/or members may call Horizon Behavioral Health toll free at 1-877-695-5612. A representative is available 24 hours a day, seven days a week, to coordinate behavioral health services for DDD members.

Horizon NJ Health members who are not clients of the DDD
- Please call or refer the Horizon NJ Health member to a participating Medicaid behavioral health professional.

3.18 Outpatient Laboratory Services

All physicians must utilize the exclusive clinical laboratory provider for Horizon NJ Health when studies are required for members.

Horizon NJ Health contracts with Laboratory Corporation of America Holdings (LabCorp) for laboratory services.

Physicians are responsible for notifying members of laboratory results. For additional information, contact the Physician & Health Care Hotline at 1-800-682-9091.

Short Turn-Around Time (STAT) Requests

LabCorp provides STAT lab services Monday through Friday from 8 a.m. until 6 p.m. Saturday hours are from 8 a.m. until 4:30 p.m. LabCorp will notify practitioners and follow up with the results for office-based lab draws as soon as the results are available. STAT turn-around time begins when the call is placed for office-based lab draws. LabCorp’s goal is to provide STAT results within four hours of the request for pick-up. LabCorp will notify the physician after hours of the test results and will follow the critical panic and alert protocol.

LabCorp Alert and Panic Results Policy

LabCorp’s Alert Results Policy allows clients to customize their alert preferences based on practice needs. LabCorp recognizes that the physician can best determine the alert settings for his or her office setting.

Alert Results (excessively abnormal test results). Physicians may want the clinical laboratory to notify them whenever a test result is excessively abnormal, although not life threatening. LabCorp calls these alert laboratory results to the physician on weekdays during normal business hours.

Panic Results (potentially life-threatening laboratory results). As mandated by federal law and regulatory
agencies, LabCorp telephones these panic laboratory results to the physician as soon as they are verified, 24 hours a day, seven days a week.

If you wish to customize the alert values that you want called or modify alert values previously set, please contact your LabCorp representative or call LabCorp Customer Service at 1-800-745-0233.

It is important to remember that if your practice is set up with LabCorp to receive only final reports, no printed results will be sent until all testing has been completed. For example, if you order a prothrombin time/international normalized ratio (PT/INR) and a routine urine culture for a patient, you will not receive the results of the PT/INR until the urine culture result is finalized. With customized alert values, you will be advised of any excessively abnormal results without having to wait for all other testing to be completed.

**Urgent/Emergent Results**

Members must be notified of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases. Urgent/emergent appointment standards must be followed. See Section 12.18 Appointment Scheduling Standards.

Rapid strep test results must be available to the member within 24 hours of the test.

**Routine Results**

Members must be notified of routine laboratory and radiology results within 10 business days of receipt of the results.

Routine testing related to the administration of methadone and atypical antipsychotic drugs and their generic equivalents are covered by Horizon NJ Health for members who are clients of the DDD. Routine testing related to the administration of the above drugs for all other Horizon NJ Health members is covered on a Fee-for-Service basis by NJ Medicaid.

To facilitate outpatient laboratory services, be sure to follow the procedures identified below:

- Horizon NJ Health encourages physicians to perform venipuncture in their office. Physicians should contact LabCorp to arrange for pick-up services.
- Participating physicians who cannot perform venipuncture in their office should send members to the nearest LabCorp Patient Service Center. Please refer to the Provider Directory for a listing of the laboratory service centers in your area or call the Physician & Health Care Hotline for assistance. A completed LabCorp requisition form must accompany the member to the service center. Please contact LabCorp to obtain laboratory requisition forms.
- Preadmission laboratory testing (PAT) should be completed by the PCP through LabCorp. However, if it is not possible to work through LabCorp, testing can be completed at the hospital where the procedure will be provided. A list of STAT, PAT and pathology tests is provided on the following page. If you do not find a test on the list, please call our Utilization Management department for authorization at 1-800-682-9094. The member must be given a referral form for any preadmission testing when utilizing the hospital laboratory. Please remember to indicate “PAT” on the referral form.
- Short Turn-Around Time (STAT) labs must only be utilized for urgent problems outside LabCorp's hours of operation. The member must be given a referral form to a participating hospital laboratory. A list of STAT, PAT and pathology tests is provided below. If you do not find a test on this list, please call our Utilization Management department for authorization at 1-800-682-9094.
- The member must be given a referral form when utilizing a participating hospital laboratory. Please remember to indicate “STAT” on the referral form.
- Horizon NJ Health will not remit payment to hospitals, physicians or other laboratories for lab services that should be rendered by LabCorp.

**LabCorp Customer Service**

1-800-631-5250

NJ FamilyCare D members are responsible for a $5 copayment when the laboratory service is not part of an office visit.
### Horizon NJ Health STAT and PAT Testing Menu

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Test Name</th>
<th>PAT</th>
<th>STAT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>CHEMISTRIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82947</td>
<td>Blood glucose, NOT test strip</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>84520</td>
<td>BUN, serum</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive metabolic panel</td>
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<tr>
<td>82565</td>
<td>Creatinine, serum</td>
<td>X</td>
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</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>82247, 82248</td>
<td>Bilirubin, indirect and direct</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>(newborns only)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>ENDOCRINE and OB-GYN</strong></td>
<td></td>
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<tr>
<td>84703</td>
<td>Beta hCG, qualitative</td>
<td>X</td>
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<tr>
<td>84702</td>
<td>Beta hCG, quantitative</td>
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<td>X</td>
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<tr>
<td>85060</td>
<td>Blood smear, provider evaluated</td>
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<td>X</td>
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<tr>
<td>85004</td>
<td>CBC and differential, automated</td>
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<tr>
<td>85007</td>
<td>CBC and differential, manual</td>
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<td>X</td>
</tr>
<tr>
<td>85027</td>
<td>CBC, differential w/ platelet ct, automated</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>85610</td>
<td>Blood clotting tests, various</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>85730</td>
<td>Investigation of blood transfusion reaction</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing, various tests</td>
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<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>URINE ANALYSIS</strong></td>
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<td></td>
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<tr>
<td>81000 to 81050</td>
<td>Urine analysis, varied tests</td>
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<td>X</td>
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<td><strong>DRUG ANALYSIS</strong></td>
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</tr>
<tr>
<td>80162</td>
<td>Digoxin</td>
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<tr>
<td></td>
<td><strong>OTHER PATHOLOGY</strong></td>
<td></td>
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</tr>
<tr>
<td>87164</td>
<td>Dark field exam</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
<tr>
<td>87210</td>
<td>Wet mount with simple stain</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
<tr>
<td>87177</td>
<td>Ova and parasites; direct</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
<tr>
<td>87220</td>
<td>Tissue exam for fungi</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
<tr>
<td>89050</td>
<td>Cell count, misc. body fluids</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
<tr>
<td>89051</td>
<td>With different count</td>
<td>POS 11 (unless otherwise specified by contract)</td>
<td></td>
</tr>
</tbody>
</table>
Completing LabCorp Requisition Forms
Horizon NJ Health physicians are reminded to completely and legibly fill out the required information on the LabCorp requisition form. This will ensure that claims and payments for services provided by LabCorp are processed in the most efficient manner and will eliminate the potential for our members to be billed for laboratory services. The Insurance section must include correct and legible information in the following fields:

- Insurance Company Name: Horizon NJ Health
- Subscriber/Member #: Horizon NJ Health patient’s ID number

Physicians may refer to the LabCorp website at www.labcorp.com for more testing information and locations of patient service centers.

Relevant LabCorp Information
- Please remember to use the correct form for LabCorp lead testing
- Please utilize the Heavy Metal Request form and indicate the source of the blood (venous or capillary)
- You can order these forms from the LabCorp Customer Service line: 1-800-631-5250
- LabCorp will customize this form with your physician information. LabCorp can also customize this form to include any other labs you may wish to include at your request. For example, if you routinely ask for a hemoglobin and hematocrit with a lead screen, you can ask LabCorp to add this test to the Heavy Metal Request form for you. You could also add CBC and urinalysis to coordinate your EPSDT lab requirements.

3.19 Pharmacy Services
Medically necessary prescriptions are a covered benefit for most Horizon NJ Health members. Pharmacy services (legend and non-legend) for dual eligible (Medicare and Medicaid) members are mostly covered by Medicare Part B or D, except for certain wrap-around services (i.e., prescription vitamins [except prenatal vitamins and fluoride preparations]).

Many over-the-counter drugs and medical supplies are also covered when ordered with a written prescription. Horizon NJ Health requires that physicians prescribe generic medications whenever possible. If the brand name is prescribed when there is a generic alternative, you will be required to obtain prior authorization and prove medical necessity. Non-covered pharmacy benefits include but are not limited to the following: fertility medications, weight loss drugs, and erectile dysfunction medications.

If a provider requests prior authorization for a formulary or non-formulary medication, a 72-hour supply of that medication may be provided to the member. Determinations for prior authorizations will be provided within 72 hours. To request prior authorization, fill out the form located at horizonNJhealth.com. Under the For Providers tab, click Resources, then Pharmacy Utilization Management Programs and Pharmacy Medical Necessity Determination.

Here you can also find a link to the Horizon NJ Health Medical Policy Manual. Click the Pharmacy link to find detailed information about prior authorization determinations for specific drugs.

Members should be directed to pharmacies that participate in the Horizon NJ Health network. When filling a prescription, the member will be required to present their member ID card to the participating pharmacy. See the Provider Directory for a list of participating pharmacies.

NJ FamilyCare C members have a $1 copayment for generic drugs and a $5 copayment for brand-name medications. NJ FamilyCare D members are responsible for a $5 copayment for both brand and generic drugs. For NJ FamilyCare D members, if a supply of more than 34 days is provided, a $10 copayment applies. In general, Horizon NJ Health allows up to a 34-day supply. For the MLTSS population currently residing in a LTC facility, there is generally a maximum of a 14-day supply of medication eligible for coverage. A supply of greater than 14 days is permitted for certain unit of use medications (i.e. ophthalmic drops). In addition, the use of institutional-sized drug products, for example, insulin, will be utilized where available for those members residing in a LTC facility.

Please refer to the Horizon NJ Health website (horizonNJhealth.com) for information on pharmaceutical management procedures, including the formulary listing, policies, quantity limits/plan limitations, step therapy, and all prior authorization/non-formulary forms. In addition, paper copies of the pharmaceutical management procedures are available upon request by contacting the Pharmacy department at 1-800-682-9094.

Pharmacy Lock-in Program
Horizon NJ Health reserves the right to lock its members into specific pharmacies when it has been determined that the member has inappropriately used his/her pharmacy benefit or when enhanced benefit coordination is necessary. For more information about the Pharmacy Lock-in Program, please contact the Physician & Health Care Hotline at 1-800-682-9091.
Immunizations and Routinely Administered Parenteral Drug Therapies
PCPs should supply and administer all immunizations and routinely administered parenteral drug therapies in their office. As long as a claim is submitted on a timely basis, PCPs will be reimbursed for some of these medications above capitation.

The Vaccines for Children Program (VFC) provides all standard immunizations for individuals under age 19 with NJ FamilyCare Plan A coverage; therefore, your office will not be reimbursed for these drugs if the member has NJ FamilyCare Plan A coverage, but will be paid an administration fee. The specific CPT-4 code for the vaccine(s) given must be entered on the claim form.

Injectables
If the prescribing physician will be administering the injectable and does not stock the medication, the physician may write a prescription and have the member pick it up and bring it to the office or the physician may contact the pharmacy and arrange to have the injectable delivered to the office. In addition, the physician is encouraged to contact one of Horizon NJ Health’s preferred injectable providers:

Caremark at 1-800-237-2767

or

Accredo at 1-800-803-2523

If the member is self-injecting, the member can obtain the injectable at a participating pharmacy with a written prescription.

Formulary
Horizon NJ Health uses a formulary to promote the prescribing of the most cost-effective products in each therapeutic category. In some cases, it may be appropriate to use an over-the-counter (OTC) product. The pharmacy benefit provides coverage for a wide range of OTC products (see below). OTC products require a written prescription from the physician. For members residing in a LTC facility, OTC medications are generally provided by the institution, rather than via the Horizon NJ Health pharmacy benefit.

Covered OTC Drugs (prescription is required)
- Alaway
- Analgesics
- Antacids
- Antidiarrheals
- Antiflatulents
- Antinauseants
- Blood glucose monitors
- Contraceptives
- Cough and cold meds.
- Diabetic test strips
- Diagnostic agents for diabetes
- Family planning
- H2 antagonists
- Hematinics
- Insulin needles and syringes
- Lancets
- Laxatives and stool softeners
- Loratadine
- Miconazole
- Nasal preps
- Omeprazole
- Ophthalmic preps.
- Optichamber
- Prevacid 24-hr
- Smoking deterrents
- Topical products
- Vaginal fungicides
- Vitamins and minerals
- Zaditor OTC
- Zegerid OTC

For a copy of the formulary as well as a listing of limitations, prior authorization criteria, generic substitution procedures, step therapy procedures and other pharmaceutical management methods, contact the Pharmacy department at 1-800-682-9094 or visit horizonNJhealth.com.

Prior Authorization
The items below require prior authorization from our Pharmacy department. This prior authorization process requires proof of medical necessity from the prescribing physician and is coordinated by our Pharmacy department. The information required to determine medical necessity should include the following: member’s diagnosis, duration of proposed treatment, treatment plan and description of failed treatment, if any exists. Upon receipt of this information, the Pharmacy department and medical director, if necessary, will review the request. Physicians are encouraged to prescribe appropriate first-line agents before using alternative drugs.
Policies/Drugs Requiring Prior Authorization

This list is not all-inclusive and is changed periodically to reflect new drugs and/or clinical policy revisions. For a complete list of drugs requiring prior authorization, including policies, visit horizonNJhealth.com or contact the Pharmacy department at 1-800-682-9094 to request a paper copy of prior authorization criteria.

- Acyclovir 5% ointment (Zovirax)
- Age Limits Exceeded
- Alcohol deterrents and Opioid dependence products
- Antiretroviral Medications
- Biological response modifiers (Actemra, Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Simponi, Stelara)
- Botulinum Toxins
- Brand Name Medically Necessary
- Celecoxib (Celebrex) for Members Younger than 60 Years Old
- Colony Stimulating Factors (G-CSF & GM-CSF)
- Denavir (Penciclovir cream)
- Dextromethorphan hydrobromide and quinidine sulfate (Nuedexta)
- Dronabinol (Marinol)
- Drug Recall Policy
- Drug Utilization Review Program
- Epoetin Alfa and Darbepoetin Alfa
- Ezetimibe
- Fentanyl Transdermal System (Duragesic)
- Formulary System Maintenance
- Formulary System Management
- Gender Restriction
- Gonadotropin Releasing Hormones agonists and antagonists
- Growth Hormone Therapy
- Hepatitis C Treatment
- Imiquimod (Aldara)
- Infant Formula
- Intravenous (IV) Iron Therapy
- Lidocaine Patch 5% (Lidoderm)
- Lost/Stolen/Vacation/Damaged Drug Supply Requests
- Lubiprostone (Amitiza)
- Malathion (Ovide)
- Medication Adherence
- Member Communication
- Mental Health/Substance Abuse Medications
- Methadone
- Modafinil (Provigil)
- Non-formulary Medications
- Nutritional Supplements/Treatments for Members 18 Years and Older
- Nutritional Supplements/Treatments for Members Younger Than 18 Years Old
- Off-label use of Prescription Drugs
- Olopatadine (Patanol, Pataday)
- Omalizumab (Xolair)
- Ondansetron (Zofran) and aprepitant (Emend)
- Oral and Intranasal Fentanyl Citrate Products
- Oxycodone controlled-release (Oxycontin)
- Pharmacy Prior Authorization
- Pimecrolimus (Elidel)
- Practitioner Communication
- Proprotein Convertase Subtilisin/kexin type 9 (PCSK9) Inhibitors
- Proton Pump Inhibitors
- Quantity Limits/Plan Limitations Exceeded
- Repository Corticotropin (H.P. Acthar Gel)
- Respiratory Syncytial Virus Infection Prophylaxis
- Rifaximin (Xifaxan)
- Rituximab (Rituxan)
- Smoking Cessation Products
- Sodium hyaluronate Injections
- Step Therapy Process
- Sublingual Immunotherapy
- Terconazole (Terazol)/Butoconazole (Gynazole)
- Testosterone Products
- Topical Tazarotene (Tazorac)
- Triptan Step Policy (Maxalt, Maxalt-MLT)
- Vaccines

To obtain prior authorization, or for more information, contact the Horizon NJ Health Pharmacy department at 1-800-682-9094 and be prepared to provide relevant, clinical information that supports the medical necessity of the requested medication.
Participating facilities must accept all Horizon NJ Health members who present themselves for admission in accordance with the agreement between Horizon NJ Health and the facility.

4.1 Hospital Admissions

Physicians admit patients to their own service and follow patients during admission. (Special arrangements are made to ensure continuity of service and case management when exceptions to this standard are required.)

Physicians must have admitting privileges to a Horizon NJ Health network hospital or facility for all age categories for which they are providing care.

Hospital admissions for non-maternity related observation require a Horizon NJ Health authorization and must be called in within 24 hours after discharge. Observations do not include emergency room (ER) observation areas or holding units.

Observation should be considered if the patient does not meet acute care criteria and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within 24 hours
- Treatment and/or procedures will require more than six hours of observation
- The clinical condition is changing and a discharge decision is expected within 24 hours
- Symptoms unresponsive to at least four hours of ER treatment

4.2 Inpatient Services

Inpatient services provided to a member during a hospital stay are considered part of the precertification for the inpatient stay and procedure. These services include, but are not limited to:

- Professional component
- Therapeutic services
- Specialist services
- Diagnostic services
- Laboratory services
- Operating room and recovery room charges
- Registered bed charges

Horizon NJ Health will reimburse for contracted levels of care. If the level of care determination is not included in your contract, Horizon NJ Health will deny payment to the facility.

All non-PAT/STAT lab/pathology services conducted in a hospital setting are subject to prior authorization, unless the procedure code is listed on the STAT and PAT Testing Menu list in Section 3.18 of the Manual.

4.3 Outpatient Services

A referral must be issued for Horizon NJ Health members by their PCP or OB-GYN for service not rendered in the PCP’s or OB-GYN’s office. Members do not need a referral for mammography services.

Members must demonstrate proof of referral when presenting to the hospital for outpatient services.

- Paper referrals – Supply the member with a completed Horizon NJ Health referral form.
- Electronic referrals – Supply the member with a prescription for the service or a printed copy of the electronic referral.

The referral is valid for up to 180 days and up to six visits from the date of issue, pending continued eligibility. The physician must obtain an authorization number from the Utilization Management department if a member is referred for more than six visits or a treatment plan to perform services is required.

Outpatient services requiring referrals include, but are not limited to:

- Diagnostic testing
- Pre-admission testing (PAT)
- Short turn-around time (STAT) laboratory services
- Oncology therapy*
- Chemotherapy*
- Radiation therapy*

*This referral is valid only for an evaluation. The hospital must call for precertification of the treatment plan to perform therapeutic services.

Utilization Management Department
1-800-682-9094
4.0 HOSPITAL SERVICES

NJ FamilyCare C members are responsible for a $5 copayment for outpatient hospital services unrelated to preventive services.

NJ FamilyCare D members are responsible for a $5 copayment for outpatient hospital services unrelated to surgery or preventive services.

4.4 Hospital Maternity Observation Notification

Maternity observation visits do not require notification. This eliminates the need for physicians to contact Horizon NJ Health to request a billing claim number for billing purposes. Observation visits for any medical need other than pregnancy must be authorized.

If the Horizon NJ Health member is receiving a routine, non-emergent non-stress test (NST), ultrasound or fetal monitoring at the hospital, a referral from the PCP or OB-GYN is required.

4.5 Newborn Care

Horizon NJ Health assumes financial responsibility for services provided to newborns of mothers who are Horizon NJ Health members for the first 60 days after birth. However, these newborns are not automatically enrolled in Horizon NJ Health at birth. Refer to Section 2.5.1 for more information about newborn eligibility.

4.6 Emergency Care

Horizon NJ Health reimburses for emergency/urgent care services provided 24 hours a day, seven days a week. All ER care should be coordinated through the PCP. Members are advised to contact their PCP whenever an ER visit is initiated.

4.7 Emergency Services

Horizon NJ Health recognizes an emergency service as 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 abuse such that a prudent layperson, who possess 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 (and, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. 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.

Members are advised to present at the nearest emergency facility and to notify the Member Services department or their PCP of their ER visit. This policy includes out-of-network services.

Emergency situations may include, but are not limited to:

- Severe pain of any kind
- Psychiatric disturbances
- Altered mental status (whether sustained or transient) for any reason
- Abrupt change in neurologic status (whether sustained or transient)
- Symptoms of substance abuse
- Any and all complications of pregnancy
- Chest pain
- Acute allergic reactions
- Shortness of breath
- Abdominal pain (e.g., acute onset, severe)
- Multiple episodes of vomiting or diarrhea, any age
- Fever greater than 102.5 in any age group
- Fever greater than or equal to 100.4 in infants three months or younger
- Injuries with active bleeding
- Injuries with functional loss of any body part (including extremities, eyes, nose, mouth and ears)
- All patients arriving at the hospital by ambulance after an injury with any body part immobilized
- All patients arriving at the hospital by paramedic ambulance

The emergency facility and PCP are responsible for educating members on the appropriate use of ER services when members present with non-life threatening conditions.

A member enrolled with NJ FamilyCare C is responsible for a $10 copayment for ER services, provided the member is not admitted into the hospital. The hospital should issue a receipt to the member upon collection of a copayment. This receipt should include the hospital’s name, address and telephone number.

A member enrolled with NJ FamilyCare D is responsible for a $35 copayment for ER services, provided the
member is not admitted into the hospital or the member is referred to the ER by the PCP for services that should have been rendered in the PCP’s office. The hospital should issue a receipt to the member upon collection of a copayment. This receipt should include the hospital’s name, address and telephone number.

4.8 Hospital Transfer Policy

When members require hospitalization, it is Horizon NJ Health’s policy to have the service rendered in a Horizon NJ Health participating hospital. In order to assure payment for emergency services and hospitalization, the physician must comply with this policy.

However, Horizon NJ Health recognizes that it may not be possible to follow this general policy when members present at a medical facility due to a medical emergency. In cases where a Horizon NJ Health member needs to be transferred to a facility that does not have a contract with Horizon NJ Health, the hospital or attending provider must notify Horizon NJ Health’s Utilization Management department for approval prior to the transfer, unless a true emergency situation arises. In the event of an emergent situation, Horizon NJ Health requires notification of admission once the member is stabilized to receive a reference number and initiate the review process, as set forth in Section 8.3 Hospital Admissions.

Horizon NJ Health will coordinate all necessary transportation for the timely transfer of the member.

4.9 Out-of-State Hospitals

Horizon NJ Health requires an authorization for all out-of-state admissions (unless it is an emergent situation) with approval by the Utilization Management department, with specific review and approval by the medical director or physician advisor. In the event of an emergent situation, Horizon NJ Health requires notification of admission once the member is stabilized to receive a reference number and initiate the review process, as set forth in Section 8.3 Hospital Admissions.

Utilization Management Department
1-800-682-9094

4.10 Centers of Excellence

Horizon NJ Health contracts with Centers of Excellence within and outside of our service area for specialized tertiary care. Admission to facilities outside our service area requires approval by the Utilization Management department, with specific review and approval by the medical director or physician advisor. Please call as soon as admission or transfer is contemplated to assure quality care and timeliness of services for the member.

Please refer to the most recent copy of the Horizon NJ Health Provider Directory for a list of participating Centers of Excellence.
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5.1 The Role of the Primary Care Provider

A primary care provider (PCP) is a licensed physician or other licensed medical practitioner practicing in the area of Family Practice, General Practice, Internal Medicine, Geriatric Medicine or Pediatric Medicine.

The PCP has the responsibility of contacting each new member to schedule an appointment for a complete age/sex-specified baseline physical. This should be completed no later than 90 days after the effective date of enrollment for children under 21 years of age and no later than 180 days after initial enrollment for adults.

The PCP is responsible for notifying members of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases by telephoning, or by arranging an appointment to discuss the result when it is deemed a face-to-face discussion may be necessary. Within 10 business days of receipt of the results, the PCP must notify members of non-urgent or non-emergent laboratory and radiology results.

The PCP is responsible for supervising, coordinating and managing member health care by providing or authorizing the services needed to ensure positive health outcomes for each member on the panel. This includes:

- Periodic communication with the member
- Providing health education and information
- Arranging for 24 hours a day, seven days a week, practice coverage
- Maintaining comprehensive medical records documenting all services provided to the enrollee, including specialty referrals, periodic preventive and well-care services and providing appropriate and timely notice to members
- Delivering direct primary care services, as needed by the member
- Compliance with all adult and pediatric care protocols
- Education on the appropriate use of emergency services
- Initiating referrals for specialty care
- Maintaining continuity of members’ health care

Members with Special Needs

The PCP supervising the care of those members with special needs has the additional responsibility to ensure a team approach to their care, when required, with an emphasis on the continuity and integration of medical care and, as needed, participating with Horizon NJ Health care management and specialty care management teams. This includes methods for well-child care, health promotion, disease prevention and specialty care.

The PCP is responsible for determining the urgency of a consultation with a specialist and, if urgent, shall arrange for the consultation appointment.

The PCP is responsible for providing or authorizing the services needed to ensure positive health outcomes for those members with special needs on their panel. This includes:

- Overall clinical direction
- Serving as a central point of integration and coordination of covered services
- Providing health counseling and advice
- Diagnosing and treating covered conditions that do not require a referral to and services of a specialist
- Arranging for inpatient care, consultations and laboratory and radiological services
- Coordinating the findings of laboratories and consultants
- Interpreting such findings to the enrollee and the enrollee’s family (or, where applicable, an authorized person)
- Upon enrollment, each member selects a PCP. Members with special needs may select a PCP or request a specialist. The name and phone number of the PCP will appear on the member’s Horizon NJ Health ID card.

Encounter Submission

PCPs must submit a CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters to the plan for each member encounter or office service, even if the service is capitated.
Horizon NJ Health is required by the State of New Jersey to report encounter data for all services rendered to our members, including capitated and fee-for-service activities. Refer to Section 9.8 - Risk Assessment Program for more information.

All encounters must be received within 180 days of the date of service. PCP claims that are eligible for reimbursement will be denied for untimely filing if they are received after 180 days of the date of service.

Claims/encounters should be submitted to Horizon NJ Health at the following address.

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

5.2 PCP Reimbursement

5.2.1 Capitation

PCPs reimbursed via capitation will receive a fixed monthly payment (capitation), which is based on the age and gender of enrollees assigned to their panel. This payment is assigned on a per member/per month (pm/pm) basis and is calculated according to the number of days a member is assigned to the PCP during that month. With each capitation payment, Horizon NJ Health shall provide the provider with a list of members who have selected the physician as their PCP.

Capitated services include all examination, administrative and medical procedures performed by the PCP that are not specifically defined as reimbursed above capitation. These services include, but are not limited to:

- Venipuncture
- X-ray services
- Laboratory services (including pregnancy testing)
- Gynecological examinations
- Family planning services

On or about the 15th of each month, Horizon NJ Health will issue a capitation check and capitation summary report of the amount of payment per member to the PCP.

Adjustments to capitation payments for members shall be subject to termination and eligibility requirements contained in the Medicaid contract. Horizon NJ Health shall limit capitation payment adjustments associated with retroactive terminations of members to two months’ capitation payments.

If a member is added to a panel after the first of the month, Horizon NJ Health will prorate the capitation payment for that member and include the partial payment with the next capitation.

If a member is dual eligible (Medicare and Medicaid), the PCP will be paid on a fee-for-service basis in accordance with coordination of benefits rules.

5.2.2 Primary Care Billable Services

In addition to the monthly capitation, Horizon NJ Health will reimburse the PCP on a NJ Medicaid Fee-for-Service basis for the following:

- Immunizations (only the administration fee will be paid for standard immunizations provided by the VFC program for Plan A members)
- Inpatient hospital care
- Routine newborn care
- Simple repair of superficial wounds to scalp, neck, axillae, external genitalia, trunk and/or extremities
- Sigmoidoscopy
- Colposcopy
- Treatment of nail conditions
- Venipuncture services for lead screening
- Capillary blood specimen
- Nebulizer therapy
- Lead screening
- EPSDT services

5.2.3 Fee-for-Service

Horizon NJ Health will reimburse the PCP each time a panel member is seen. PCPs who are reimbursed on a fee-for-service basis will receive monthly member panel listings.

Services eligible for reimbursement are listed below.

- Office visits
- Immunizations (only the administration fee will be paid for standard immunizations provided by the VFC program)
- Inpatient hospital care
- Routine newborn care
- Simple repair of superficial wounds to scalp, neck, axillae, external genitalia, trunk and/or extremities
- Sigmoidoscopy
- Colposcopy
- Nebulizer therapy
- Treatment of nail conditions
- Intramuscular injection of antibiotics
- Electrocardiogram
- Venipuncture
- Allergy injections
- Maternity services (family practice physicians)

To ensure prompt reimbursement of your claim, be sure to:

- Submit a completed CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters.
- Submit EPSDT services on a CMS 1500 (HCFA 1500) form with EPSDT codes. Refer to Section 9.7 Early and Periodic Screening Diagnosis and Treatment (EPSDT) Information Missing or Incomplete for coding procedures.
- Verify that the standard CMS 1500 (HCFA 1500) form contains the following information:
  - Member’s full name
  - Member’s address
  - Member’s date of birth
  - Horizon NJ Health ID number
  - Diagnosis
  - Date of service
  - Physician’s Employer Identification Number
  - Physician’s signature and physician/vendor number
  - Procedure code(s) - Current Procedural Terminology (CPT) and/or HCPCS
- Non-emergent outpatient service invoices (except for the professional component) must have a referral form attached or include the referral number in field #22

PCPs must submit a CMS 1500 (HCFA 1500) form or HIPAA-compliant 837 transaction for electronic submitters to the plan for each member encounter or office service, even if the service is capitated. On a monthly basis, Horizon NJ Health is required to report all encounters to the State of New Jersey.

All claims must be received within 180 days of the date of service. If received after 180 days of the date of service, PCP claims eligible for reimbursement will be denied for untimely filing.

Claims should be submitted to Horizon NJ Health at the following address:

Horizon NJ Health
Claims Processing Department
PO Box 24078
Newark, NJ 07101-0406
Phone: 1-800-682-9091

Family planning claims should include the member’s Social Security Number.

### Member Copayments for Primary Care Provider and Specialty Office Visits

Refer to Section 3 Benefit Overview of this Manual for member copayments specific to certain benefits.

#### 5.3 EPSDT Coding and Reimbursement

The New Jersey Division of Health Services, Division of Medical Assistance and Health Services (DMAHS) will pay a $10 incentive payment to Horizon NJ Health for a pass through to PCPs when an encounter record has a procedure code and diagnosis code as set forth below.

EPSDT covers children from birth to their 21st birthday.

Important: Preventive visits are evaluation and management services. Physicians and health care professions should not use additional evaluation and management codes in conjunction with these services.

For lead testing, please utilize 83655 with the appropriate ICD-10 code.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99460</td>
<td>Normal Newborn, Inpatient Care; History and Examination</td>
</tr>
<tr>
<td>99381</td>
<td>New Patient, Initial Preventive Medicine; infant (age under 1 year)</td>
</tr>
<tr>
<td>99382</td>
<td>New Patient, Initial Preventive Medicine; early childhood (age 1 - 4 years)</td>
</tr>
<tr>
<td>99383</td>
<td>New Patient, Initial Preventive Medicine; late childhood (age 5 - 11 years)</td>
</tr>
<tr>
<td>99384</td>
<td>New Patient, Initial Preventive Medicine; adolescent (age 12 - 17 years)</td>
</tr>
<tr>
<td>99385</td>
<td>New Patient, Initial Preventive Medicine; (age 18 – 39 years)*</td>
</tr>
<tr>
<td>99391</td>
<td>Established Patient, Periodic Preventive Medicine; infant (age under 1 year)</td>
</tr>
</tbody>
</table>
## 5.0 PRIMARY CARE PROVIDER

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99392</td>
<td>Established Patient, Periodic Preventive Medicine; early childhood (age 1 – 4 years)</td>
</tr>
<tr>
<td>99393</td>
<td>Established Patient, Periodic Preventive Medicine; late childhood (age 5 – 11 years)</td>
</tr>
<tr>
<td>99394</td>
<td>Established Patient, Periodic Preventive Medicine; adolescent (age 12 – 17 years)</td>
</tr>
<tr>
<td>99395</td>
<td>Established Patient, Periodic Preventive Medicine; (age 18 – 39 years)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>ICD-10 Diagnoses (effective October 1, 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00.00</td>
<td>Encounter for general adult medical examination without abnormal findings</td>
</tr>
<tr>
<td>Z00.01</td>
<td>Encounter for general adult medical examination with abnormal findings</td>
</tr>
<tr>
<td>Z00.110</td>
<td>Health examination for newborn under 8 days old</td>
</tr>
<tr>
<td>Z00.111</td>
<td>Health examination for newborn 8 to 28 days old</td>
</tr>
<tr>
<td>Z00.121</td>
<td>Encounter for routine child health examination with abnormal findings</td>
</tr>
<tr>
<td>Z00.129</td>
<td>Encounter for routine child health examination without abnormal findings</td>
</tr>
<tr>
<td>Z00.5</td>
<td>Encounter for examination of potential donor of organ and tissue</td>
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<tr>
<td>Z00.6</td>
<td>Encounter for examination for normal comparison and control in clinical research program</td>
</tr>
<tr>
<td>Z00.70</td>
<td>Encounter for examination for period of delayed growth in childhood without abnormal findings</td>
</tr>
<tr>
<td>Z00.71</td>
<td>Encounter for examination for period of delayed growth in childhood with abnormal findings</td>
</tr>
<tr>
<td>Z00.8</td>
<td>Encounter for other general examination</td>
</tr>
<tr>
<td>Z02.0</td>
<td>Encounter for examination for admission to educational institution</td>
</tr>
<tr>
<td>Z02.1</td>
<td>Encounter for pre-employment examination</td>
</tr>
<tr>
<td>Z02.2</td>
<td>Encounter for examination for admission to residential institution</td>
</tr>
<tr>
<td>Z02.3</td>
<td>Encounter for examination for recruitment to armed forces</td>
</tr>
<tr>
<td>Z02.4</td>
<td>Encounter for examination for driving license</td>
</tr>
<tr>
<td>Z02.5</td>
<td>Encounter for examination for participation in sport</td>
</tr>
<tr>
<td>Z02.6</td>
<td>Encounter for examination for insurance purposes</td>
</tr>
<tr>
<td>Z02.81</td>
<td>Encounter for paternity testing</td>
</tr>
<tr>
<td>Z02.82</td>
<td>Encounter for adoption services</td>
</tr>
<tr>
<td>Z02.83</td>
<td>Encounter for blood-alcohol and blood-drug test</td>
</tr>
<tr>
<td>Z02.89</td>
<td>Encounter for other administrative examinations</td>
</tr>
<tr>
<td>Z76.2</td>
<td>Encounter for health supervision and care of other healthy infant and child</td>
</tr>
</tbody>
</table>

### 5.3.1 EPSDT Worksheets

Horizon NJ Health, along with the other Medicaid health maintenance organizations (HMOs) in New Jersey and the New Jersey DMAHS, developed age-appropriate medical record tools for physicians to use for EPSDT visits.

These medical record tools are free of copyright and can be used by all Medicaid HMOs. The use of the medical record tools is not mandatory. It is up to each physician’s office whether to use the age-appropriate forms.

A copy of the forms can be printed from the Horizon NJ Health website at horizonNJhealth.com.
6.0 REFERRALS TO SPECIALTY CARE PROVIDERS

The primary care provider (PCP) is responsible for providing all basic primary care services, including the authorization of referrals for specialty and other care to members, as needed. When a PCP determines there is a need for medical services or treatment outside of his or her scope of care, the PCP must approve and arrange all referrals to the participating specialty care physician.

The PCP must complete and submit a referral each time a member is referred for specialty care services. Completing the referral is a mechanism for the reimbursement of the specialty medical services provided by a specialty physician. The completed referral assists the PCP in maintaining a record of all member-referred services.

A referral must be submitted prior to specialty care service being rendered. Retroactive referrals are referrals that are issued more than two business days after the specialist has already seen the patient.

Referrals are valid for up to 180 days and up to six visits from the date of issue, pending continued eligibility. If a member is referred for more than six visits, the PCP or specialty care physician must obtain an authorization from the Utilization Management department. When a treatment plan is required, the specialty care physician must obtain an authorization from the Utilization Management department.

If the member has not visited the specialty care physician within 180 days from the time of referral, the member’s condition should be re-evaluated by the PCP and a new referral should be issued.

Referrals are submitted electronically on NaviNet. The following fields must be completed:

1. The name of the participating specialty care physician. (Refer to the Provider Directory for the names of Horizon NJ Health participating specialty care physicians).

2. The referral will indicate “consult only” or “consult and treat.” If “consult and treat” is indicated, a number of visits will be specified. The specialty care physician must contact the PCP to obtain additional referrals if additional services or visits are necessary.

3. The PCP’s office should forward a pertinent medical summary to the specialist (including history, lab results and radiology studies needed for appropriate specialty care).

6.1 Electronic Referrals

Horizon NJ Health referrals are submitted through NaviNet, a free, multi-payer Web portal. To sign up for NaviNet, visit their website at www.navinet.net.

The NaviNet referral submission transaction allows PCPs to electronically submit a referral to Horizon NJ Health for real-time approval. Once a PCP submits a referral and receives a referral ID from Horizon NJ Health, the member may visit the assigned specialist.

6.1.1 Referral Submission

To access Referral Submission, you will choose the Referrals menu option underneath Workflows. There is one transaction menu for both Referral Submission and Referral Inquiry.

To begin the referral submission, you will need to search for the member. You can search for the member using the member ID or by using the name and date of birth. The effective date of the referral will automatically appear as the current date. If you need to backdate the referral, it must be done by changing the effective date.

To complete the referral, you will need to enter the service type, place of service, diagnoses and then the
6.0 Referrals to Specialty Care Providers

Provider details. When you are entering diagnosis codes, you can enter partial codes or descriptions to see any diagnoses which meet the criteria you are searching for.

You can choose the referred from provider from within the dropdown menu.

To choose the referred to provider or facility, you can search using specialty and provider/facility fields.

If you have any clinical notes for the referred to provider or facility, you can enter them in the free text field.

When you have entered all of the information for the referral, click submit.

You may print a copy of the referral for the member and for the patient records.

6.1.2 Paper Referral Form

To access Referral Inquiry, you will choose the Referrals menu option underneath Workflows.

To search for a referral, first choose your group or provider as the referred to provider or the referred from provider. Then choose the provider or facility from the dropdown menu.

You can search by a date range or for a particular member. The response screen provides information such as the status bar, referral number, member information, referred from and to provider information, and any clinical information that was submitted on the referral. You can view or print this referral as a PDF by clicking the option at the top right.

6.2 A Standing Referral

Horizon NJ Health will authorize a standing referral for members who require a specialist’s ongoing care. The standing referral is pursuant to the treatment plan, which must be approved by Horizon NJ Health in consultation with the PCP, specialist, care manager and the member or, when applicable, an authorized person.

6.3 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

6.4 Self-Referrals

In some cases, Horizon NJ Health members may receive services without obtaining a referral from their PCP. When provided by a participating physician or health care professional, referrals are not required for:

Gynecological care
- Mammogram
- Obstetrical care
- Routine eye examination
- Dental care
- Behavioral health care for DDD members
- Emergency room visits
6.0  REFERRALS TO SPECIALTY CARE PROVIDERS

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7.1 The Role of the Specialty Care Physician

Specialty care physicians provide non-primary care services to patients upon referral from their PCP. The specialty care physician must coordinate care through the PCP and obtain necessary precertification for hospital admissions or specified diagnostic testing and procedures. If a specialty care physician is scheduled to perform a procedure on a Horizon NJ Health member and, due to some unforeseen circumstance, is unable to perform the procedure, the specialty care physician must make reasonable efforts to find another Horizon NJ Health participating specialty care physician to conduct the procedure.

Depending on the type of referral received from the PCP, the specialty care physician may be asked to only consult and communicate with the PCP or consult and treat. A specialist acting as the PCP for a member with special needs has the responsibility for overall health coordination and assurance that the member receives all necessary specialty care and for providing or arranging all routine preventive care and health maintenance services, which may not customarily be provided by or be the responsibility of such a specialist. A request for a specialist to act as a PCP should be made through Horizon NJ Health’s Utilization Management department at 1-800-682-9094.

For members with special needs who are chronically ill or have complex health care needs, their traditional PCP will have the responsibility of providing primary care services and for overall coordination of care, including specialty care.

It is important for the specialty care physician to communicate regularly with the PCP regarding any specialty treatment. The specialist treating members with special needs, in conjunction with the PCP, must develop a team approach to care management.

Except for ER visits, routine OB-GYN services, mammograms, dental services, annual eye examinations and behavioral health services for DDD members, all members must obtain a valid referral from their PCP or OB-GYN prior to receiving services from a specialty care physician.

Prior to rendering services, the specialty care physician should call the Horizon NJ Health Physician & Health Care Hotline to verify member eligibility. (See Section 2.0 Eligibility for more information on verifying eligibility at NaviNet.)

Horizon NJ Health specialty care physicians are also required to maintain the same office standards as the PCP. See Section 12.17 Office Standards for more information.

7.2 Referrals for Care

Referrals are valid for 180 days and up to six visits from the date of issue (pending continued eligibility). The PCP or specialty care physician must obtain an authorization from the Utilization Management department if a member is referred for more than six visits or a treatment plan to perform services is required.

Horizon NJ Health has enabled electronic referrals to be completed on NaviNet. NaviNet users have access to real-time Horizon NJ Health administrative information and tools.

With the implementation of electronic referrals, specialists may encounter members who do not have a paper referral form. Members appearing for treatment without a referral form should be seen once the member’s eligibility and the submission of a referral are verified. Specialists may accept a physician script as proof of a referral.

Specialists can confirm that a referral has been submitted by completing a referral inquiry on the NaviNet website or by calling the Physician & Health Care Hotline at 1-800-682-9091.
7.3 Specialty Care Reimbursement

The specialty care physician will be paid by Fee-for-Service. Horizon NJ Health reserves the right to modify the Horizon NJ Health fee schedule.

To ensure prompt reimbursement of your claim, be sure to:

• Attach a photocopy of the referral form, if available, to all claims for services authorized on the original referral. In absence of a paper referral form, enter the referral number into field #22 of the CMS 1500 (HCFA 1500) form
• Mail the referral form, if available, when submitting claims electronically
• If you determine that the need for additional specialty care is not authorized on the original referral, you must contact the member’s PCP to obtain another referral
• If you determine that the need for additional diagnostic testing is not authorized on the original referral, you must complete Section D of the referral form from the PCP
• Verify that the standard CMS 1500 (HCFA 1500) form contains the following information:
  • Member’s full name
  • Member’s address
  • Member’s date of birth
  • Horizon NJ Health ID number
  • Diagnosis
  • Date of service
  • Physician’s employer identification number
  • Physician’s signature and physician/vendor number
  • Referral number
  • Procedure code(s) – CPT (Current Procedural Terminology), Health Care Financial Administration Common Procedure Coding System (HCPCS)
• Non-emergent outpatient service invoices (except for the professional component) must have a referral form attached

Completed claims should be submitted to:

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

All claims must be received within 180 days of the date of service. Claims received after 180 days of the date of service will be denied for untimely filing.
8.1 Prior Authorization Requirements

Horizon NJ Health has specific requirements for prior authorization and other medical management needs, as covered under the specific Medicaid benefit package. The prior authorization process evaluates the medical necessity of a procedure or course of treatment and the appropriate location of service, prior to the delivery of services. Prior authorization must be obtained prior to an elective or non-emergent admission, including transfers to another facility or before outpatient services are rendered. Participating and non-participating facilities must submit online via NaviNet and CareAffiliate or by fax request a minimum of 14 calendar days prior to rendering services. Failure to notify UM may result in services being delayed or denied.

Please refer to the prior authorization reference list on the website horizonnjhealth.com/for-providers/resources for the most commonly requested procedures.

8.2 Prior Authorization Process

Prior authorization must be obtained prior to an elective or non-urgent admission or before services that require prior authorization are rendered. The procedure for obtaining prior authorization is outlined below.

- The prior authorization process can take up to 14 calendar days for completion. Therefore, requests should be sent in as soon as possible to allow adequate time to respond to them. Staff is available during normal business hours (Monday-Friday 8 a.m.-5 p.m.) with on-call support staff available after hours to meet urgent requests. Staff identifies by name, title, and organization when initiating and returning calls regarding UM issues.

Requests for prior authorization must include:
  - Member ID number
  - Member’s name, address and date of birth
  - Specific clinical information, such as diagnosis, severity, supporting evidence of diagnosis, and planned treatment
  - Member’s designated contact

Critical clinical information supporting the prior authorization request should be submitted with the Prior Authorization Request form. Examples of clinical information include, but are not limited to, history of presenting problem, clinical exam and diagnostic test results, operative and pathological reports, treatment plan, progress notes and consultations. If clinical information that supports the request is not provided on time, the request will be administratively denied. After the required information is submitted, the provider may be asked to furnish additional information for review by a Horizon NJ Health medical director.

- The UM department uses nationally recognized criteria during the prior authorization process. If criteria are met, the provider will receive notification via fax or mail. Providers can check real-time status through the Navinet/CareAffiliate system with the ability to print the final outcome of the request irrespective of how the request was submitted. See Section 11.4.5 Prior Authorization and Authorization Criteria.

Members are notified by mail of approvals and denials; this notification includes information about appeal rights.

Prior authorizations are valid only for the dates requested.

If you disagree with any Horizon NJ Health medical necessity decisions, please see Section 10.5 Utilization Management Physician Appeals Process regarding appeal rights or call our UM department. Medical Appeals at 1-800-682-9094, extension 89606.

Prior to providing care for services requiring prior authorization, the provider should verify that a prior authorization has been obtained. Providers may have to reschedule non-urgent services if prior authorization is required and has not been obtained.

Utilization Management Department
1-800-682-9094

Medical management decisions are subject to appeal through the Appeals Resolution Process.

Horizon NJ Health UM decisions are benefit determinations only and do not constitute treatment recommendations or directives.

Providers are solely responsible for making medical treatment decisions in consultation with their patients.

Members may request a reconsideration of a benefit determination, in accordance with the procedure, as described in Section 10.2 Utilization Management Member Appeals Process.
8.0 PRECERTIFICATION

8.2.1 MLTSS Prior Authorization Process

When the care plan 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 timely. 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 then 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.

8.2.2 CareAffiliate

CareAffiliate is an online authorization tool accessed through NaviNet® that enables providers to submit authorization requests securely over the Internet using a single-page data entry form that captures pertinent client-defined data. Providers are able to communicate directly with Horizon NJ Health; checking the statues of requests in real time and receiving notifications when requests are completed.

The main features in CareAffiliate include:

- Authorization requests
- Viewing status of authorization requests
- It can also be used for authorizations for home care, DME purchase/rental, surgical procedures and inpatient admissions.

Providers can access CareAffiliate through NaviNet. Select Horizon NJ Health from the Plan Central page; mouse over Referrals and Authorization on the left-hand navigation; then select Utilization Management Requests.

8.3 Hospital Admissions

Horizon NJ Health’s UM department should be contacted at 1-800-682-9094 for all notices of admissions, observations (except OB observations) and requests for precertification of elective admissions (See Sections 8.1 and 8.2 for precertification requirements and process).

If a medical emergency (including maternity) leads to a hospital admission or if a member receives observation services (See Section 4.1 for observation criteria), the UM department must be notified by calling 1-800-682-9094 within 24 hours of the admission to receive a reference number and initiate the medical utilization review process. This is not an authorization.

Horizon NJ Health conducts concurrent medical review (See Section 11.4.12 Concurrent Review) in order to approve an unplanned admission or review additional information received for elective and non-urgent admissions.

Denied services may be appealed. See Section 10.0 Complaints and Appeals Process for more information.

Hospitals are instructed to notify and consult with the PCP for appropriate history, advice and instructions.

8.4 Ambulatory Surgical Center

In general, Horizon NJ Health does not require physicians to obtain prior authorization from the UM department for surgical procedures performed by a participating surgeon at an ambulatory surgical center (ASC) in the Horizon NJ Health network. Pain management procedures at an ASC, cosmetic procedures, gastric banding adjustments and varicose vein surgery and other select procedures require prior authorization.

However, if the surgical procedure is performed at a facility other than an ASC in the Horizon NJ Health network or by an out-of-network provider, prior authorization must be obtained by faxing or submitting online to the UM department at least 14 calendar days in advance of the surgery. If the procedure cannot be performed at the participating ASC with which the physician is affiliated, the physician must obtain prior authorization prior to performing the surgical procedure. Horizon NJ Health will deny provider claims for payment if prior authorization is not obtained for surgical procedures performed at a facility other than a participating ASC and by a participating provider.

Horizon NJ Health encourages specialists to perform all medically necessary and appropriate surgical procedures at the freestanding ASC with which they are affiliated. If you are not affiliated with a center, we recommend that you obtain affiliation with a participating ASC. There are
more than 40 ASCs in Horizon NJ Health’s network. Please refer to the online Provider Directory at www.horizonNJhealth.com to view participating freestanding ASCs. To better service and accommodate our members and physicians, Horizon NJ Health is continually expanding our ASC network. Please feel free to contact our Physician & Health Care Hotline at 1-800-682-9091 with information regarding any freestanding ASC with which you are affiliated that is not participating with Horizon NJ Health.

8.5 Short Procedure Unit

Horizon NJ Health providers may utilize a Horizon NJ Health participating hospital short procedure unit (SPU) for a precertified, medically necessary procedure. The provider should conduct the request for prior authorization of a SPU or non-participating ASC by contacting faxing or submitting online to the Horizon NJ Health UM department. In the event that prior authorization has not been obtained due to an emergent situation, Horizon NJ Health must be notified within 24 hours to get retro authorization. The criteria listed below outlines some of the indicators used by the UM department to assess appropriateness:

The criteria listed below outlines some of the indicators used by the UM department to assess appropriateness:

- Treatment plan appropriate to diagnosis
- Facility appropriateness
- Provider, hospital and ASC participation with Horizon NJ Health
- Member eligibility on date of service

If a request to utilize the SPU or nonparticipating ASC is denied by Horizon NJ Health, the facility will receive notification of the denial. At the time of determination, a written notification of the denial is sent to the member, PCP and/or specialist.

Horizon NJ Health requests that prior authorization for procedures performed at a hospital SPU or ASC is obtained 14 calendar days in advance of the surgery. Due to monthly changes in member eligibility, all procedures are pending verification of eligibility for the date of service requested. In those instances that a procedure performed in the SPU requires an inpatient admission, Horizon NJ Health must be notified within 24 hours by faxing or submitting online to the UM department.

8.6 Radiology

Horizon NJ Health has partnered with National Imaging Associates, Inc. (NIA) for outpatient imaging management services. Prior authorization will be required for the following non-emergent outpatient radiology procedures:

- CT/CTA
- MRI/MRA
- PET
- Nuclear Cardiology/Nuclear Stress/MIPI
- Select Non-Advanced Radiology Procedures
  - Non OB/GYN ultrasounds
- Stress Echocardiography
- Echocardiography
- Cardiac Computed Tomography Angiography (CCTA)
- Cardiac Catheterization
- Radiation Oncology Management for Radiation Therapy
- Cardiac Implantable Devices
  - Implantable Cardioverter Defibrillator (ICD)
  - Pacemaker
  - Cardiac Resynchronization Therapy (CRT) Pacemaker

The Medical Specialty Solutions Services performed in the following settings do not require authorization through NIA:

- Inpatient
- Observation
- Emergency Room

Physicians can call the NIA Call Center to obtain authorization at 1-800-642-7299. Call center hours are Monday through Friday, 8 a.m. to 8 p.m.

Horizon NJ Health’s physicians and health care professionals can use RadMD to submit all requests for authorizations online.

www.RadMD.com is available from 5 a.m. to midnight EST Monday through Friday, and 8 a.m. to 1 p.m. EST on Saturday. For assistance or technical support, please contact radmdsupport@magellanhealth.com or call 1-877-80-RadMD (877-807-2363) Monday through Friday, 8 a.m. to 8 p.m.

If you perform any diagnostic imaging services you are required to complete a Diagnostic Imaging Provider Assessment Application.

All providers performing primary, advanced and cardiac diagnostic imaging in a free standing or professional office location must be approved by NIA’s provider assessment process. If you do not obtain approval by NIA you will not be selectable for authorization and claims for these services will not be paid.
To access the online application:

- Contact NIA Provider Assessment Department at 1-800-424-6005 to obtain your login information
- Direct your Web browser to: www.RadMD.com.
- Click on the link for Diagnostic Imaging Provider Assessment Application (located under Online Tools).
- Enter your login and click “Login”. Your login is: NIA_ForeignProviderID

A separate application is required for each practice location performing diagnostic imaging services. If your practice has more than one location performing these services, you must obtain a separate login for each practice location.

Upon receipt of your completed provider assessment application, NIA and Horizon NJ Health will process your information and your final status will be communicated to you in writing.
This guide is intended to offer hospitals, physicians and health care professionals the information required for Horizon NJ Health to accurately and efficiently process claims prepared by or for hospitals, physicians and health care professionals for medical 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 rejection, 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 this document.

In the event of additional questions about Horizon NJ Health programs or policies, please review the entire Manual or contact the Physician & Health Care Hotline at 1-800-682-9091.

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 regulatory requirement does not permit this timeframe. Hospitals, physicians and health care professionals 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 hospital, physician or health care professional 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/NJFC beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance.

A provider enrolled in the Medicaid/NJFC 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/NJFC 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/NJFC 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.

## 9.1 Requirements for Filing Claims

### 9.1.1 General Requirements

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).

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. Claims submitted by nonparticipating Horizon NJ Health providers will be paid on the lesser of billed charges or the Horizon NJ Health nonparticipating provider 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:
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(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, including timeliness of claims processing, shall mean:

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.

Horizon NJ Health shall pay all clean claims from hospitals, physicians and other health care professionals within 30 days of the date of receipt of EDI claims and within 40 days for paper claims. MLTSS claims will be paid within 15 days of the receipt of EDI claims and within 30 days for paper claims.

The time limitation does not apply to claims from providers under investigation for fraud or abuse.

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.

Practitioners and facilities may not use a P.O. 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. Horizon NJ Health is required to report all claims to the State of New Jersey for services provided to members through electronic media. Therefore, all billing addresses, whether submitted on paper or electronically, must contain a physical billing address. To have payments sent to a different address or P.O. Box, the pay-to provider name and address field on the 837-I and 837-P transaction must be used.

9.1.2 National Practitioner Identifier (NPI)

Horizon NJ Health requires all practitioners use their NPI numbers for all claim submissions. To ensure our systems properly identify you as an individual, group or facility, Horizon NJ Health requires you register the NPI with your taxonomy and tax identification numbers.

Another requirement that will affect both timeliness and payment is the use of name differential on your W-9. Horizon NJ Health continues to accept the use of your provider identification numbers (legacy ID).

The continued use of the legacy ID is recommended, as the claims processing system uses this number for adjudication and payment activities. Please make sure your name matches the name used on your W-9.

Below are some helpful hints, which will facilitate accurate and consistent management of your claims.

- Physicians, facilities, and health care professionals are required to have an NPI. Please register for one if you have not already secured your NPI.
- Groups are not technically required to have an NPI, but are encouraged to have one as long as there is a legal entity associated with the business name and tax identification number. To register the group NPI with Horizon NJ Health, we will need the W-9 for the business and all associated individual NPIs paid to that tax ID number.
- Facilities, including hospitals and groups chosen to subpart their type 2 NPI, will need to choose a master NPI if all of the registered numbers are under the same tax identification number. Designating a master NPI number will help Horizon NJ Health assign claims to the right location for payment purposes. A valid W-9 for the business and all associated individual NPIs that are paid to that tax ID number should be registered with Horizon NJ Health.
- Where an NPI number is shared among different locations using the same tax ID number, the Horizon NJ Health legacy ID is needed to distinguish where the claim payment should be sent.
- Nonparticipating practitioners and facilities are also required to adhere to the NPI requirements. To facilitate payment for claims, Horizon NJ Health encourages you to register your NPI with us in the same manner described above. To complete this task, please visit the “For Providers” section of horizonNJhealth.com and download our NPI Collection Form. Once completed, fax your forms and CMS documentation to Horizon NJ Health at 1-609-583-3004.

9.1.3 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 CMS 1500 (HCFA 1500) version 02/12 or UB-04 claims form, or via electronic submission.
a HIPAA-compliant 837 or NCPDP format. These claims forms and electronic submissions must be consistent with the instructions provided by the CMS requirements, as stated in the Claims Manual, which can be accessed at www.cms.gov/Manuals/IOM/list.asp.

The hospital, physician and health care professional, 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 hospital, physician or health care professional that performed the services.

• Professional services are not reimbursable to a hospital unless the hospital is specifically contracted for professional services. Horizon NJ Health policy is to reimburse these services only when billed on a CMS 1500.

• 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
  – When appropriate, verification of the referral for specialist or non-primary care physician claims (excluding “self-referral” types of care)
  – 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 hospital, physician or health care professional that has received authorization to provide services to the eligible member
  – Verification that the hospital, physician or health care professional 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. Hospitals, physicians and health care professionals 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

**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 hospital, physician or health care professional must re-submit corrected claims within 180 calendar days from 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.

Horizon NJ Health encourages all hospitals, physicians, and health care professionals to submit claims electronically. We utilize the TriZetto Provider Solutions (TTPS) Direct Data Entry (DDE) SimpleClaim system. All providers that previously used TriZetto to directly enter their Horizon NJ Health claims must switch to DDE SimpleClaim.

For more information on registering, please go to https://trizettoprovidersolutions.wufoo.com/forms/horizon-nj-health-providers/. If you have any further questions about registering with TTPS for DDE claim submission, please call TriZetto at 1-800-556-2231.

While Horizon NJ Health strongly encourages submitting claims via EDI, if a paper claim is necessary, please submit red and white paper claims only 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** – Out-of-state, non-Horizon NJ Health providers should send claims to their local Blue Cross Blue Shield Plan.

**NOTE** – Out-of-state, non-Horizon NJ Health providers should send claims to their local Blue Cross Blue Shield Plan.

**NOTE** – Be sure to include the member’s Social Security Number and Horizon NJ Health or Medicaid ID number on all family planning claims.

**IMPORTANT** – Requests for reimbursement for retail pharmacy and all outpatient drugs for persons designated as aged, blind or disabled should be submitted directly to the State of New Jersey.

**IMPORTANT** – Requests for reimbursement for mental health services for all enrollees, except the developmentally disabled or MLTSS members, should be submitted directly to the State of New Jersey.

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

**NOTE** – Horizon NJ Health subcontracts with Davis Vision to provide and/or coordinate vision services for eligible members. All services, except ophthalmologic procedures, are coordinated and paid by Davis Vision. Please call 1-877-226-3729 for information about submitting invoices.

**NOTE** – Horizon NJ Health subcontracts with Scion Dental to provide and/or coordinate dental services for eligible members. Please call the Provider Call Center at 1-855-878-5368 for routine provider questions related to eligibility, claims, authorizations, credentialing, contracting, adding/changing provider data/locations, and fee schedules.

**NOTE** – Horizon NJ Health subcontracts with Laboratory Corporation of America, Inc. (LabCorp) for most routine and specialized laboratory services. Generally, Horizon NJ Health is responsible for payment of
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claims for PAT/STAT laboratory service provided in hospitals and ambulatory surgical centers. Horizon NJ Health will also provide reimbursements for claims for laboratory services included on LabCorp’s excluded test listing. An authorization is required for any test included on this listing; please submit claims to Horizon NJ Health as specified above. Unless otherwise specified within specific contractual arrangements, laboratory services should be referred to LabCorp.

Benefits to sending claims electronically include:

- Cleaner claim submission
- Confirmation of submitted claims within 24 hours
- Faster processing and payment
- Administrative efficiencies
- No postage or handling of paper claims

For more information on EDI, review Section 9.3 Procedures for Electronic Submission - Electronic Data Interchange.

9.1.4 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.

- Horizon NJ Health’s Appeals department utilizes specific criteria when reviewing valid proof of timely filing.
- 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.

For claims selected electronically:

- Submit an electronic data interchange (EDI) acceptance report. This must show that Horizon NJ Health or one of its affiliates received, accepted and/or acknowledged the claim submission.

NOTE: A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.

*The acceptance report must:

1. Include the actual wording that indicates the claim was either “accepted,” “received” and/or “acknowledged.” (Abbreviations of those words are also acceptable.)

*Show the claim was accepted, received, and/or acknowledged within the timely filing period.

For paper claims:

*Submit a screen shot from accounting software that shows the date the claim was submitted. The screen shot must show:

1. Correct patient name
2. Correct date of service
3. Submission date of claim
4. The submission date must be within the timely filing period.
5. Certified mail receipts as valid proof of timely filing.

Other valid proof of timely filing documentation

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/rejection letter from another insurance carrier
- Another insurance carrier’s explanation of benefits
- Letter from another insurance carrier or employer group indicating coverage termination prior to the date of service of the claim
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim

All of the above must include documentation that the claim is for the correct patient and the correct date of service.

The date on the other carrier’s payment correspondence starts the timely filing period for submission to Horizon NJ Health.

In order to be considered timely, the claim must be received by Horizon NJ Health within 90 days from the date on the other carrier’s correspondence.

If the claim is received after the timely filing period, it will not meet timely filing criteria.

REFER TO – Section 10.0 Complaint and Appeals Process for complete instructions of the submission timeframes and procedures for administrative or medical appeals.

Corrected claims must be submitted within 365 calendar days from the initial date of service via EDI submission or red and white paper to the following address:

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

Correcting electronic HCFA 1500 claims

If you don't know where the 2300 loop or 2300 NTE ADD fields are in the form you use, contact your software vendor. If your software vendor has additional questions, direct them to the EDI Helpline.

1. Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03.

2. To ensure we process the claim accurately, add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier). For example: NTE*ADD* (changed CPT)
3. Enter the original claim number in the 2300 loop in the REF*F8*.

**Correcting paper claims**

CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original Explanation of Payment (EOP). 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.

UB-04 should be submitted with the appropriate resubmission code in the third digit of the bill type (for corrected claim this will be 7), the original claim number in Box 64 of the paper claim and a copy of the original EOP. 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.

**9.2 Claim Forms (Paper)**

Horizon NJ Health requires that all hospitals, physicians and health care professionals use the standard CMS 1500 (HCFA 1500) or UB-04 claim forms to report services, which are reimbursable or capitated. The CMS 1500 (HCFA 1500) claim form must be completed for all professional medical services. The UB-04 claim form must be completed for all facility claims. When services are rendered by MLTSS providers, facilities should file a UB-04 form, and nonfacilities should use the CMS 1500. Horizon NJ Health does not accept handwritten or black and white claims.

**9.2.1 CMS 1500 (HCFA 1500) Claim Form (Paper Submissions)**

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

As of October 1, 2014, Horizon NJ Health no longer accepts any claim billed on the 8/5 version of the CMS 1500 claim form and will only accept form version 02/12. The National Uniform Claim Committee (NUCC) created the CMS 1500 form (version 02/12) to accommodate coding changes for ICD-10. There are two significant changes on the revised CMS 1500, the claim form used to submit paper claims to Medicare and the required claim form to submit paper claims to Horizon NJ Health.

The CMS 1500 Form (version 02/12) gives physicians the ability to:

- Identify whether they are using ICD-9-CM or ICD-10-CM codes.
- Include up to 12 codes in the diagnosis field (the limit on the 08/05 version is four codes in the diagnosis field).
- Include information that will improve the accuracy of the data reported, such as being able to identify the role of the provider and specific dates of illness.
- Align paper copy claim submissions with the ASC X12 Health Care Claim: Professional (837P) transaction.

CMS has advised providers to use the following process to assure clean claims submission.

All information must be:

- Aligned within the data fields.
- On an original red ink on white paper claim 02/12 version form.
- Typed. Do not print, hand-write or stamp any extraneous data on the form.
- In black ink.
- In large, dark font, such as PICA or ARIAL 10-, 11- or 12-point type.
- In capital letters.


**Required Fields for CMS 1500 (HCFA 1500) Claim Form**

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.

**Place of Service Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus - Outpatient Hospital</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
</tbody>
</table>
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#### 1500 (HCFA 1500) Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions and Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE PROGRAM IDENTIFICATION</td>
<td>Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select “D”, other.</td>
<td>R</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED I.D. NUMBER</td>
<td>Plan’s member identification number</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Enter the patient’s name as it appears on the member’s HNJH ID card</td>
<td>R</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE/SEX</td>
<td>MMDDYY/M or F</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Enter the patient’s name as it appears on the member’s Horizon NJ Health I.D. card or enter the mother’s name when the patient is a newborn.</td>
<td>R</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT RELATIONSHIP TO INSURED</td>
<td>Always indicate self</td>
<td>R</td>
</tr>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS (Number, Street, City, State, zip code)/TELEPHONE (include area code)</td>
<td>Enter the patient’s complete address and telephone number. (Do not punctuate the address or phone number.)</td>
<td>R</td>
</tr>
<tr>
<td>8</td>
<td>PATIENT STATUS</td>
<td>Enter the patient’s marital status, indicate if the patient is employed or is a student.</td>
<td>R</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Refers to someone other than the patient. REQUIRED if patient is covered by another person’s policy</td>
<td>C</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>REQUIRED if # 9 is completed</td>
<td>C</td>
</tr>
<tr>
<td>9b</td>
<td>OTHER INSURED’S BIRTH DATE/SEX</td>
<td>REQUIRED if # 9 is completed. MM DD YY/M or F by check box</td>
<td>C</td>
</tr>
<tr>
<td>9c</td>
<td>EMPLOYER’S NAME OR SCHOOL NAME</td>
<td>This field is related to the insured in field # 9.</td>
<td>C</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>REQUIRED if # 9 is completed.</td>
<td>C</td>
</tr>
<tr>
<td>10a,b,c</td>
<td>IS PATIENT’S CONDITION RELATED TO:</td>
<td>Indicate Yes or No for each category</td>
<td>R</td>
</tr>
<tr>
<td>10d</td>
<td>RESERVED FOR LOCAL USE</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>INSURED’S POLICY GROUP OR FECA NUMBER</td>
<td>Required when other insurance is available</td>
<td>C</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S BIRTH DATE/SEX</td>
<td>Same as # 3</td>
<td>C</td>
</tr>
<tr>
<td>11b</td>
<td>EMPLOYER’S NAME OR SCHOOL NAME</td>
<td>Required if employment is indicated in field # 10</td>
<td>C</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>Enter name of Horizon NJ Health</td>
<td>C</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN?</td>
<td>Y or N by check box. If yes, complete # 9 a-d</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</td>
<td>MMDDYY</td>
<td>C</td>
</tr>
<tr>
<td>15</td>
<td>IF PATIENT HAS SAME OR SIMILAR ILLNESS GIVE FIRST DATE</td>
<td>MMDDYY</td>
<td>C</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>MMDDYY</td>
<td>C</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>REQUIRED, if a physician other than the member’s primary care physician rendered invoiced services</td>
<td>C</td>
</tr>
<tr>
<td>17a</td>
<td>UNLABELED FIELD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>REQUIRED, when place of service is in-patient. MMDDYY</td>
<td>C</td>
</tr>
<tr>
<td>19</td>
<td>RESERVED FOR LOCAL USE</td>
<td>Enter the Individual Provider’s Medical Assistance I.D. (MAID) number</td>
<td>R</td>
</tr>
</tbody>
</table>
### 1500 (HCFA 1500) Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions and Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>OUTSIDE LAB CHARGES</td>
<td>Diagnosis codes must be valid ICD-10 codes for the date of service. “E” codes are NOT acceptable as a primary diagnosis. NOTE: Paper claims with invalid diagnosis codes will be denied for payment.</td>
<td>Not Required</td>
</tr>
<tr>
<td>21</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)</td>
<td>Diagnosis codes must be valid ICD-10 codes for the date of service. “E” codes are NOT acceptable as a primary diagnosis. NOTE: Paper claims with invalid diagnosis codes will be denied for payment.</td>
<td>R</td>
</tr>
<tr>
<td>22</td>
<td>MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</td>
<td>For resubmissions or adjustments, enter the DCN (Document Control Number) of the original claim. NOTE: Resubmissions may NOT currently be submitted via EDI.</td>
<td>C</td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
<td>Enter the referral or authorization number. Refer to Section 3.1.6, Benefit Matrix, to determine if services rendered require an authorization or referral.</td>
<td>C</td>
</tr>
<tr>
<td>24a</td>
<td>DATE(S) OF SERVICE</td>
<td>From date: MMDDYY. If the service was performed on one day there is no need to complete the To Date.</td>
<td>R</td>
</tr>
<tr>
<td>24b</td>
<td>PLACE OF SERVICE</td>
<td>Enter the HCFA standard place of service code.</td>
<td>R</td>
</tr>
<tr>
<td>24c</td>
<td>EMG</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>24d</td>
<td>PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER</td>
<td>Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service.</td>
<td>R</td>
</tr>
<tr>
<td>24e</td>
<td>DIAGNOSIS POINTER</td>
<td>Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>24f</td>
<td>CHARGES</td>
<td>Enter charges</td>
<td>R</td>
</tr>
<tr>
<td>24g</td>
<td>DAYS OR UNITS</td>
<td>Enter quantity. Anesthesia services are to be entered in true minutes.</td>
<td>R</td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT FAMILY PLAN</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>24i</td>
<td>ID QUAL</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>24j</td>
<td>RENDERING PROVIDER ID #</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>25</td>
<td>FEDERAL TAX I.D. NUMBER SSN/EIN</td>
<td>Physician or Supplier’s Federal Tax ID numbers</td>
<td>R</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT’S ACCOUNT NO.</td>
<td>The physician’s billing account number</td>
<td>R</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT?</td>
<td>Always indicate Yes. Refer to the back of the CMS 1500 (HCFA 1500-12-90) form for the section pertaining to Medicaid Payments.</td>
<td>R</td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGE</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>29</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>C</td>
</tr>
<tr>
<td>30</td>
<td>BALANCE DUE</td>
<td>REQUIRED when # 29 is completed</td>
<td>C</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS/DATE</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>REQUIRED unless #33 is the same information. Enter the physical location. (P.O. Box #s are not acceptable here.)</td>
<td>R</td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>REQUIRED</td>
<td>R</td>
</tr>
<tr>
<td>32b</td>
<td>UPFRONT MODIFIER</td>
<td>Enter “PWK 02” when Modifier 59 is billed</td>
<td>R</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO AND PHONE # (include area code)</td>
<td>Enter the complete name and address of the physician. Do not punctuate the address or phone number. PIN #: Enter Horizon NJ Health assigned individual physician ID. GRP #: Enter Horizon NJ Health assigned group physician ID.</td>
<td>R</td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>REQUIRED</td>
<td>R</td>
</tr>
<tr>
<td>33b</td>
<td>UNLABELED FIELD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.0 BILLING GUIDE

32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Residential Treatment Center
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Center
56 Psychiatric Residential Treatment Center
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

Type of Service Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Services</td>
</tr>
<tr>
<td>2</td>
<td>Surgery</td>
</tr>
<tr>
<td>3</td>
<td>Consultations</td>
</tr>
<tr>
<td>4</td>
<td>Radiology (total component)</td>
</tr>
<tr>
<td>5</td>
<td>Laboratory (total component)</td>
</tr>
<tr>
<td>6</td>
<td>Radiation Therapy (total component)</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>8</td>
<td>Assistant Surgery</td>
</tr>
<tr>
<td>9</td>
<td>Other (e.g., prosthetic eyewear, contacts,</td>
</tr>
<tr>
<td></td>
<td>ambulance)</td>
</tr>
<tr>
<td>D</td>
<td>DME</td>
</tr>
<tr>
<td>F</td>
<td>ASC</td>
</tr>
</tbody>
</table>

Required and Conditional Field Indicator

**IMPORTANT** – An authorization number and/or referral number must be included in box #23 on a CMS 1500 (HCFA 1500) claim form or box #63 on a UB-04 form.

The required fields that must be completed for the standard CMS 1500 (HCFA 1500) or UB-04 claim forms are in the respective claim form areas. If the field is required without exception, an “R” (required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

9.2.2 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>Hospital/Inpatient (Part A)/Admit through Discharge</td>
</tr>
<tr>
<td>112</td>
<td>Hospital/Inpatient (Part A)/Interim – First Claim</td>
</tr>
<tr>
<td>113</td>
<td>Hospital/Inpatient (Part A)/Interim – Continuing Claims</td>
</tr>
<tr>
<td>114</td>
<td>Hospital/Inpatient (Part A)/Interim – Last Claim</td>
</tr>
<tr>
<td>115</td>
<td>Hospital/Inpatient (Part A)/Replacement of Prior Claim</td>
</tr>
<tr>
<td>121</td>
<td>Hospital/Hospital Based or Inpatient (Part B)/Admit Through Discharge</td>
</tr>
<tr>
<td>211</td>
<td>Skilled Nursing/Inpatient (Part A)/Admit Through Discharge</td>
</tr>
<tr>
<td>212</td>
<td>Skilled Nursing/Inpatient (Part A)/Admit Through Discharge</td>
</tr>
<tr>
<td>213</td>
<td>Skilled Nursing/Inpatient (Part A)/Admit Through Discharge</td>
</tr>
<tr>
<td>214</td>
<td>Skilled Nursing/Inpatient (Part A)/Admit Through Discharge</td>
</tr>
<tr>
<td>321</td>
<td>Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge</td>
</tr>
<tr>
<td>331</td>
<td>Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge</td>
</tr>
<tr>
<td>711</td>
<td>Clinic/Rural Health Clinic (RHC)/Admit Through Discharge</td>
</tr>
<tr>
<td>721</td>
<td>Clinic/Independent Renal Dialysis Facility/Admit through Discharge</td>
</tr>
<tr>
<td>731</td>
<td>Clinic/FQHC/Admit Through Discharge</td>
</tr>
<tr>
<td>831</td>
<td>Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge</td>
</tr>
</tbody>
</table>

Type of Admission Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency</td>
</tr>
<tr>
<td>2</td>
<td>Urgent</td>
</tr>
<tr>
<td>3</td>
<td>Elective</td>
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</tbody>
</table>
### UB-04 Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions and Comments</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>UNLABELED FIELD</td>
<td>Line a: Enter the complete physician name. Line b: Enter the complete address or post office number. Line c: City, state, and ZIP code. Line d: Enter the area code, telephone number.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>UNLABELED FIELD</td>
<td>Enter the Facility Medical Assistance ID (MAID) number.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>3a</td>
<td>PATIENT CONTROL NO.</td>
<td>Physician’s patient account/control number</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>3b</td>
<td>MED REC NO.</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>Enter the appropriate three-digit code. 1st position indicates type of facility. 2nd position indicates type of care. 3rd position indicates billing sequence.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>5</td>
<td>FED. TAX NO.</td>
<td>Enter the number assigned by the federal government for tax reporting purposes.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>6</td>
<td>STATEMENT COVERS PERIOD FROM/THROUGH</td>
<td>Enter dates for the full ranges of services being invoiced. MMDDYY</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>7</td>
<td>UNLABELED FIELD</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>8a</td>
<td>PATIENT NAME</td>
<td>Last name, first name, and middle initial. Enter the patient name as it appears on Horizon NJ Health ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name, e.g. McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>8b</td>
<td>UNLABELED FIELD</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>9a</td>
<td>PATIENT ADDRESS</td>
<td>Enter the complete mailing address of the patient.</td>
<td>R</td>
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</tr>
<tr>
<td>9b</td>
<td>UNLABELED FIELD</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>9c</td>
<td>UNLABELED FIELD</td>
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<td>R</td>
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</tr>
<tr>
<td>9d</td>
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<td>R</td>
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<tr>
<td>9e</td>
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<td>R</td>
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<tr>
<td>10</td>
<td>BIRTHDATE</td>
<td>MMDDYY</td>
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<tr>
<td>11</td>
<td>SEX</td>
<td>Enter the patient’s sex, as recorded at the time of registration. Only M, F, and U are acceptable.</td>
<td>R</td>
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<td></td>
<td>ADMISSION INFO 12-17</td>
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<tr>
<td>12</td>
<td>DATE</td>
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<tr>
<td>13</td>
<td>HR</td>
<td>Admission Hour</td>
<td>R</td>
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</tr>
<tr>
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<td>TYPE</td>
<td>Admission Type</td>
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<tr>
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<td>SRC</td>
<td>Source of Admission</td>
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<td>16</td>
<td>DHR</td>
<td>Discharge Hour</td>
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<td>R</td>
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<tr>
<td>17</td>
<td>STAT</td>
<td>Patient Status (disposition)</td>
<td>R</td>
<td>Not Required</td>
</tr>
<tr>
<td></td>
<td>CONDITION CODE 18-28</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>18</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>19</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
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<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>21</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>22</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>23</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
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<tr>
<td>24</td>
<td>CONDITION CODE</td>
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<td>C</td>
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<td>CONDITION CODE</td>
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<td>CONDITION CODE</td>
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<td>C</td>
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<tr>
<td>27</td>
<td>CONDITION CODE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>28</td>
<td>CONDITION CODE</td>
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<td>C</td>
<td>C</td>
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</tbody>
</table>
# UB-04 Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions and Comments</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>ACDT STATE</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>CODE DATE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>32</td>
<td>CODE DATE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>33</td>
<td>CODE DATE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>34</td>
<td>CODE DATE</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>35</td>
<td>OCCURRENCE SPAN CODE FROM/THROUGH</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>36</td>
<td>OCCURRENCE SPAN CODE FROM/THROUGH</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>37</td>
<td>UNLABELED FIELD</td>
<td>REQUIRED, for resubmissions or adjustments. Enter the DCN (Document Control Number) of the original claim. Resubmissions may NOT currently be submitted via EDI.</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>38</td>
<td>UNLABELED FIELD</td>
<td>Not Required</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>CODE AMOUNT</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>39a</td>
<td>CODE AMOUNT</td>
<td>Value Code/Value Amount Missing</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>CODE AMOUNT</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>41</td>
<td>CODE AMOUNT</td>
<td>REQUIRED, when applicable</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>42</td>
<td>REV.CD.</td>
<td>Revenue Code</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>43</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>Revenue Code description — NDC</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATES/HPSS CODE</td>
<td>Enter the applicable rate, CPT, HCPCS, OR HPSS code and modifier based on the Bill Type of Inpatient or Outpatient.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>45</td>
<td>SERV. DATE</td>
<td>Report line item dates of service for each revenue code or HCPCS/CPT code.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>46</td>
<td>SERV. UNITS</td>
<td>Report units of service</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>47</td>
<td>TOTAL CHARGES</td>
<td>Total Charge amount is missing. If a value greater than or equal to zero is not present, the claim will be rejected. If total charge does not equal total of line item changes, the claim will be rejected</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES</td>
<td>REQUIRED, when Medicare is primary</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>49</td>
<td>UNLABELED FIELD</td>
<td>Not Required</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>PAYER</td>
<td>Enter the name for each payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer, B, secondary; and C, tertiary.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID</td>
<td>Report the Health Plan ID assigned by Horizon NJ Health.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>52</td>
<td>REL. INFO</td>
<td>Release of Information Certification Indicator. This field is required on paper and electronic invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the physician have all necessary release information on file. It is expected that all released invoices contain “Y”.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>53</td>
<td>ASG. BEN.</td>
<td>Valid entries are “Y” (yes) and “N” (no).</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>The A, B, C indicators refer to the information in Field 50.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td>Enter the estimated amount due (the difference between “Total Charges” and any deductions, such as other coverage).</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>REQUIRED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Not Required</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>INSURED’S NAME</td>
<td>Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>59</td>
<td>P. REL.</td>
<td>Enter the patient’s relationship to insured. For Medicaid programs, the patient is the insured. (Code 01: Patient is Insured)</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>
### Patient Status Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to Home or Self Care (routine discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Discharged/Transferred to Another Short-Term General Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Discharged/Transferred to SNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Discharged/Transferred to ICF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to Another Type of Institution (including distinct parts) or Referred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Discharged/Transferred to Home Under Care of Organized Home Health Service Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Left Against Medical Advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Discharged/Transferred to Home Under Care of an IV Drug Therapy Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an Inpatient to this Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Expired (or did not recover – Christian Science Patient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Still Patient or Expected to Return for Outpatient Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### UB-04 Claim Form

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions and Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Enter Horizon NJ Health referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.</td>
<td>R</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>REQUIRED if field 64 contains 1, 2, or 4. Line A refers to the primary payer; B, secondary; and C, tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>66</td>
<td>DX</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>67 a-q</td>
<td>A-Q</td>
<td>Enter the complete ICD-10-CM diagnosis code. Include the 4th and 5th digits if applicable. Each diagnosis code must be valid for the date of service.</td>
<td>R</td>
</tr>
</tbody>
</table>

**OTHER DIAG. CODES 68-75**

<table>
<thead>
<tr>
<th>68 a-e</th>
<th>UNLABELED FIELD</th>
<th>R</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>ADMIT DX</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON DX (a-c)</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Enter the complete ICD-10-CM diagnosis code. Include the 4th and 5th digits if applicable. Each diagnosis code must be valid for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>73 a-e</td>
<td>UNLABELED FIELD</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>74 a-e</td>
<td>PRINCIPAL PROCEDURE CODE DATE</td>
<td>Enter the procedure code for the principal procedure performed during the period covered by the invoice. Inpatient claims and all surgical procedures require ICD-10-CM codes. Outpatient claims require CPT/HCPCS codes.</td>
<td>R</td>
</tr>
<tr>
<td>75 a-e</td>
<td>OTHER PROCEDURE CODE DATE</td>
<td>Enter the procedure code for the other procedure performed during the period covered by the invoice. Inpatient claims and all surgical procedures require ICD-10-CM codes. Outpatient claims require CPT/HCPCS codes.</td>
<td>R</td>
</tr>
<tr>
<td>76</td>
<td>ATTENDING PROVIDER NPI</td>
<td>Attending Provider</td>
<td>R</td>
</tr>
<tr>
<td>77</td>
<td>OPERATING</td>
<td>REQUIRED for reporting external cause of injury. Enter the complete ICD-10-CM diagnosis code. Include the 4th and 5th digits if applicable</td>
<td>C</td>
</tr>
<tr>
<td>78</td>
<td>OTHER</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>79</td>
<td>UFRONT MODIFIER</td>
<td>Enter “PWK 02” when Modifier 59 is billed</td>
<td>R</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>81 a-d</td>
<td>CC</td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>
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

Commonly Used Revenue Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 – 129</td>
<td>Room and Board Charges</td>
</tr>
<tr>
<td>130 – 249</td>
<td>Semi-private; Private; Ward, Nursery, Subacute, ICU, CCU</td>
</tr>
<tr>
<td>250 – 259</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>260 – 269</td>
<td>IV Therapy</td>
</tr>
<tr>
<td>270 – 279</td>
<td>Medical/Surgical Supplies &amp; Devices</td>
</tr>
<tr>
<td>280 – 289</td>
<td>Oncology</td>
</tr>
<tr>
<td>290 – 299</td>
<td>Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>300 – 319</td>
<td>Laboratory/Laboratory Pathological</td>
</tr>
<tr>
<td>320 – 339</td>
<td>Radiology Diagnostic/Therapeutic</td>
</tr>
<tr>
<td>340 – 349</td>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>350 – 359</td>
<td>CT Scan</td>
</tr>
<tr>
<td>360 – 369</td>
<td>Operating Room Services</td>
</tr>
<tr>
<td>370 – 379</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>410 – 449</td>
<td>Therapy Services</td>
</tr>
<tr>
<td>450 – 459</td>
<td>Emergency Codes</td>
</tr>
<tr>
<td>540 – 548</td>
<td>Ambulance Services</td>
</tr>
<tr>
<td>720 – 729</td>
<td>Labor and Delivery</td>
</tr>
<tr>
<td>730 – 750</td>
<td>Outpatient Surgery</td>
</tr>
<tr>
<td>800 – 880</td>
<td>Radiology</td>
</tr>
<tr>
<td>900 – 919</td>
<td>Psychiatric/Psychological</td>
</tr>
<tr>
<td>920 – 999</td>
<td>Nuclear Medicine</td>
</tr>
</tbody>
</table>

9.2.3 Taxonomy Codes

Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique ten-character alphanumeric code that enables providers to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual provider and organizational provider level. Taxonomy codes have three distinct levels: Level I is Provider Type, Level II is Classification, and Level III is the Area of Specialization.

Examples and discussion of taxonomy codes can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/taxonomy.html.

For paper UB04 institutional claims, the taxonomy code should be placed in box 81 and should be submitted with the “B3” qualifier. For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier “ZZ” in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level.

CMS 1500 (08-05) Professional Claim Form (for enumerated providers)

Billing Provider NPI Field 33a
Billing Provider TIN Field 25
Referring Provider NPI Field 17b
Rendering Provider NPI Field 24j
Service Facility Location NPI Field 32a

Important: Make sure that your claim software supports the revised 1500 claim form (08-05).

Reference the 1500 Reference Instruction Manual at Nucc.org for specific details on completing this form.

UB-04 Paper Institutional Claim Form (for enumerated providers)

Billing Provider NPI Locator 56
Billing Provider TIN Locator 05
Billing Provider Taxonomy Code Locator 81
Attending Provider NPI Locator 76
Operating Provider NPI Locator 77
Other Provider NPI Locator 78-79

9.3 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 hospitals, physicians and health care professionals. 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 quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

IMPORTANT – Referrals are valid for up to 180 days from the date indicated in box 3 (Date of Service) of the Horizon NJ Health referral form. The referral number on the claim does not generate a payment. The actual referral must be submitted with each claim to avoid claim processing delays or denials.

NOTE – Hospitals, physicians and health care professionals submitting claims electronically should make sure the referral number is present on the claim. Referral forms must be submitted separately, by mail to:

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

NOTE – EDI Technical Support Team is available during regular business hours, 8 a.m. through 5 p.m., Monday through Friday. It can be reached at 1-800-556-2231.

9.3.1 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 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. 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.

Transmission Requirements
Once the material is 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.

NOTE – Contact EDI Technical Support at 1-800-556-2231 to notify them of your intention to begin EDI transmissions.

9.3.2 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 Center for Medicare and Medicaid Services website at www.cms.hhs.gov.

9.3.3 Electronic Claim Flow Description

In order to send claims electronically to Horizon NJ Health, all EDI claims must first be forwarded to TriZetto using payer 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 their immediate 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

9.3.4 Invalid Electronic Claim Record

Rejections/Denials

All claim records sent to Horizon NJ Health must first pass TriZetto'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 TriZetto or your vendor in order to identify and resubmit these claims accurately.

Common Rejections

- Missing or invalid member ID
- 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 health care professional National Provider Identifier (NPI) numbers whenever applicable. Per federal requirements, atypical providers are excluded.
- No physical billing address on file

NOTE – Hospital, physician or health care professional identification number validation is not performed at TriZetto. TriZetto will reject claims for hospital, physician or health care professional information only if the hospital, physician or health care professional number fields are empty.

9.3.5 Submitting Corrected Claims with EDI

Providers using electronic data interchange (EDI) can submit “professional” corrected claims electronically rather than via 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 “6” for adjustment of prior claims or “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.
9.3.6 Electronic Billing Inquiries

Please direct inquiries as follows:

**Action**
- If you would like to be authorized to transmit electronic claims
- If you have specific EDI technical questions
- If you have general EDI questions or questions on where to enter required data

**Contact**
- TriZetto Technical Support at 1-800-556-2231

**Action**
- If you have questions about your claim status (receipt or completion dates)
- If you have questions about claims that are reported on the Remittance Advice
- If you need to know a provider ID number

**Contact**
- Physician & Health Care Hotline at 1-800-682-9091

**Action**
- If you would like to update provider, payee, UPIN, tax ID number, physical billing address or payment address information
- For questions about changing or verifying provider information

**Contact**
- Physician & Health Care Hotline in writing at:
  
  Email: providerfileops2@horizonblue.com
  
  fax: 1-973-274-4126
  
  phone: 1-800-682-9091

9.4 Common Coding Requirements

9.4.1 Diagnosis Codes

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

The Centers for Medicare and Medicaid Services (CMS) provides specific guidelines to aid in standardizing U.S. coding practices. The guidelines for outpatient facilities, physician offices and ancillary care 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.
- For surgical procedures, code the diagnosis applicable to the procedure. If, after the procedure has been done, the condition necessitating the surgery is more specifically identified, or even determined to be different than the preoperative diagnosis, code the most specific diagnosis determined to be the reason for the surgery.

Horizon NJ Health has adopted these diagnosis guidelines for its health plan and recommends that hospitals, physicians and health care professionals remain informed about these requirements through updated ICD-10-CM coding manuals. 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 hospitals, physicians and health care professionals with zeros (00000) and an explanation that the codes are not valid.
9.4.2 Procedure Codes

**Common Procedure Terminology**

CPT is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. It was developed and is updated and published annually by the American Medical Association (AMA). CPT codes communicate to physicians, health care professionals, 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 physicians and health care professionals 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 American Medical Association (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 hospitals, physicians and health care professionals with zeros (00000) and an explanation that the codes are not valid.

9.4.3 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 for 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:

- 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** – All family planning procedures must be reported using the “FP” modifier. Claims submitted without the modifier will be denied and returned to the submitter to be re-coded and resubmitted.

**IMPORTANT** – Modifiers should not be used to 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 physicians and health care professions, including the use of modifiers. For more information on the Evaluation and Management Services Guide please visit the Medicare Learning Network (MLN) at www.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.

9.4.4 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.

All anesthesia providers are required to indicate the true amount of minutes in the days/units field of the claim form when billing for services.
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.

9.4.5 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.

9.4.6 Taxonomy Codes

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level.

9.4.7 Pharmacy (HCPC Codes)

When billing for all “J” and “Q” codes via revenue codes 634, 635, 636 and 637, the appropriate National Drug Codes (NDC) number, metric units, unit of measure, and revenue code must be submitted as well. Failure to submit the NDC number, metric units, unit of measure, and revenue code along with the “J” or “Q” code will result in the claim being rejected. This guideline applies only to facility claims.

9.5 Common Causes of Claim Processing Delays, Rejections or Denials

- Authorization or referral 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
- Hospital, physician or health care professional 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

9.5.1 Newborn Claim Information

Missing or Invalid

All newborns receive an individual member number. Always include the first and last name of the mother and baby on the claim. If the baby has not been named, insert “Girl” or “Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

IMPORTANT – The claim for baby must include the baby’s date of birth.

IMPORTANT – On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith A, Baby Girl Smith B, etc.

9.5.2 Attachments Missing From Original Claim

Hospitals, physicians and health care professionals are required to submit an invoice for implantable items, referrals and other insurance EOBs. 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:

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

Signed consent forms for sterilization are required for payment under federal requirements. (See Section 3.3 Family Planning.) These forms should be submitted to the address below:

Horizon NJ Health
PO Box 24078
Newark, NJ 07101-0406

Signed receipt of information form, FD-189 must be submitted during the request for pre-certification for hysterectomies.
## Remark and Denial Codes

<table>
<thead>
<tr>
<th>Remark Code</th>
<th>Denial Code</th>
<th>Description</th>
<th>HIPAA Remark Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDD</td>
<td></td>
<td>Definite Duplicate Claim</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>CRS</td>
<td></td>
<td>Code Superceded - AMA CPT Guidelines</td>
<td>N56</td>
<td>Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
</tr>
<tr>
<td>CRT</td>
<td></td>
<td>Code Superceded - AMA CPT Guidelines - Denied</td>
<td>N56</td>
<td>Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
</tr>
<tr>
<td>F47</td>
<td></td>
<td>F47</td>
<td>N9</td>
<td>Adjustment represents the estimated amount a previous payer may pay.</td>
</tr>
<tr>
<td>F50</td>
<td></td>
<td>Claim Adjustment-Third Party Denied or Benefits Exhausted</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>I02</td>
<td>X02</td>
<td>Illegible Records Submitted; Please Refile</td>
<td>M127</td>
<td>Missing patient medical record for this service.</td>
</tr>
<tr>
<td>I04</td>
<td>X04</td>
<td>Correct NDC Code and/or Drug Name Required for Consideration</td>
<td>M58</td>
<td>Missing/incomplete/invalid claim information. Resubmit claim after corrections.</td>
</tr>
<tr>
<td>I05</td>
<td>X05</td>
<td>Invalid/Inappropriate/Deleted Code, Modifier or Description</td>
<td>N56</td>
<td>Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
</tr>
<tr>
<td>I06</td>
<td>X06</td>
<td>Itemized Bill, Dates of Service, Charges or Invoice Required</td>
<td>M58</td>
<td>Missing/incomplete/invalid claim information. Resubmit claim after corrections.</td>
</tr>
<tr>
<td>I08</td>
<td>X08</td>
<td>Diagnosis Invalid/Missing/Deleted/ Requires 4th or 5th digit</td>
<td>M81</td>
<td>You are required to code to the highest level of specificity.</td>
</tr>
<tr>
<td>I10</td>
<td></td>
<td>E-Code Cannot Be Used As Primary Diagnosis</td>
<td>M76</td>
<td>Missing/incomplete/invalid diagnosis or condition.</td>
</tr>
<tr>
<td>I11</td>
<td>X11</td>
<td>EOB from Primary Carrier Required</td>
<td>MA04</td>
<td>Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.</td>
</tr>
<tr>
<td>I18</td>
<td></td>
<td>Paid Billed Charges</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.</td>
</tr>
<tr>
<td>I19</td>
<td>X19</td>
<td>Carrier of Service Scion Dental</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>I24</td>
<td>X24</td>
<td>Carrier of Service-Davis Vision</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>I26</td>
<td>X26</td>
<td>Exhaustion of Benefits</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>I27</td>
<td>X27</td>
<td>Submit Medical Records to Horizon NJ Health Appeals Unit</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>I28</td>
<td></td>
<td>Reprocessed-Claim Subject to Interest</td>
<td>MA67</td>
<td>Correction to a prior claim.</td>
</tr>
<tr>
<td>I30</td>
<td>X30</td>
<td>Service Exceeds Lifetime Limitation</td>
<td>N117</td>
<td>This service is paid only once in a patient’s lifetime.</td>
</tr>
<tr>
<td>I37</td>
<td>X37</td>
<td>Resubmit with Appropriate Modifier and/or Units</td>
<td>M53</td>
<td>Missing/incomplete/invalid days or units of service.</td>
</tr>
<tr>
<td>I42</td>
<td>X42</td>
<td>Illegible/Incomplete/Inappropriate Referral Received</td>
<td>M62</td>
<td>Missing/incomplete/invalid treatment authorization code.</td>
</tr>
<tr>
<td>I43</td>
<td>X43</td>
<td>Bi-Lateral Procedure Previously Paid with Modifier &quot;50&quot;</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>I44</td>
<td>X44</td>
<td>Resubmit with ICD-10 Principal Procedure Code</td>
<td>M123</td>
<td>Missing/incomplete/invalid name, strength or dosage of the drug furnished.</td>
</tr>
</tbody>
</table>
### Remark and Denial Codes

<table>
<thead>
<tr>
<th>Remark Code</th>
<th>Denial Code</th>
<th>Description</th>
<th>HIPAA Remark Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>144</td>
<td>X44</td>
<td>Resubmit with ICD-10 Principal Procedure Code</td>
<td>M123</td>
<td>Missing/incomplete/invalid name, strength or dosage of the drug furnished.</td>
</tr>
<tr>
<td>147</td>
<td>X47</td>
<td>Non-contracted Level of Care</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>148</td>
<td>Z48</td>
<td>Resubmit to Primary Carrier for Appeals Process</td>
<td>N36</td>
<td>Claim must meet primary payer’s processing requirements before we can consider payment.</td>
</tr>
<tr>
<td>164</td>
<td>X64</td>
<td>Capitated to Another Provider</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>165</td>
<td></td>
<td>Duplicate Claim - Previously Denied Appropriately</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>168</td>
<td></td>
<td>This service is not covered when performed in this setting</td>
<td>M77</td>
<td>Missing/incomplete/invalid place of service.</td>
</tr>
<tr>
<td>183</td>
<td>X83</td>
<td>Mother's Bill not Received; Refile</td>
<td>M58</td>
<td>Missing/incomplete/invalid claim information. Resubmit claim after corrections.</td>
</tr>
<tr>
<td>4</td>
<td>N02</td>
<td>Redundant Procedure Disallow</td>
<td>N19</td>
<td>Procedure code incidental to primary procedure.</td>
</tr>
<tr>
<td>d</td>
<td>N06</td>
<td>Assistant Surgeon Disallow</td>
<td>M41</td>
<td>We do not pay for this as the patient has no legal obligation to pay for this.</td>
</tr>
<tr>
<td>Q17</td>
<td></td>
<td>Administrative Overturn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R00</td>
<td>X00</td>
<td>Payment Included in Other Billed Services</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
</tr>
<tr>
<td>R01</td>
<td>X01</td>
<td>Authorization or Referral not Obtained and/or not the Member's PCP</td>
<td>M62</td>
<td>Missing/incomplete/invalid treatment authorization code.</td>
</tr>
<tr>
<td>R07</td>
<td>X07</td>
<td>Received after Timely Filing Limit</td>
<td>MA119</td>
<td>Provider level adjustment for late claim filing applies to this claim.</td>
</tr>
<tr>
<td>R09</td>
<td>X09</td>
<td>Requested Hospital Documents not Received</td>
<td>M127</td>
<td>Missing patient medical record for this service.</td>
</tr>
<tr>
<td>R10</td>
<td>X10</td>
<td>Not Enrolled on Date of Service</td>
<td>N30</td>
<td>Patient ineligible for this service.</td>
</tr>
<tr>
<td>R15</td>
<td></td>
<td>This procedure is considered incidental to or a part of the primary</td>
<td>N19</td>
<td>Procedure code incidental to primary procedure.</td>
</tr>
<tr>
<td>R18</td>
<td></td>
<td>Resubmit with ICD-10 Principal Procedure Code or Valid HCPCS or CPT Code</td>
<td>MA66</td>
<td>Missing/incomplete/invalid principal procedure code.</td>
</tr>
<tr>
<td>R37</td>
<td></td>
<td>Combined Payment - Mother &amp; Baby</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
</tr>
<tr>
<td>R38</td>
<td></td>
<td>Contracted Fee</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>R39</td>
<td>X39</td>
<td>Duplicate Claim Previously Paid at Correct Rate or Capitation</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>R40</td>
<td>X40</td>
<td>Duplicate Claim - Original Still Under Investigation</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>R42</td>
<td></td>
<td>DRG Payment</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>Remark Code</td>
<td>Denial Code</td>
<td>Description</td>
<td>HIPAA Remark Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
<td>-------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>R43</td>
<td></td>
<td>Interim Bill Payment</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>R44</td>
<td></td>
<td>Multiple Surgical Reduction</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>R45</td>
<td>X45</td>
<td>Complete Medical Records Required for Consideration; Refile</td>
<td>N101</td>
<td>Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letter &quot;N&quot;.</td>
</tr>
<tr>
<td>R46</td>
<td>X46</td>
<td>Over Maximum Procedure/Benefit Limit</td>
<td>N130</td>
<td>Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
</tr>
<tr>
<td>R47</td>
<td></td>
<td>Payment Reflects Coordination of Benefits, if $0, Max Liability Met</td>
<td>N9</td>
<td>Adjustment represents the estimated amount a previous payer may pay.</td>
</tr>
<tr>
<td>R49</td>
<td>X49</td>
<td>Previous Payments Equal to Purchase Price</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
</tr>
<tr>
<td>R50</td>
<td>X50</td>
<td>Same Procedure Paid to a Different Provider</td>
<td>MA29</td>
<td>Missing/incomplete/invalid provider name, city, state or ZIP code.</td>
</tr>
<tr>
<td>R51</td>
<td>X51</td>
<td>Service Not Covered</td>
<td>N30</td>
<td>Patient ineligible for this service.</td>
</tr>
<tr>
<td>R55</td>
<td></td>
<td>Billed Info Reflects Lower Degree Acuity/Treatment</td>
<td>M25</td>
<td>The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for the service.</td>
</tr>
<tr>
<td>R56</td>
<td></td>
<td>Administrative Approval</td>
<td>N10</td>
<td>Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.</td>
</tr>
<tr>
<td>R60</td>
<td>X60</td>
<td>Dates and/or Services Outside Referral/Authorization</td>
<td>M62</td>
<td>Missing/incomplete/invalid treatment authorization code.</td>
</tr>
<tr>
<td>R61</td>
<td>X61</td>
<td>No PCP Referral</td>
<td>N54</td>
<td>Claim information is inconsistent with precertified/authorized services.</td>
</tr>
<tr>
<td>R65</td>
<td></td>
<td>Interim Bill 2nd Cycle Payment</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.</td>
</tr>
<tr>
<td>R66</td>
<td>Z34</td>
<td>Interim Bill Final Cycle Payment</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.</td>
</tr>
<tr>
<td>R67</td>
<td>X67</td>
<td>Discrepancy with Level of Care - Appeal Required</td>
<td>M25</td>
<td>The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for the service.</td>
</tr>
<tr>
<td>R70</td>
<td>X70</td>
<td>EPSDT Screening Didn't Comply with Periodicity Schedule</td>
<td>N78</td>
<td>The necessary components of the child and teen checkup (EPSDT) were not completed.</td>
</tr>
<tr>
<td>R71</td>
<td>X71</td>
<td>Duplicate of Previously Submitted EPSDT Screening</td>
<td>M86</td>
<td>Service denied because payment already made for same/similar procedure within set time frame.</td>
</tr>
<tr>
<td>Remark Code</td>
<td>Denial Code</td>
<td>Description</td>
<td>HIPAA Remark Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>------------------------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>R72</td>
<td>X72</td>
<td>Provider was not Member's PCP</td>
<td>N95</td>
<td>This provider type/provider specialty may not bill this service.</td>
</tr>
<tr>
<td>R78</td>
<td>R78</td>
<td>Members Age Not Valid for Procedure Code</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>R79</td>
<td>X79</td>
<td>Special Project-Adjustment</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>R81</td>
<td>X81</td>
<td>Charges Considered Included in Inpatient Admission</td>
<td>M15</td>
<td>Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.</td>
</tr>
<tr>
<td>R84</td>
<td>X84</td>
<td>Please Obtain Individual Provider ID Number</td>
<td>M57</td>
<td>Missing/incomplete/invalid provider identifier.</td>
</tr>
<tr>
<td>R86</td>
<td>X86</td>
<td>Invalid/Missing Revenue Code on Submitted Claim</td>
<td>M50</td>
<td>Missing/incomplete/invalid revenue code(s).</td>
</tr>
<tr>
<td>R89</td>
<td>X89</td>
<td>Authorization on File for Technical Component</td>
<td>N45</td>
<td>Payment based on authorized amount.</td>
</tr>
<tr>
<td>R91</td>
<td>X91</td>
<td>Inappropriate Coding for Contract/Agreement</td>
<td>M51</td>
<td>Missing/incomplete/invalid procedure code(s).</td>
</tr>
<tr>
<td>R95</td>
<td>X95</td>
<td>Clinic Claim Submitted without Physician Name</td>
<td>MA29</td>
<td>Missing/incomplete/invalid provider name, city, state or ZIP code.</td>
</tr>
<tr>
<td>R96</td>
<td>X96</td>
<td>EOB/Attachments are Incomplete/Illegible</td>
<td>N205</td>
<td>Information provided was illegible</td>
</tr>
<tr>
<td>R97</td>
<td>X97</td>
<td>Date of Service Cannot be Greater than Claim Received Date</td>
<td>M52</td>
<td>Missing/incomplete/invalid “from” date(s) of service.</td>
</tr>
<tr>
<td>X12</td>
<td></td>
<td>Motor Vehicle Accident-Auto Carrier is Primary</td>
<td>MA85</td>
<td>Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the Plan ID when effective.</td>
</tr>
<tr>
<td>X13</td>
<td></td>
<td>Workman's Compensation is Primary Carrier</td>
<td>MA85</td>
<td>Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the Plan ID when effective.</td>
</tr>
<tr>
<td>X21</td>
<td></td>
<td>Bill through pharmacy program</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>X25</td>
<td></td>
<td>Included in Settlement payment</td>
<td>N19</td>
<td>Procedure code incidental to primary procedure.</td>
</tr>
<tr>
<td>X32</td>
<td></td>
<td>Appeal - Denial Upheld</td>
<td>N10</td>
<td>Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.</td>
</tr>
<tr>
<td>X33</td>
<td></td>
<td>Appeal - Original Claim Payment Upheld</td>
<td>N10</td>
<td>Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.</td>
</tr>
<tr>
<td>X35</td>
<td></td>
<td>Authorization Denied for this Date of Service</td>
<td>N41</td>
<td>Authorization request denied.</td>
</tr>
<tr>
<td>X55</td>
<td></td>
<td>Members Age Not Valid for Diagnosis Code</td>
<td>M67</td>
<td>Missing/incomplete/invalid other procedure code(s).</td>
</tr>
<tr>
<td>X56</td>
<td></td>
<td>Clinic Claim Submitted Without Physician Name</td>
<td>M58</td>
<td>Missing/incomplete/invalid claim information. Resubmit claim after corrections.</td>
</tr>
<tr>
<td>X57</td>
<td></td>
<td>This &quot;V&quot; Diagnosis Cannot be Billed Alone</td>
<td>M64</td>
<td>Missing/incomplete/invalid other diagnosis.</td>
</tr>
<tr>
<td>X62</td>
<td></td>
<td>Invalid or Missing DRG</td>
<td>N208</td>
<td>Missing/incomplete/invalid DRG code.</td>
</tr>
</tbody>
</table>
**9.5.3 Claims and Clinical Editing**

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have spearheaded a correct coding initiative that intends to establish norms for coding medical services. Medicaid programs are required to apply National Correct Coding Institute (NCCI) edits to physician and outpatient hospital claims. Services deemed to be a part of a more complex service as defined by the NCCI will be re-bundled or denied as established by current criteria set by CMS in its claims processing manual. Horizon HJ Health also uses the CMS Claims Processing Manual as a guide to managing payments for services provided to its members, including the medically unlikely edits (MUE) subset and redundant edits. CMS publishes the majority of existing MUEs on the CMS website at www.cms.gov/nationalCorrectCodInitEd/.

Horizon HJ Health uses McKesson ClaimCheck software for our claim system. This software ensures that the claim editing system is transparent to all participating providers and claim payments are accurate and consistent with standard business practices and medical policies.

ClaimCheck edits are applied to all claims submitted to Horizon HJ Health by physicians, health care professionals and hospitals.

Horizon NJ Health also offers a claim modeling tool, Clear Claim Connection, which allows users to view how a claim will process based on the entered diagnosis and procedure codes. Use of the system will benefit providers, resulting in fewer claim denials due to coding errors. Participating providers will be able to access Clear Claim Connection through the NaviNet portal. Once signed on to NaviNet, providers will see the link in the left column of the Horizon NJ Health Plan Central (Clear Claim Connection does not guarantee payment).

**9.6 Coordination of Benefits**

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

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<table>
<thead>
<tr>
<th>Remark Code</th>
<th>Denial Code</th>
<th>Description</th>
<th>HIPAA Remark Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X68</td>
<td>X68</td>
<td>Invalid Number of Units Submitted on Claim</td>
<td>M53</td>
<td>Missing/incomplete/invalid days or units of service.</td>
</tr>
<tr>
<td>X77</td>
<td></td>
<td>Incorrect Provider/TIN Identification Number Submitted</td>
<td>M58</td>
<td>Missing/incomplete/invalid claim information. Resubmit claim after corrections.</td>
</tr>
<tr>
<td>X94</td>
<td></td>
<td>Provider Number Submitted via EDI Incorrect/Terminated</td>
<td>MA129</td>
<td>This provider was not certified for this procedure on this date of service.</td>
</tr>
<tr>
<td>X78</td>
<td>X78</td>
<td>Combined payment - Mother and Baby</td>
<td>N14</td>
<td>Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.</td>
</tr>
<tr>
<td>Z19</td>
<td>Z19</td>
<td>Carrier for Service - Horizon HMO</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>Z47</td>
<td>Z47</td>
<td>Submit Charges to Medicaid Fee-for-Service Program</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>Z50</td>
<td></td>
<td>Submit Charges to Medicaid Fee-for-Service Program</td>
<td>N193</td>
<td>Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>Z92</td>
<td></td>
<td>Please resubmit with valid HCFA Place of Service Code</td>
<td>M77</td>
<td>Missing/incomplete/invalid place of service.</td>
</tr>
<tr>
<td>ZZ9</td>
<td>ZZ9</td>
<td>Procedure/Revenue Code not Payable for Provider Specialty Types</td>
<td>N95</td>
<td>This provider type/provider specialty may not bill this service.</td>
</tr>
<tr>
<td>Z55</td>
<td></td>
<td>Provider Not Eligible by Contract for Payment</td>
<td>N381</td>
<td>Consult our contractual agreement for restrictions/billing/payment information related to these charges.</td>
</tr>
</tbody>
</table>
• 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 explanation of benefits 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. Hospitals, physicians and health care professionals 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, PCP referral and primary insurer’s explanation of benefits (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 coordination of benefit (COB) claims must be submitted with a copy of the EOB from the primary insurer.

Submit paper 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 their 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 hospital, physician or health care professional 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.

9.6.1 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. Hospitals, physicians and health care professionals 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 health care professional, unless Medicare does not cover the service. When Horizon NJ Health, by default, becomes the primary payor, the hospital, physician or health care professional 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.
9.0 BILLING GUIDE

NOTE – When Medicare is primary...

- and the procedure is covered by Medicare, an authorization or referral 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 or referral is required by Horizon NJ Health if one is normally required by Horizon NJ Health.

IMPORTANT – The hospital, physician or health care professional may re-bill for services originally denied by Medicare when Medicare overturns the denial. The hospital, physician or health care professional must submit the re-bill within 60 days of the date of Medicare’s EOB.

9.6.2 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 hospital, physician or health care professional must submit a copy of the primary insurer’s EOB or 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 hospitals, physicians or health care professionals may not bill Horizon NJ Health members for deductibles and coinsurance or balances above our 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 10.0 Complaint 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 hospitals, physicians or health care professionals should obtain the appropriate referrals or prior authorizations needed to obtain coverage under Horizon NJ Health. Failure to do so may result in denial for 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.

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 explanation of benefits or a denial letter in order to be considered for payment.

In all cases, Horizon NJ Health’s referral, 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 hospital, physician or health care professional 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 referral, 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.
Worker’s 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 hospital, physician or health care professional’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 hospital, physician or health care professional 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. For more information on the referral form, refer to Section 6.0 Referrals to Specialty Care Providers.

9.6.3 Reimbursement
Medicare
If a member has Medicaid and Medicare coverage, the hospital, physician or health care professional 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.

NOTE – Horizon NJ Health considers the deductible, coinsurance and copayments a component of the total primary care capitation for primary care reimbursement for services, which are capitated. If your primary care contact is for Fee-for-Service reimbursement, please first bill the primary carrier and then bill Horizon NJ Health with the carrier(s) EOB.

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 explanation of benefits 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 that results 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.

9.6.4 Services That Do Not Require a Primary Insurer EOB
Services Not Covered by Traditional Medicare
• Hearing aids
• Diapers/Under-pads/Incontinence items
• EPSDT
• Personal care assistants (Medicare FFS only)
• Medical day care (Medicare FFS only)

Physician and health care 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 skilled nursing facility, 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.

9.6.5 Denials from Primary Insurers
If the primary insurer denies payment to the hospital, physician or health care professional 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.
9.0 BILLING GUIDE

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 health care professional must provide notice again that the service is exhausted or not covered by the primary carrier.

**NOTE** – The hospital, physician or health care professional 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 hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim.

9.7 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT claims are paid based on the periodicity schedule. The biological component of immunizations is only paid where the Vaccine for Children (VFC) program does not offer the biological or the supply is not available. Administration of VFC-sponsored immunizations is paid on a per-visit basis; therefore, multiple shots given in a single visit will result in a per-vaccine administration payment. Physicians and health care professionals are encouraged to use combination immunizations when available.

To allow for efficiencies in monitoring, tracking and reporting encounter data to the Department of Human Services, Division of Medical Assistance and Health Services (DMAHSH), an “EP” modifier should be used when reporting EPSDT services, including venipuncture CPT codes 36406, 36415 and 36416 when used for lead testing.

Horizon NJ Health sends quarterly EPSDT underutilization reports to physicians, identifying members whose EPSDT services are overdue. Compliance with using the EP modifier will increase the accuracy of these reports.

9.8 Risk Assessment Program/Encounters

Horizon NJ Health is required by the State of New Jersey to report encounter data for all services rendered to our members, including capitated and fee-for-service activities. All physicians, hospitals and health care professionals are required to submit timely, accurate and complete encounter data. This is required even when the member is covered by another insurer.

Health care resource consumption in chronic disease can be very high. The State of New Jersey is using a risk adjustment payment model in an attempt to fairly distribute Medicaid funds in proportion to the severity of illness. Horizon NJ Health is required to submit encounter data to the State of New Jersey as an estimate of the prevalence of disease in the population we serve.

It is paramount that accurate data be gathered on the prevalence of illness of Horizon NJ Health members. This leads to accurate, severity-adjusted payment from the State to the health plan and, ultimately, the provider.

For example: Not only should members seek medical care for acute conditions, they should also visit their provider for chronic conditions, such as diabetes or hypertension. Moreover, if a member visits for an acute issue and a chronic issue is relevant or discussed, we ask that this is documented in both the records and the encounter claim form.

For further information, please call Horizon NJ Health’s Risk Adjustment nurse at 1-800-682-9094, ext. 89625.

All services must be submitted on the CMS 1500 (HCFA 1500) or the UB-04 claim form, or via electronic submission in a HIPAA-compliant 837I, 837P or NCPDP format. Horizon NJ Health is required to submit this data in a HIPAA standard file format to the State. Any coded field or data element contained in a HIPAA transaction must adhere to the national set of codes, including medical services and diagnosis. Due to the requirement to submit all services to the State, all requirements for EDI transactions are also applied to paper claims.

The State of New Jersey will reject encounter data if it does not meet their processing criteria. In some instances, Horizon NJ Health will be required to reverse payment already made to the provider if the encounter does not meet the State’s criteria. A complete list of all possible encounter rejections can be obtained by going to
www.njmms.com. Under the Information section, select Edit Codes, then Encounter Edits. The following are some causes for rejections:

**Facility Services**

- **NPI** – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider, Attending Provider, Operating Provider and Other Provider fields, if applicable. The NPI is required by the State of New Jersey’s Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement.

- **Type of Bill** – The bill type must be consistent with the type of service rendered with applicable revenue codes and corresponding HCPCS. Common bill types are listed in Section 9.2.2 of this manual.

- **Statement Covers Period** – Any practitioner billing for services must ensure that the dates of service are within the time period indicated in the Statement Covers Period stated on the claim. If a date of service is outside the dates placed in the From/Through field, the encounter will be rejected.

- **Principle Procedure Date** – Any practitioner billing for surgical services must ensure that the dates of service are within the time period indicated in the Statement Covers Period indicated on the claim. If the Principle Procedure date or Other Procedure date field is outside the dates reported in the Statement Covers Period, the encounter will be rejected.

- **Revenue Codes** – All revenue codes billed must be valid for the type of claim being billed.

- **Labaratory Services** – When billing revenue codes 300-319, the corresponding HCPCS or CPT codes must be billed.

- **Physician Administered Drug** – Outpatient services are required to report units of measure for all drugs, including their corresponding NDC code when billing with “J” or “Q” codes, with the exception of Q0091 and Q0092. The corresponding 11 digit NDC code must be reported along with the correct unit of measure:
  - F2 - International measure
  - GR - Gram
  - ME - Milligram
  - ML - Milliliter
  - UN - Unit (for example, tablet, capsule)

Claims cannot be paid by Horizon NJ Health without this information.

- **Diagnosis Codes** – All diagnosis codes must be reported and coded to the 7th digit, if available

**Professional Services**

- **NPI** – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider and Service Facility Location if applicable. The NPI is required by the State of New Jersey’s Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement.

- **Physician Administered Drugs** – All claims submitted for physician-administered prescription drugs, regardless of setting, must include the 11-digit NDC number, the quantity of the drug administered or dispensed and the two-digit qualifier identifying the unit of measure (UOM). This requirement is a result of the Federal Deficit Reduction Act of 2005. Outpatient-administered drugs are identified by the HCPCS procedure codes J0120 - J9999; Q0035, Q0081, Q0091, Q0111 - Q0115, Q0138 - Q0139, Q0144, Q0162 - Q0181, Q0481 - Q4130, Q3001, Q3014 - Q3031, Q9955 - Q9968. Acceptable UOM for these codes are:
  - F2 – International measure
  - GR – Gram
  - ME - Milligram
  - ML – Milliliter
  - UN – Unit (for example, tablet, capsule)

- The Division of Medical Assistance and Health Services has created a website with key billing information. Visit www.njmms.com and click on Physician Administered Drugs (UOM). By entering the NDC for the drug being administered, information regarding the drug name and the correct UOM will be displayed.

- **Transportation Services** – When billing for transportation services, a valid origin and destination modifier are required. Horizon NJ Health members shall be transported to and from medical appointments in a manner that results 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. The CMS-1500 claim form should be completed by choosing modifiers that appropriately support the member’s place of departure and destination locations.

- **Procedure Codes** – All codes are to be in HIPAA-compliant format. The use of CPT Level III codes (local codes) is no longer valid.
• Diagnosis Codes – All diagnosis codes must be reported and coded to the 7th digit, if available
• Retroactive Terminations – Horizon NJ Health participates in the Medicaid and NJ FamilyCare programs. Our members must maintain eligibility in order to receive services. There may be times when a member’s eligibility is retroactively terminated, as determined by the Medicaid/NJ FamilyCare program. This retroactivity will result in an encounter rejection. Horizon NJ Health is required to reverse payment already made to the physician, hospital and health care professional
• Medical Claims for Fluoride Varnish – providers should use the following procedure and diagnosis codes when submitting medical claims for fluoride varnish applications:
  • 99420-DA
  • Z41.8 (ICD-10)

9.9 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 hospitals, physicians or health care professionals 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 the Physician & Health Care Hotline at 1-800-682-9091 for assistance.

These explanation codes represent the current set of codes that are returned to the hospital, physician or health care professional on the RA. Please review the following list before calling the Physician & Health Care Hotline for questions about RA codes.

If an electronic RA is requested, it will be submitted in the HIPAA-compliant 835 format. The explanation codes do not apply to an electronic RA transaction.

<table>
<thead>
<tr>
<th>McKesson RA Explanation Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N01</td>
<td>This procedure is considered incidental to or a part of the primary procedure</td>
</tr>
<tr>
<td>N02</td>
<td>This procedure is considered redundant to the primary procedure</td>
</tr>
<tr>
<td>N03</td>
<td>This procedure is considered secondary to the primary procedure</td>
</tr>
<tr>
<td>N04</td>
<td>This service is considered a part of the original surgical procedure</td>
</tr>
<tr>
<td>N05</td>
<td>This service is not covered when performed on the same day as a surgical procedure</td>
</tr>
<tr>
<td>N06</td>
<td>This procedure does not normally require the services of an assistant surgeon</td>
</tr>
<tr>
<td>N08</td>
<td>No criteria found for procedure</td>
</tr>
<tr>
<td>N09</td>
<td>This procedure is normally performed for cosmetic purposes</td>
</tr>
<tr>
<td>N10</td>
<td>This procedure is considered experimental in nature and not a covered service under the plan</td>
</tr>
<tr>
<td>N11</td>
<td>This procedure is no longer considered clinically effective</td>
</tr>
<tr>
<td>N12</td>
<td>This procedure contains an Info, Issue or Review Message</td>
</tr>
<tr>
<td>N13</td>
<td>This procedure code was deleted or not valid on date of service</td>
</tr>
<tr>
<td>N14</td>
<td>Member’s sex not valid for procedure code</td>
</tr>
<tr>
<td>N15</td>
<td>This service is not normally performed for members in this age range</td>
</tr>
<tr>
<td>N16</td>
<td>This service is not normally performed for members in this age range</td>
</tr>
<tr>
<td>N17</td>
<td>Service performed not valid for place of service code submitted</td>
</tr>
<tr>
<td>N19</td>
<td>This service is not covered when performed for the reported diagnosis</td>
</tr>
<tr>
<td>N22</td>
<td>Not covered per medical necessity</td>
</tr>
<tr>
<td>N25</td>
<td>The charges for this service have been combined into the primary procedure</td>
</tr>
<tr>
<td>N26</td>
<td>Pretreatment Procedure Disallow</td>
</tr>
<tr>
<td>N27</td>
<td>Invalid Modifier Disallow</td>
</tr>
<tr>
<td>N28</td>
<td>PreOp Conflict Within One Day</td>
</tr>
<tr>
<td>N29</td>
<td>Clinical Daily Maximum Exceeded</td>
</tr>
<tr>
<td>N30</td>
<td>Lifetime Maximum Exceeded</td>
</tr>
<tr>
<td>N50</td>
<td>Current Procedure Rebundle</td>
</tr>
<tr>
<td>N51</td>
<td>History Procedure Rebundle</td>
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<tr>
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<td>History Daily/Lifetime Maximum Occurrence</td>
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9.10 LabCorp Testing/Billing

Some tests are not available via LabCorp and must be completed at a hospital or clinical setting and billed accordingly. Some of these tests cannot be performed in hospitals and will require prior authorization. Please contact LabCorp Customer Service for more information on tests that are not available via LabCorp.

LabCorp Customer Service
1-800-631-5250

Information about testing not available through LabCorp is also available at www.genetests.org.
9.11 Out-of-State Medicaid Claims for Blue Cross and Blue Shield Association Plans

State Medicaid agencies contract with Blue Cross and/or Blue Shield Plans as Managed Care Organizations (MCOs) to provide comprehensive Medicaid benefits on a risk basis. Both federal and state regulations guide these relationships, but the eligible population, covered benefits and specific rules regarding each state’s Medicaid program may differ from state to state. Many state Medicaid programs require providers to enroll as Medicaid providers with that state’s Medicaid agency before payment can be issued. In other cases, a state Medicaid program will accept a provider’s Medicaid enrollment in the state where the provider practices.

Medicaid Reimbursement and Billing
Claims for all Horizon NJ Health Medicaid members should be submitted to your local BCBS Plan.

If you are contracted with Horizon NJ Health, your Medicaid rates will only apply for services provided to Horizon NJ Health members. These rates do not apply to services provided to out-of-state Medicaid members.

When you provide services to a Medicaid member from another state, you must accept that state’s Medicaid allowance (less any member responsibility such as copayments) as payment in full. Please note that billing out-of-state Medicaid members for any amounts in excess of the Medicaid-allowed amount for Medicaid-covered services is specifically prohibited by federal regulations (42 CFR 447.15).

Medicaid Billing Data Requirements
When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims.

As a reminder, applicable Medicaid claims submitted without these data elements will be denied. Prior to March 2016, applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- National Drug Code (NDC)
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Provider Enrollment Requirements
As indicated above, some states require that out-of-state providers enroll in their state’s Medicaid program in order to be reimbursed. Some of these states may accept a provider’s Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state’s Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state’s Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local BCBS plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.
Complaint/Grievance Resolution for Physicians and Members

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

The procedure for initiating a complaint is outlined below:

1. When a member or physician is dissatisfied with care or service received, a complaint can be initiated through any of the following:
   - Call a Horizon NJ Health representative (1-877-7NJ-HEALTH [877-765-4325] for members; physicians can call 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 complaint.
   - 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#insurance).

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

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

4. A complaint resolution analyst will investigate the complaint and you will be notified within the following timeframes:
   - Urgent cases, including verbal notification, will be addressed within 48 hours.
   - Those complaints 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 complaint through a telephone call, a written notification that includes the outcome will be sent within 30 days.
   - Complaints not resolved within five business days will be considered a grievance. Grievances will receive written notification that includes the outcome within 30 days.

5. Members will be informed through the letter (cited above) about the right to an appeal within 90 days of the resolution. No penalty will be taken against a member for filing a complaint/grievance or subsequent appeal. Fair Hearing Procedures, including the Medicaid member’s right to access the Medicaid Fair Hearing process, are also included in the resolution letter.

6. Unless an appeal is requested, the complaint/grievance is considered to be satisfactorily resolved.

7. Horizon NJ Health is required by the State contract to investigate all complaints and alleged incidents reported by or related to our members, which may include:
   - Phone call to the health care practitioner or facility by Provider Contracting & Servicing to clarify the circumstances of the complaint
   - Request for medical record and/or written response from the health care practitioner or facility, which is due within 10 calendar days
   - Site visit

8. Within the complaint 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 complaints are thoroughly investigated. After all the information is gathered, a medical director makes a determination if there is a quality issue.

9. For provider complaints/grievances related to administrative issues, quality of care, actions, sanctions or terminations, refer to Section 12.29 and Section 12.30.
10.2 Utilization Management Member Appeals Process

Horizon NJ Health has appeals policies to receive and adjudicate utilization management appeals made by members or, with the member’s documented consent, providers who are acting on behalf of members. This procedure ensures timely resolution, provides easy access and offers prompt, fair and full investigation of member appeals.

The procedure to process an appeal is as follows:

1. A member or provider, acting on behalf of a member with the member’s documented consent, may submit an appeal within 90 days of a denial letter for an inpatient service, outpatient service, or out-of-hospital service or claim, or within 90 days of the date of an adverse complaint/grievance resolution letter. Hospitals may obtain consent from the covered person prior to receiving hospital services. The consent is valid for all stages of internal and external appeals. Patients may revoke consent at any time. All appeals from a physician must be submitted with a written/signed consent from the member, except when the request is for an expedited resolution. Physicians and/or all other health care professionals must provide the covered person a notice of an appeal whenever an appeal is initiated, and again each time the appeal is continued to the next stage, including any appeal to an Independent Utilization Review Organization (IURO). All written appeals must be submitted to the following address:

   Horizon NJ Health
   Utilization Management Member Appeals
   Attn: Appeals Coordinator
   210 Silvia Street
   West Trenton, NJ 08628

2. A member may also make an appeal by contacting the Appeals department at 1-800-682-9094.

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, i.e., medical record
   Actions that can be appealed include:
   - 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
   - Denial of coverage of routine patient costs in connection with an approved clinical trial
   - 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
   - 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

Horizon NJ Health will continue services in place while an appeal is pending. If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of denial. If the appeal is denied, the member may be required to pay for the cost of these services.

If Horizon NJ Health does not provide the services while an appeal is pending and a decision is made to reverse the denial, Horizon NJ Health must provide services that were not furnished. If a decision to uphold denied services is made, Horizon NJ Health still must pay for provisions of the services that were provided while the appeal was pending.

Stage One Appeal

Stage One 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 non-certification, 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.

Stage One utilization management appeal determinations, including written notification, shall be completed within 10 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 a Stage Two appeal. Stage Two appeals must be filed within 90 days of the Stage One appeal letter. 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.

Stage Two Appeal
If a Stage Two appeal is received, it is acknowledged by Horizon NJ Health in writing within 10 business days of receipt and referred to the Appeals Committee, which is a panel of physicians and/or other health care professionals selected by Horizon NJ Health, who have not been involved in the utilization management determination.

The Appeals Committee shall have, upon request, a consulting practitioner who is trained or who practices in the same specialty as would typically manage the case under appeal.

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.

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.

You or your provider may get a copy of the regulations and/or criteria, which includes access to and copies of all documents, used in this decision free of charge upon request.

At this appeal level, the Appellant is provided with the opportunity to present pertinent information regarding the case directly to the Appeals Committee either in person or via telephone. The in-person or phone call presentation will be completed in a reasonable time frame, as dictated by the health care issue being presented, and will take place in a community location convenient and accessible to the appellant. The in-person or phone presentation before the Appeals Committee is non-adversarial. Horizon NJ Health shall permit the appellant to be accompanied by a representative of the appellant’s choice to any proceedings and grievances. 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.

Stage Three Appeal
If the Appeals Committee upholds the second-stage appeal, the member (or physician acting on behalf of the member with member’s written consent) may request a Stage Three appeal with the Independent Utilization Review Organization (Iouro) assigned by the New Jersey Department of Banking and Insurance (DOBI). All Stage Two determination notifications shall state the reasons for the decision. Members who have gone through Stages One and Two of the appeals process for denial of personal care assistant (PCA) services may proceed to a Medicaid Fair Hearing if they wish to appeal Stage Three.

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329
Phone: 1-609-292-5316, ext. 50998
Toll-free: 1-888-393-1062
Those appeals, initiated by a member or physician acting on behalf of a member with the member’s documented consent, will include instructions on how to file an external appeal excluding appeals for Personal Care Assistant (PCA) services. DOBI has determined these appeals are not eligible for the IURO process.

Stage Three appeals must be filed within four months from the Stage Two appeal letter. 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 fully complied with the internal appeal levels at Horizon NJ Health, unless they have expressed the right to waive the internal appeals process.
4. 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.

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, 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 overturned the claim, it will be reprocessed for payment (if previously processed) within 10 business days.

### 10.3 Member Complaint Appeals Process

The member can request an appeal for any unfavorable decision or complaint/grievance resolution.

All appeal requests must be sent to the appeals coordinator at Horizon NJ Health at the following address:

**Horizon NJ Health**  
**Utilization Management Member Appeals**  
**Attn: Appeals Unit**  
**210 Silvia Street**  
**West Trenton, NJ 08628**

This request must be received within 90 days of the complaint/grievance resolution letter.
Once all required information is received, the request will be reviewed. The case will be reviewed within 20 business days, not to exceed 30 calendar days, and the member will be notified in writing of the decision. The appellant has the opportunity to present pertinent information regarding the case directly to the appeals committee, either in person or via telephone. The in-person or phone call presentation will be completed in a reasonable timeframe, as dictated by the health care issue being presented, and will take place in a community location that is convenient and accessible to the appellant. The in-person or telephone presentation before the appeals committee is non-adversarial. Horizon NJ Health shall permit the appellant to be accompanied by a representative of the appellant’s choice to any proceedings and grievances. All notifications shall state reasons for the decision and include information on how to access the Medicaid Fair Hearing process.

10.4 Additional Appeal Rights

NOTE – Notwithstanding anything to the contrary, Medicaid, NJ FamilyCare A and NJ FamilyCare D (program status code 380) members have the right to file for a Medicaid Fair Hearing. Medicaid Fair Hearings must be requested within 20 days of the correspondence. Members have the right to represent themselves at the Medicaid Fair Hearing or to be represented by an attorney, friend or other spokesperson. Hearings will take place in community locations that are convenient and accessible to the member. Medicaid Fair Hearings are obtained through the New Jersey Department of Human Services by writing to the following address:

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

A member may also appeal to the New Jersey State Department of Health and Insurance and/or the State Department of Banking and Insurance.

Their addresses are:

New Jersey State Department of Health and Senior Services
Office of Managed Care
P.O. Box 360
Trenton, NJ 08625-0360

Or

New Jersey Department of Insurance
Office of Enforcement and Consumer Protection
20 West State Street
P.O. Box 329
Trenton, NJ 08625-0329
1-609-292-5316

10.5 Utilization Management Physician Appeals Process

Horizon NJ Health has policies and procedures to receive and adjudicate appeals from physicians, vendors and facilities of health care services related to adverse utilization management determination(s). Any physician can request a reconsideration of a determination not to certify an admission or a continued hospitalization or a level of care determination.

Medical appeals refer to appeals of determinations regarding medical appropriateness filed directly by the physician not on behalf of the member.

Please note that a physician has the option of filing a Physician Utilization Management Appeal or a Member Utilization Management Appeal (on behalf of the member). Hospitals may obtain consent from the covered person prior to receiving hospital services. The consent is valid for all stages of internal and external appeals. Patients may revoke consent at any time. Physicians and/or all other health care professionals must provide the covered person notice of an appeal whenever an appeal is initiated and again each time the appeal is continued to the next stage, including any appeal to an IURO. A physician may not initiate both utilization management appeals processes with respect to the same appeal.
10.6  Utilization Management Physician Medical Appeal

The procedure to process an appeal is as follows:

1. A physician, vendor and/or facility may submit a formal written request for further review of a Horizon NJ Health utilization management decision. The appeal must be submitted within 90 days from the date of the denial letter. All written appeal requests must be submitted to the following address:

   Horizon NJ Health
   Utilization Management Member Appeals
   Attn: Appeals Coordinator
   210 Silvia Street
   West Trenton, NJ 08628

2. All appeals, regardless of level or type, must include the following information:
   • Name, address and phone number of the physician(s), vendor or facility making the appeal
   • Member’s ID number
   • Date(s) of service
   • Name(s) of provider, vendor or facility where services were rendered
   • Specific details regarding the actions in question
   • The nature and reasoning for the appeal
   • The desired outcome
   • Supporting documentation, i.e., medical record

Actions that can be appealed include:
   • 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
   • Denial of coverage of routine patient costs in connection with an approved clinical trial
   • 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
   • 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
Horizon NJ Health will continue services in place while an appeal is pending. If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of denial. If the appeal is denied, the member may be required to pay for the cost of these services.

If Horizon NJ Health does not provide the services while an appeal is pending and a decision is made to reverse the denial, Horizon NJ Health must provide services that were not furnished. If the decision to uphold denied services is made, Horizon NJ Health still must pay for provisions of the services that were provided while the appeal was pending.

Stage One Appeal
Stage One pre-service 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 non-certification 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.

Stage One utilization management appeal determinations, including written notification, shall be completed within 20 business days and will not exceed 30 calendar days of the initiation of the Stage One appeal request.

If the appeal is not resolved to the physician’s satisfaction, Horizon NJ Health will provide a written explanation of how to proceed to a Stage Two appeal. Stage Two appeals must be filed within 90 days of receipt of the action from the Stage One 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. You or your provider may get a copy of the regulations and/or criteria, which includes access to and copies of all documents, used in this decision free of charge upon request.
**Stage Two Appeal**

Upon receipt of all required information, the case will be presented to Horizon NJ Health’s Stage Two Appeal Panel, which is a panel of physicians, Registered Professionals, Medical Directors not involved in the utilization management determination. The committee will review the case and make a determination.

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.

Stage Two utilization management appeal determinations, including written notification, shall be completed within 20 business days. 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. You or your provider may get a copy of the regulations and/or criteria, which includes access to and copies of all documents, used in this decision free of charge upon request.

**10.7 Utilization Management Administrative Appeals Process**

Horizon NJ Health has policies and procedures to receive and adjudicate appeals from physicians, vendors, and facilities of health care services related to adverse utilization management determination(s). Any physician can request a reconsideration of a determination not to certify an admission or continued hospitalization or of a level of care determination.

The procedure to process an administrative appeal is as follows:

1. A physician, vendor, and/or facility may submit a formal written request for further review of a Horizon NJ Health utilization management decision. The appeal must be submitted within 90 days from the date of the denial letter or remittance advice, whichever date is earlier. All written appeal requests must be submitted to the following address:

   Horizon NJ Health
   Utilization Management Member Appeals
   Attn: Appeals Coordinator
   210 Silvia Street
   West Trenton, NJ 08628

2. All appeals, regardless of level or type, must include the following information:
   - Name, address and phone number of the physician(s), vendor or facility making the appeal
   - Member’s ID number
   - Date(s) of service
   - Name(s) of provider, vendor or facility where services were rendered
   - Specific details regarding the actions in question
   - The nature and reasoning for the appeal
   - The desired outcome
   - Supporting documentation, i.e., medical record

Actions that can be appealed include:
   - Denial of precertification for a procedure/testing provided
   - Service(s) provided is considered not a covered benefit
   - Failure to provide medical documentation during the concurrent review process
   - The reduction, suspension or termination of a previously authorized service
   - Failure to provide services in a timely manner
   - Denial of a service based on late notification

**Continuation of Benefits**

Horizon NJ Health will continue services in place while an appeal is pending. If the member requests a Medicaid Fair Hearing and wishes to request continuation of benefits, they must do so in writing within 10 days of the date of denial. If the appeal is denied, the member may be required to pay for the cost of these services.

If Horizon NJ Health does not provide the services while an appeal is pending and a decision is made to reverse the denial, Horizon NJ Health must provide services that were not furnished. If the decision to uphold denied services is made, Horizon NJ Health still must pay for provisions of the services that were provided while the appeal was pending.

**Stage One Appeal**

A Horizon NJ Health employee who serves as an appeals resolution analyst shall review all Utilization Management administrative appeals. Appeals resolution analysts are personnel of Horizon NJ Health who are not responsible on a day-to-day basis for processing Utilization Management authorization requests. The
appeals resolution analyst shall review all submitted documentation and review the appeal based on the administrative denial reason. Upon review by the appeals resolution analyst, a decision will be rendered.

Stage One utilization management administrative appeal determinations, including written notification, shall be completed within 20 business days and will not exceed 30 calendar days of the initiation of the Stage One appeal request.

If the administrative denial is overturned, the medical record is forwarded to the Utilization Management department to be handled as a retrospective review request. The medical record is evaluated for medical appropriateness and medical necessity, based on Horizon NJ Health policies and/or applicable national medical criteria guidelines.

If the appeal is not resolved to the appellant’s satisfaction, we will provide a written explanation of how to proceed to a Stage Two appeal. Stage Two appeals must be filed within 90 days of the Stage One appeal letter.

Stage Two Appeal
Upon receipt of all required information, the case will be presented to Horizon NJ Health’s Stage Two Appeal Committee, which is a panel of physicians and/or other health care professionals not involved in the utilization management determination. The committee will review the case and make a determination.

Stage Two utilization management appeal determinations, including written notification, shall be completed within 20 business days and will not exceed 30 calendar days of the initiation of the Stage Two appeals.

If the administrative denial is overturned, the medical record is forwarded to the Utilization Management department to be handled as a retrospective review request. The medical record is evaluated for medical appropriateness and medical necessity, based on Horizon NJ Health policies and/or applicable national medical criteria guidelines.

10.8 Claim Appeals Process

This section describes procedures through which participating and nonparticipating physicians, 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 physicians, 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 physicians, facilities and health care professionals continue to dispute after pursuing their appeal through Horizon NJ Health’s Stage One internal appeals process.

Common Appeal Reasons
No Referral or Authorization: Referral or authorization was provided by PCP 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.

Not Member’s PCP: Physician or other health care practitioner was the member’s PCP on the date of service and/or covering for a physician or other health care practitioner on the date of service.

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

Lack of Explanation of Benefit (EOB): Third party liability information has been provided to show the member is not eligible for other coverage or has reached their benefit limit.

Claims Editing Discrepancy: Physician, 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 physician, 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 physician, facility or health care professional is dissatisfied with a claim payment, including determinations, prompt payment or no payment made by Horizon NJ Health, he/she may file a claim appeal, as described herein. All claim appeals must be initiated on the applicable appeal application form created by the Department of Banking and Insurance. The appeal must be received by Horizon NJ Health within 90 calendar days following receipt by the physician, facility or health care professional of the payer’s claim determination.

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

Mail:
Horizon NJ Health
Claim Appeals
P.O. Box 63000
Newark, NJ 07101-8064

Fax:
1-973-522-4678

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.

NOTE – Corrected Claims should be sent to Horizon NJ Health, Claims Processing Department, P.O. Box 24078, Newark, NJ 07101-0406. These claims should not be submitted through the appeals process, unless the original submission is considered to be correct.

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 physician, 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 the Department of Banking and Insurance’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 physicians, 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 physician or 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. Physicians and health care professionals may aggregate claims to reach the $1,000 minimum under circumstances in which the same claim issue is involved.

The Department of Banking and Insurance (DOBI) awarded the independent arbitration organization contract to MAXIMUS, Inc. Parties with claims eligible for arbitration may complete an application accessible online at www.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 physicians or 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 PICPA, can be found on MAXIMUS’s website at www.njpicpa.maximus.com or on the DOBI website at www.state.nj.us/dobi/index.html.

**Additional Review**
Notwithstanding the above, physicians 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
  - P.O. Box 367
  - Trenton, NJ 08625-0367

  Or

- **New Jersey Department of Banking and Insurance**
  - Division of Enforcement and Consumer Protection
  - P.O. Box 329
  - Trenton, NJ 08625-0329
Horizon NJ Health is available to assist you in providing health care services to our members. This section describes each of the service departments by function.

11.1 Professional Contracting & Servicing
A Professional Contracting & Servicing department representative is available to visit your 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 affiliation or recredentialing documents related to your credentialing or recredentialing process
- Changing the open or closed status of your panel (this applies to PCPs only and requires a 90 day waiting period)
- Requesting inservice/orientation for yourself, staff or facility
- Changing your address including your billing address

Please fax or mail your notification to our Professional Contracting & Servicing department at:

Horizon NJ Health
Professional Contracting and Servicing
210 Silvia Street
West Trenton, NJ 08628
Fax: 973-274-4126

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 horizonnjhealth.com/for-providers.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Documentation Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocation or Add New Location</td>
<td>1) Communication from provider</td>
<td>Specify whether you are closing an existing office and/or adding an additional location</td>
</tr>
<tr>
<td></td>
<td>2) List of providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) W-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4) ADA Survey (American Disabilities Act Survey) and site visit for PCPs and OB/GYNs</td>
<td></td>
</tr>
<tr>
<td>Add Provider to New Location/Group</td>
<td>1) Communication from provider</td>
<td>There is a 90 day waiting period, per policy. Provider must have at least 50 members. We do not close panels for specialists.</td>
</tr>
<tr>
<td></td>
<td>2) List of location(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) W-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4) ADA Survey for new location</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5) Site visit for OB/GYNs and PCPs for new location</td>
<td></td>
</tr>
<tr>
<td>Close or Open Panel</td>
<td>1) Communication from provider</td>
<td></td>
</tr>
<tr>
<td>Update Other Demographics (hours, phone, fax, suite, languages, age limits, panel limit)</td>
<td>1) Communication from provider</td>
<td>If updating a suite, verify if site visit is needed (if PCP or OB/GYN)</td>
</tr>
<tr>
<td>TIN Change or Purchase of Another Entity</td>
<td>1) Communication from provider</td>
<td>Note whether you are assuming liability of prior TIN.</td>
</tr>
<tr>
<td></td>
<td>2) W-9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) List of providers</td>
<td></td>
</tr>
<tr>
<td>Billing and Remittance Change</td>
<td>1) Communication from provider</td>
<td>Be sure the billing address is not a PO box; must be a physical location.</td>
</tr>
<tr>
<td></td>
<td>2) W-9</td>
<td></td>
</tr>
<tr>
<td>Term from Location/Group</td>
<td>1) Communication from provider</td>
<td>Advise where paneled members should be moved/transfered, if applicable.</td>
</tr>
</tbody>
</table>
11.2 **Physician & Health Care Hotline**
The Physician & Health Care Hotline 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.

Physician & Health Care Hotline
1-800-682-9091
24 hours a day, seven days a week
Translation services are available by calling 1-800-682-9094, ext. 89469

11.3 **Member Services Department**
The Member Services department provides information to members regarding eligible services. Members should be referred to this department to address any questions about their eligibility and/or benefits. Bilingual representatives are available.

Member Services Department
1-877-7NJ-HEALTH (877-765-4325)

11.3.1 **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 are available to MLTSS members 24 hours a day, 7 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 MLTSS system
- Be a resource for members by providing information, making referrals to other staff members, and resolving issues if possible

MLTSS Member Services can be reached 24 hours a day, 7 days a week at 1-844-444-4410 (TTY: 1-844-889-7700).

11.3.2 **Provider Contact Numbers for MLTSS Services**
**Nursing Facilities**
Provider contact number for when a resident that is auto-assigned or has self-selected the MCO and needs a NJ Choice Assessment performed; also to assist with issues in assigning or administering hospice services: 1-844-444-4410
Home and Community-Based Services
For any member issues: 1-844-444-4410
Claims, Eligibility and Enrollment Issues for all MLTSS Providers: 1-855-777-0123

11.4 **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
Physician & Health Care Hotline
1-800-682-9091
24 hours a day, seven days a week

11.4.1 **UM Ethical Standards**
Horizon NJ Health adheres to the following principles in the conduct of the UM program:

- UM decisions are made 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 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.
11.4.2 Retrospective Review

When a retrospective review is required in instances in which an admission and discharge occur over a weekend, Horizon NJ Health will accept the clinical review within seven days of discharge. The hospital must contact the UM department to request this type of review.

Utilization Management Department
1-800-682-9094

11.4.3 Goals

The goals of the UM department are to:

- Oversee the provision of high quality, cost-effective health care services to our members
- Monitor utilization of medical resources through use of precertification, concurrent and retrospective review and case management
- Trend utilization patterns and conduct comparative analysis
- Work with the Quality Management department in all integrated processes
- Communicate utilization patterns to participating physicians

The UM department is responsible for all preauthorization, inpatient concurrent and retrospective review and outpatient case management. Other responsibilities include identifying network needs and assisting in recruitment of additional physicians and participating in the educational process of physicians on a day-to-day basis.

11.4.4 Staffing Qualifications

Licensed nursing professionals (RNs) with three to five years of nursing experience staff the UM department. We also employ non-clinical, administrative support personnel and licensed practical nurses (LPNs). Additionally, a minimum of one year of UM experience in a managed care program is preferred. Staff is identified by name, title and organization name when initiating and returning calls regarding UM issues.

11.4.5 Precertification and Authorization Criteria

Pre-authorizations and/or authorizations of all medical services are conducted using one of the following Horizon NJ Health approved approaches:

- MCG criteria for concurrent review and to pre-certify elective and short procedures (SPU)
- Medical policies (uniform medical policy manual) developed and approved by the Medical Policy Committee at Horizon Blue Cross Blue Shield of New Jersey and medical policies developed and approved by the UM and Continuous Quality Improvement Committees at Horizon NJ Health
- Interqual neonatal level of care criteria for concurrent review of neonatal admissions

Information about the above criteria is available on the Horizon NJ Health website at horizonNJhealth.com. Providers can obtain a copy of the benefit provision, guideline protocol or other content at no cost by contacting Horizon NJ Health at 1-800-682-9094, ext. 89469.

Horizon NJ Health medical directors are available to discuss clinical determinations with the treating provider. They can be contacted at 1-800-682-9094, ext. 89469.

11.4.6 Patient Hospital Generic Quality Improvement Guideline Screens

The Quality Management department annually reviews data and monitors the quality of care through the application of the following types of inpatient screens and reports, implemented by the UM nursing staff.

Criteria for quality referral:
- Surgical or invasive procedures
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Potential criminal events
- Other

11.4.7 Neonatal Utilization Management Program

The Neonatal Utilization Management (UM) program is for all neonates admitted to the neonatal intensive care unit (NICU). The program is designed to ensure that Horizon NJ Health neonatal members have access to high-quality, evidenced-based care throughout the first year of life.

The Neonatal UM program uses InterQual Level of Care for Acute Pediatrics Criteria - Nursery – worldwide leaders in utilization review criteria whose nationally recognized guidelines offer a description of evidence-based “best practices.”

The team of experienced NICU nurses, a biostatistician and care specialist foster collaborative relationships with providers. These relationships facilitate a well-managed continuum of care from admission to the NICU through the first year of life.
Key components to this program include:

- UM on a daily basis
- Neonatal nurses who are available 24 hours a day, seven days a week
- Dedicated team with more than 40 years’ combined NICU experience
- Neonatal case management

To learn more about the program, call 1-800-682-9094, ext. 89469.

11.4.8 Emergency Services

The UM nursing staff is the point of contact for all notifications of emergency admissions, including maternity.

If a medical emergency leads to a hospital admission or observation service, the Horizon NJ Health UM department must be notified by the hospital or physician within 24 hours of the admission to receive a reference number and initiate the review process, as set forth in Section 8.3 Hospital Admissions.

Hospitals are instructed to notify and consult with the PCP for appropriate history, advice and instructions.

Horizon NJ Health recognizes an emergency service as a health care service 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 abuse 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 (and, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part. 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. Members are advised to present at the nearest emergency facility and to notify the Member Services department or their PCP of their emergency room visit. This policy includes out-of-network services.

11.4.9 Utilization Review and Reports

Horizon NJ Health produces reports for analysis that focus on the review and detection of over and underutilization. The reports provide a mechanism to monitor and identify deviations of patterns of treatment from established standards, baselines or norms. These reports profile utilization of facilities, physicians and enrollees and compare them against experience and norms for comparable entities. Physicians are notified of this information via profiles, newsletters, drug utilization review and UM committee.

11.4.10 Discharge Planning

The main objective of the Discharge Planning program is to ensure appropriate and timely discharge from a hospital to a more appropriate level and setting of care. When a member is hospitalized and it has been determined that they may be in need of special assistance at the time of discharge, case managers make the appropriate contacts with Social Services and community service groups and lend assistance in the overall transition.

Medical review programs and protocols are in place to effectively control both in- and out-of-network utilization. In-network utilization is driven by the actual referral generated by the PCP/specialist. All out-of-network utilization is reviewed when a physician contacts UM to receive preadmission authorization.

Both primary and specialty physicians play an important role in each of the utilization review programs. In coordinating care, Horizon NJ Health’s network physicians must drive this process and work directly with health services staff in the coordination of medical services.

11.4.11 Drug Utilization Review

Horizon NJ Health has a comprehensive, concurrent and retrospective Drug Utilization Review (DUR) program. Horizon NJ Health systematically obtains and analyzes drug utilization data from contracted physicians. Physicians are required to submit such data under their contract. The objective of the data analysis is to profile patterns of drug usage by physician and member (physician profile, frequency of drug, type, usage, cost, trend, volume, etc.) This data is used in both the Quality Improvement and UM programs.

Concurrent DUR utilizes innovative information technology to proactively warn the dispensing pharmacist of potential drug misadventures. The Clinical Decision Support System (CDSS) checks all incoming prescriptions, compares them to patient demographics and checks for potential clinical conflicts that may result.
if the prescription is dispensed, such as drug-drug interactions, drug-allergy conflicts, drug therapy limits, drug-disease conflicts, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, underutilization, drug-age conflicts, drug-gender conflicts and drug-pregnancy conflicts.

11.4.12 Concurrent Review

MCG guidelines are Horizon NJ Health’s concurrent review criteria. The need for hospital admission or continued stay is based on the patient’s present condition, underlying medical condition and the nature of the services provided. For surgical cases, the need for post-operative care and the potential for complications are also considered. When a case does not meet criteria, it is referred to a medical director for a medical necessity determination.

Horizon NJ Health medical directors are available to speak with providers regarding UM determinations. They can be reached at 1-800-682-9094, ext. 89469.

All inpatient cases will be monitored on an ongoing basis by a Horizon NJ Health concurrent review coordinator. Concurrent review will be performed by licensed RN/LPNs and supported by Horizon NJ Health medical directors, who will determine and document the medical need for continued stay in a facility and/or initiate appropriate discharge planning.

Notification of all Horizon NJ Health inpatient admissions is required within 24 hours of admission. Failure to provide timely notification will result in an administrative denial. Daily concurrent review is required for all inpatient admissions; certain arrangements can be made based on the acuity and type of admission. Critical clinical information is required to conduct concurrent review. Examples of critical elements include, but are not limited to, history of presenting problem, clinical exam and diagnostic test results, operative and pathological reports, treatment plan, progress notes and consultations. If critical elements of review are not obtained, an administrative denial will be issued. Once clinical information is obtained by a Horizon NJ Health concurrent review nurse, criteria tools are utilized and referral to the medical director occurs, if necessary. The determination will be provided to the facility within 24 hours of receipt of clinical information. If Horizon NJ Health requests additional information to approve or deny an authorization, a response is required within 72 hours from the time that a request for additional information is made.

Daily communication is faxed to the hospital UM department via the Daily Hospital Log. The log includes, but is not limited to, the last-approved day and adverse determinations, if applicable, including the medical director’s name and phone number.

The attending physician, PCP, facility and member are notified in writing within 24 hours of receipt of the clinical information. The clinical rationale for an adverse determination may be requested in writing. All requests should be sent to:

Medical Director
Horizon NJ Health
210 Silvia Street
West Trenton, NJ 08628

11.4.13 Second Opinion

Horizon NJ Health’s medical and utilization staff administers requests for second surgical opinions. Horizon NJ Health utilizes a combination of Milliman Care Guidelines criteria as a resource for second opinion determinations and medical director review for all elective surgical procedures and for the treatment of serious medical conditions, such as cancer.

Members may request a second opinion from a specialty care provider for any medical condition by contacting their PCP, who is responsible for the medical management of the patient’s care.

PCPs may contact the Horizon NJ Health UM department to complete the registration process prior to referring the member to a specialty care provider for a second opinion, which may include evaluation and treatment. Requests for second opinions with non-participating providers undergo the same type of review as other requests involving non-participating providers.

11.5 Pharmacy Department

The Pharmacy department reviews requests for medications requiring prior authorization. The Pharmacy department is available to assist physicians in managing pharmaceutical services provided to members.

Questions pertaining to the formulary or prior authorizations can be directed to:

Pharmacy Department
1-800-682-9094
24 hours a day, seven days a week
11.0 SERVICE DEPARTMENTS

11.6 Quality Management Department

The Quality Management department assists physicians by ensuring that Horizon NJ Health members receive the highest standard of health care. If you identify a quality of care issue, please contact the Horizon NJ Health Physician & Health Care Hotline to report your issue.

Physician & Health Care Hotline
1-800-682-9091
24 hours a day, seven days a week

Additional information regarding the Quality Management department may be found in Section 13.1 Continuous Quality Improvement.

11.7 Health & Wellness Center

The Health & Wellness Center can offer support to physicians who are required to provide health education/anticipatory guidance services to members. Please contact Horizon NJ Health Physician & Health Care Hotline if members require additional information about health issues (e.g., asthma, EPSDT, etc.) or want to participate in special health education programs (e.g., lead, diabetes, GEMS, etc.).

Health & Wellness Center
1-800-682-9094
Monday through Friday, 8 a.m. to 5 p.m.

11.8 MLTSS

Horizon NJ Health’s Managed Long Term Services and Supports (MLTSS) benefits focus on preventive in-home, medically appropriate care, offering a comprehensive menu of service options across beneficiary groups or care settings in the home, an alternate community setting like assisted living or in a nursing facility. Services offered range from assisted living services to home-delivered meals to home and vehicle modifications to lawn care.
12.1 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 and a description of the referral process
4. To have a second opinion
5. To request a standing referral when needed for a medical condition
6. To receive care from an out-of-network provider when a participating Horizon NJ Health provider is not available
7. If a member has a chronic disability, to be referred to specialists who are experienced in treating their disability
8. To have a doctor make the decision to deny or limit a member’s coverage
9. 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
10. 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
11. To be free from inappropriate balance billing
12. To be treated with respect and with recognition of their dignity and right to privacy at all times
13. To receive care without regard to race, color, religion, sex, age or national origin
14. To participate with their doctor in making decisions about their health care
15. To information and open discussion about the member’s own medical condition, and the right to choose from different ways of treating their condition, regardless of cost or benefit coverage
16. 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
17. To refuse medical treatment with an understanding of the results of refusal
18. To call 911 in a potential life-threatening situation – without prior approval from Horizon NJ Health
19. To have Horizon NJ Health pay for a medical screening exam in the emergency room to determine whether an emergency medical condition exists
20. 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
21. 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.
22. To timely notification of changes to the member’s benefits or the status of their provider
23. To make an advance directive about medical care. Federal law requires providers to ask about a member’s advance directive
24. To receive information about Horizon NJ Health, its services, doctors and providers and the member’s rights and responsibilities
25. To offer suggestions for changes in policy and procedure, including the member’s rights and responsibilities
26. To have access to a member’s own medical records - at no charge to the member
27. To privacy of the member’s medical information and records
28. To refuse the release of personal information (except when required or permitted by law)
29. To be informed in writing if Horizon NJ Health decides to end a member’s membership
30. To tell Horizon NJ Health when a member no longer wishes to be a member
31. To appeal a decision to deny or limit coverage, first within Horizon NJ Health and then through an independent organization
32. To appeal any Horizon NJ Health decision, the care it provides, benefits or membership
33. To make a complaint about the organization or the care provided in the member’s primary language
34. To know that a member or their doctor cannot be penalized for filing a complaint or appeal
35. 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 complaint or appeal
36. To give consent and make informed decisions about treatment of a member’s minor dependents
37. 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 emergency room 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.
- Minors 14 years or older presenting themselves for drug/alcohol or mental health services. Services will be rendered as medically necessary without parental consent.

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 the member can understand their health problem 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

12.1.1 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 to you.
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-hour/seven-day-a-week care management services and that they will need to work with family and friends to safeguard against potential risks.

7. Develop an emergency backup 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 backup 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.

12.2 Member Non-Compliance

Please call the Member Services department when a member does not abide by the member responsibilities, continues with disruptive behavior at the physician’s practice or refuses to comply with the recommended treatment program. Our Member Services department will contact the member to discuss their responsibilities as a Horizon NJ Health member and seek to find a resolution to the situation.

**Member Services**
1-877-7NJ-HEALTH (877-765-4325)
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 treatment 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 their PCP
- 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

12.3 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 HMO and the New Jersey Department of Human Services.

12.4 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 (HCAPP) 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 (as indicated in the underscored language). 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 us reach decisions about medical necessity for coverage purposes reflect compliance with both definitions.

12.5 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.

12.6 Confidentiality Statement

The physician and health care professional agree and understand that all information, records, data and data elements collected and maintained for the operation of the physician and health care professional, 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.S.A. 10:49-9.4. 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 provider agreement with Horizon NJ Health including the Department of Health and Human Services and to such others as may be authorized by Division of Medical Assistance and Health Services (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.A.S. 9:6-8.10a and 9:6-8.4 and consistent with the need to protect the members’ confidentiality.

12.6.1 Enrollee-Specific Information

With respect to any identifiable information concerning Horizon NJ Health members that is obtained by the physician, it: (a) shall not use any such information for any purpose other than carrying out the express terms of the provider 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 the provider 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.

12.6.2 Employees

The physician and health care professional shall instruct their 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 information data concerning Medicaid beneficiaries enrolled pursuant to the provider 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 the provider agreement with Horizon NJ Health.

The provisions of this section shall survive the termination of the provider 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.

12.7 Affirmative Statement

The physician and health care professional are 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 utilization management (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.

12.8 Non-Discrimination Statement

The physician and health care professional shall comply with the following requirements regarding non-discrimination:

- The physician and health care professional 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 physician and health care professional 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 physician and health care professional network and certifies that the providers meet ADA requirements to the best of the physician’s and health care professional’s knowledge. The physician and health care professional warrant that they 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 physician and health care professional to be in compliance with the Act. Where applicable, the physician and health care professional 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 physician and health care professional 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 physician and health care professional, 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 complaint or grievance/appeal.
- The physician and health care professional 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 the provider 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, the physician and health care professional shall not discriminate with respect to participation, reimbursement or indemnification as to any physician and health care professional, who is acting within the scope of the physician’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 physician and health care professional, 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 physician and health care professional agree 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 physician and health care professional.

Cultural Competency
Physicians shall demonstrate cultural competency in the following ways:

• Assess members and document in the medical record the presence or absence 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

12.9 Indemnification and Hold Harmless
As required by the New Jersey Medicaid program, at all times during the term of the agreement between Horizon NJ Health and the physician or health care professional, the physician or health care professional 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 physician or health care professional or physician’s or health care professional’s employee(s) arising with respect to the physician’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 the 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 agreement with Horizon NJ Health regardless of the reason for termination, including insolvency of Horizon HMO or Horizon NJ Health, and shall be constructed 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.

12.10 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 will only accept hospitals that are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the American Osteopathic Association (AOA) as participants in its program.

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

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

In addition to the above, physicians are required to provide the following credentialing information:

- Education/training
- Full, unrestricted admitting privileges at a Horizon NJ Health contracted hospital
- New Jersey Controlled Dangerous Substance (CDS) certificate
- Drug Enforcement Administration (DEA) certificate
- Board certification for specialty
- Information regarding breaks in practice/training
- Satisfactory inquiry of National Practitioner Data Bank (NPDB)
- Satisfactory inquiry of Department of Treasury, Division of Property Management (Treasury website)

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.

Medical record reviews will be conducted to ensure that all records are in compliance with our medical record-keeping standards.

Updates to all credentialing information must be reported as changes occur. Copies of physician 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.

12.11 Recredentialing

Recredentialing of physicians 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 physician
- 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.

12.12 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 physician 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. Contact the Physician & Health Care Hotline at 1-800-682-9091.

### 12.13 Treatment of Minors Policy

Physicians and health care professionals agree to comply with Horizon NJ Health’s Medical Treatment of Minors’ Policy, which provides that the medical treatment of minors will be rendered 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 STD (sexually transmitted diseases) services
- Minors 14 years or older presenting themselves for drug/alcohol or mental health treatment

### 12.14 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 at horizonNJhealth.com. Please follow the directions below to complete the surveys. The surveys will take approximately ten 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
- Sign and date the survey
- Please use black or blue ink

The surveys are considered complete once you have recorded your responses to all applicable questions and signed and dated both surveys. Providers specializing in the treatment of members with developmental disabilities must have adequate support staff to meet the needs of these patients.

Once you have completed and signed the ADA provider survey and the special needs survey, please fax the forms to...
1-609-583-3004 or mail the forms to the following address.

Horizon NJ Health
Attn: Professional Contracting & Servicing Department
210 Silvia Street
West Trenton, NJ 08628

For your convenience, the following Internet address and telephone number for the Department of Justice offer a source of clarification with regard to ADA compliance.

www.usdoj.gov/crt/ada/adahom1.htm
1-800-514-0301

If you have any questions regarding this survey, you may call our Physician & Health Care Hotline at 1-800-682-9091. A Physician Services representative is available to assist your office 24 hours a day, seven days a week.

12.15 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 (877-652-2873). Calls can be received 24 hours a day, seven days a week.

The physician 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 following questions have been developed by the Family Violence Prevention Fund. A complete copy of the guidelines can be found at www.fvpf.org.

Domestic Violence Screening Tools

Framing Questions:
- 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?

For History Intake Forms/New Patient Questionnaires

Option 1:
- Have you ever been hurt or threatened by your boyfriend/husband/partner?
-OR-
- Have you ever been hit, kicked, slapped, pushed or shoved by your spouse/partner?
-OR-
- Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?
-AND-
- Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:
- Are you currently or have you ever been in a relationship in which you were physically hurt, threatened or made to feel afraid?
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Option 3:
• Have you ever been forced or pressured to have sex when you did not want to?
• Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

12.15.1 Reporting Abuse, Neglect or Exploitation

All members have the right to be free from exploitation, fraud and abuse. Providers, including Care Managers, are required to report suspected abuse, neglect or exploitation of any:
• Are you in a relationship with a person who physically hurts or threatens you?
• Did someone cause these injuries? Was it your partner/husband?

Adult Protective Services
The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports may be made to those County APS offices or to:
The Public Awareness, Information, Assistance & Outreach Unit
1-800-792-8820

Child Protective Services
The New Jersey Division of Child Protection and Permanency (DCP&P) handles all reports of child abuse and neglect, including those occurring in institutional settings such as child care centers, schools, foster homes and residential treatment centers. These must be reported to the State Central Registry (SCR).

Child Abuse Hotline (SCR)
24-Hour Toll-Free Hotline: 1-877 NJ ABUSE (1-877-652-2873)
TTY: 1-800-835-5510

Facility-Based Complaints and Investigation
Office of the Ombudsman for the Institutionalized Elderly investigates claims of abuse and neglect of people age 60 and older living in nursing facilities and other long-term health care facilities, such as assisted living facilities.
24-Hour Toll-Free Hotline: 1-877-582-6995
Email: ombudsman@advocate.state.nj.us

12.15.2 Defining Critical Incidents

The CMS (Centers for Medicare and Medicaid Services), as well as the State of New Jersey, requires that measures be employed to protect the health and welfare of Horizon New Jersey 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
• Missing person or unable to contact
• Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical)
• Theft with law enforcement contact
• Law enforcement contact
• Severe injury or fall resulting in the need for medical treatment
• Medical or psychiatric emergency, including suicide attempt
• Medication errors with serious consequences
• Inappropriate or unprofessional conduct by a provider involving the member
• Sexual abuse and/or suspected sexual abuse
• Abuse and neglect, including self-neglect, and/or suspected abuse and neglect
• Elopement/wandering from home or facility
• Eviction/loss of home
• Cancellation of utilities
• Natural disasters
• Frequent falls that result in serious injury
• Repeat hospitalizations for unexplained reasons

Write: The Office of the Ombudsman
P.O. Box 852
Trenton, NJ 08625-0852
Fax: 609-943-3479

NJ Division of Health Facilities Evaluation and Licensing investigates all complaints against health care facilities, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute and long-term care facilities.
24-Hour Toll-Free Hotline: 1-800-792-9770
Write: New Jersey Department of Human Services Division of Health Facilities Evaluation and Licensing
P.O. Box 367
Trenton, NJ 08625-0367
12.15.3 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.

To report a critical incident involving an MLTSS member, providers must call MLTSS Provider Services at 1-855-777-0123 within one business day of discovery. The Provider Services representative will take all information given by the provider about the critical incident and submit it to Horizon NJ Health’s MLTSS Quality staff. Horizon NJ Health’s MLTSS Quality staff 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 Quality staff 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.

12.16 HIV Testing and Education of Pregnant Women

According to Chapter 174 of the Public Laws of 1995, “The law states that a provider or other health care practitioner, who is the primary care giver for a pregnant woman or a woman seeking treatment within four weeks of giving birth, must counsel that woman about HIV and AIDS, discuss the benefits of being tested for HIV and offer the option of being tested.” The member may reject the option of being tested, without prejudice. In addition, counseling and education regarding prenatal transmission of HIV and AZT treatments to both mother and her newborn should be made available during pregnancy.

12.17 Office Standards

As part of the Quality Management Program, Horizon NJ Health has adopted specific primary care physician/specialist office care standards. These standards are in compliance with the standards of the Department of Human Services, Division of Medical Assistance and Health Services, for providing service to Horizon NJ Health members. Office standards include:

- Medical records are filed systematically
- Medical records are stored in a secure manner
- Only authorized persons have access to medical records
- Patient information is not viewable to non-office personnel
- Medical records are internally organized
- Systems are in place for covering physicians, so they have access to medical records
- Process for documentation of missed appointments exists
- There is a policy/procedure, process or workflow to provide family planning to minors

Periodically, office personnel are trained about confidentiality and HIPAA regulations.

12.18 Appointment Scheduling Standards

Horizon NJ Health has adopted the following appointment scheduling standards to ensure timely access to quality medical care. Physicians will be advised of these standards through this Manual and by participating in physician orientation programs. Compliance with these standards will be audited by periodic on-site review of physician offices and/or “secret shopper” phone calls.

For Medical Appointments

- Emergency services: immediate
- Urgent care: within 24 hours
- Symptomatic acute care: within 72 hours
- Routine care: within 28 days
- Specialist referrals: within four weeks or sooner, as medically indicated.
- Urgent specialty care: within 24 hours of referral
- Baseline physicals for new adult enrollees: within 180 calendar days of initial enrollment
- Baseline physicals for new child enrollees and adult clients of DDD: within 90 days of initial enrollment or in accordance with EPSDT guidelines
- Prenatal care: within three weeks of a positive pregnancy test (home or laboratory), and within three
days of identification of high risk, seven days in first and second trimester and three days in third trimester

- Routine physicals: within four weeks for routine physicals for school, camp, work or similar
- Lab and radiology services: within three weeks for routine care and 48 hours for urgent care
- Waiting time in office: less than 45 minutes

Initial Pediatric Appointments
- Within three months of enrollment

For Dental Appointments
- Emergency dental treatment: no later than 48 hours or earlier, as condition warrants
- Urgent care appointments: within three days of referral
- Routine non-symptomatic appointment: within 30 days of referral

For Mental Health/Substance Abuse Appointments (Clients of the Division of Developmental Disabilities only)
- Emergency services: immediate; urgent care within 24 hours
- Routine care: within ten days of request
- Waiting time in office: less than 45 minutes

12.19 Medical Record-Keeping Standards

Horizon NJ Health has adopted medical record-keeping standards based on state and federal regulations, as well as the guidelines of national accrediting agencies (i.e., NCQA, URAC). Compliance with these standards will be audited through periodic on-site review of physician offices and chart sampling. Horizon NJ Health has the right to request and review medical records in connection with services provided to our members. Upon request, providers shall provide copies of the medical records within the timeframe set forth. The standards are as follows:

- Each page in the record contains the patient’s name and/or ID number.
- Personal/biographical data include address, employer, home and work telephone numbers, marital status and emergency contact name and telephone number.
- All entries in the medical record contain author’s identification. Author identification may be a handwritten signature, unique electronic identifier, initials or a stamped signature. All practitioners, including solo practitioners, are required to adhere to this standard.
- All entries are dated.
- The record is legible to someone other than the writer and office personnel. A second surveyor will examine any record judged to be illegible by the initial surveyor.
- Significant illnesses and medical conditions are indicated in the medical record.
- Documentation shows reason of visit (i.e., chief complaint).
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, it is appropriately noted in the record.
- Past medical history (for patients seen three or more times) is easily identified and include serious accidents, operations and illnesses and sexual activity information (e.g., age, number of partners). For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illness.
- The history and physical examination identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints.
- For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substance abuse (for patients seen three or more times).
- There is documentation of annual mammography services for women aged 50 to 75 at least annually.
- There is documentation of prostate cancer screening for male enrollees aged 50 to 75 at least every two years.
- There is documentation of a colorectal screening test for all enrollees aged 50 to 75 at least annually.
- There is documentation of colorectal screening includes one of the following tests:
  - Annual fecal occult blood test
  - Flexible sigmoidoscopy once every five years
  - Colonoscopy once every 10 years
- Abbreviations and symbols must be appropriate.
- Laboratory and other studies are ordered, as appropriate, signed and the results discussed with the patient.
- The treatment plans are consistent with the diagnosis.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed. Missed or canceled appointments must be documented, as well as follow-up outreach.
- Unresolved problems from previous office visits are
addressed in subsequent visits.

• There must be documentation for follow-up for missed appointments for EPSDT exams. Appropriate and reasonable outreach shall be documented and must consist of a minimum of three attempts to reach the enrollee.

• If a consultant is requested, there is a note from the consultant in the record and this note is initialed by the physician to indicate that the consult was reviewed.

• Consultation, laboratory and imaging reports filed in the chart are initialed by the physician who ordered them to signify review. Review and signature by professionals, other than the ordering physician such as RNs, LPNs, PAs and medical assistants, do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of provider review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans and the results were shared with the patient.

• Immunizations are documented for pediatric members (ages 20 years and under).

• Body mass index (BMI) for members 18 years and older is documented, including BMI percentile for members 2 to 17 years of age.

• Discharge summaries are included as part of the medical records for hospital admissions, which occur while the patient is enrolled in the plan.

• Cultural/language/visual/auditory and religious factors affecting care are noted in the medical record. If no barriers to care are identified, a notation indicating this should be included in the record.

• For members age 18 years and older, the medical record shall document whether or not the member has executed an advance directive (e.g., living will or durable power of attorney for health care).

• Medical records must be protected against loss, destruction or unauthorized use and retained for at least ten years following the member’s most recent service or until the member reaches age 23. 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.

12.20 Reporting of Urgent/Emergent Lab/X-Ray Results

• All providers will notify members of laboratory and/or radiology results within 24 hours of receipt in urgent or emergent cases.

• Providers may arrange an appointment to discuss results when it is deemed face-to-face discussion with the member may be necessary or appropriate. Urgent/emergent appointment standards must be followed.

• Rapid strep test results must be available to the member within 24 hours of the test.

Definitions:

Urgent care – treatment of a condition that is potentially harmful to a patient’s health and for which his/her physician determined that it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration

Urgent lab/radiology result – a laboratory or radiology result that warrants urgent care

Emergent care – services that are necessary to evaluate or stabilize an emergency medical condition

Emergent lab/radiology result – a lab or radiology result that necessitates emergent care

Emergency medical condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (and with respect to a pregnant woman, her unborn child) in serious jeopardy, serious impairment to bodily functions or any bodily organ or part.

Member – an enrolled participant in Horizon NJ Health related to Managed Medicaid programs and NJ FamilyCare.

Provider – a participating physician, network hospital or other health care professional or entity who has a contractual arrangement with Horizon NJ Health related to the Managed Medicaid or NJ FamilyCare programs.
12.21 Advance Directives
Horizon NJ Health requires that network providers and health care practitioners comply with all federal and state regulations related to advance directives.

In summary, the Federal Patient Self-Determination Act (Part 489, Subpart 1) requires that hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home-care, providers of personal care services and hospices maintain written policies and procedures concerning advance directives with respect to individuals receiving medical care, ages 18 years and older. Written information must be provided to individuals regarding the provider’s written policies and the individual’s rights related to advance directives. Additionally, the individual’s medical record must include documentation indicating whether or not the individual has executed an advance directive.

The New Jersey Administrative Code (13:35-6-6.5-1-ix) requires that health care professionals, regulated by the Board of Medical Examiners, must document the presence or absence of any advance directive for health care for an adult or emancipated minor and associated pertinent information. Documented inquiry shall be made on the routine intake history form for all new patients. The treating doctor shall also make and document a specific inquiry of a patient in appropriate circumstances, such as when providing treatment for a significant illness, when an emergency has occurred presenting an imminent threat to life, or when surgery is anticipated with the use of general anesthesia.

For the purposes of this Manual, an advance directive means a written instruction that relates to the provision of health care when the individual is incapacitated. All physicians agree to comply with New Jersey law respecting advance directives and not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care publishes a guideline for members on advance directives. This document can be found on the Horizon NJ Health website at horizonNJhealth.com

12.22 Coverage Arrangements
Primary care providers (PCPs) and specialty care physicians are required to make arrangements for practice coverage when they are away from the office. A Horizon NJ Health participating provider of the same or similar specialty should provide coverage.

12.23 After-Hours Coverage
All primary care and specialty care physicians must be available to Horizon NJ Health members 24 hours a day, seven days a week, as stated in the contractual agreement. PCPs and specialists should make arrangements via an answering service during off-hours. If an answering machine is used, a forwarding telephone number to connect with a physician must be given. Instructions for emergency room care in life-threatening situations are acceptable. Instructions for emergency room care in place of contact with a physician when there is no life-threatening emergency (e.g., sore throat, pain in ear, etc.) are unacceptable.

Response Time
The physician shall respond to after-hours phone calls, including those from special needs members, regarding medical care within the following timeframes: 15 minutes for crisis situations, 45 minutes for non-emergent, symptomatic issues and the same day for non-symptomatic concerns.

If a PCP or specialist is identified as non-compliant, education regarding the 24-hour standards is provided by the Professional Contracting & Servicing department. The PCP or specialist will be re-audited within 30 to 60 days. If this does not produce a favorable outcome, Horizon NJ Health will implement the corrective action plan, as outlined below:

1. A certified letter will be mailed to the PCP or specialist by the Horizon NJ Health Quality Management department reviewing the contractual obligation to provide after-hours coverage. The PCP or specialist will have two weeks (10 business days) to respond to Horizon NJ Health with an improvement action.
2. A Professional Service representative will re-audit the PCP or specialist during non-office hours and within 30 days of receipt of the certified letter to verify that a new procedure has been implemented.
3. If a satisfactory improvement action procedure has been implemented, a letter, signed by the Quality
Management department will be sent to the PCP and specialist thanking him/her for his/her cooperation.

4. If a satisfactory procedure is not implemented, a detailed report on the case will be forwarded to the Quality Management department for review and further investigation.

For more information about the Horizon NJ Health corrective action plan, contact the Physician & Health Care Hotline at 1-800-682-9091.

Office Practice Standards for PCPs/Specialists

Maximum Number of Intermediate/Limited Patient Encounters

• Four per hour (adults and children)

12.24 Notification of Open/Closed Status

A PCP may make a change in the status of his or her practice so that it is open, limited or closed for enrollment of new Horizon NJ Health members. As a provider, you must notify the Physician & Health Care Hotline in writing 90 days in advance of your intent to limit your panel size. Horizon NJ Health will process your request for limiting or closing your panel size once you have met a minimum of 50 Horizon NJ Health members. If a closed panel is reduced to less than 50 Horizon NJ Health members, it will be automatically reopened until the minimum is met again. The closing or limiting of your panel shall not close your office to the assignment of members who, prior to becoming Horizon NJ Health members, had been your existing patients. Your change in status must apply to all members. No individual exceptions will be permitted once a selection of open or closed status is made. Requests should be mailed or faxed to the following address:

Horizon NJ Health
Professional Relations Department
210 Silvia Street
West Trenton, NJ 08628
Fax: 1-609-583-3004
1-800-682-9094

12.25 Change in Address

A Horizon NJ Health Request for Change of Information Form must be completed and submitted in advance when a participating physician changes phone numbers, practice locations, billing address, tax ID or any operational changes, such as business hours. Copies of the form are available from the Physician & Health Care Hotline at 1-800-682-9091, the Horizon NJ Health website at horizonNJhealth.com. Submit the completed and signed form to:

Horizon NJ Health
Professional Relations Department
210 Silvia Street
West Trenton, NJ 08628
Fax: 1-609-583-3004
1-800-682-9094

12.26 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.

12.27 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.

12.28 Coordination of Benefits

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 that are primary to Horizon NJ Health include (but are not limited to):

- Private health insurance, including assignable indemnity contracts
- Health maintenance organizations (HMOs)
- Traditional Medicare
- Medicare Advantage
- For-profit and non-profit 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 payor is deemed responsible for payment, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s explanation of benefits (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 amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed. When you provide services to a member who has any other coverage, bill the member’s primary insurer directly. Make sure that you follow that insurer’s standard claim submission policies and forms.

Upon receipt of payment and/or an EOB, submit applicable claims to Horizon NJ Health for consideration of deductibles, copayments and coinsurance amounts. Horizon NJ Health reimburses after coordination of benefits (COB) and only up to the primary contracted rate for the service. The claim, PCP referral and the 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 COB.

With the exception of Medicare, Horizon NJ Health’s notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

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:

Claims Processing Department
P.O. Box 24078
Newark, NJ 07101-0406
Phone 1-800-682-9091

NOTE – Although a primary insurer may have unique coding specific to their business, providers must bill with valid ICD-9-CM, CPT-4 and HCPCS codes. Unique or invalid codes specific to other insurers will cause claim processing delays or denials.

IMPORTANT – The hospital, physician or health care professional 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, deductibles, copayment amounts and all associated messages and notes. Incomplete information may result in a claim processing delay or denial.

### 12.29 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:

- Physician notification of Horizon NJ Health standards and clinical practice guidelines. (See Appendix A
Preventive and Clinical Guidelines.

- Physician 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, which 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 physician to ensure that all decisions are made fairly with the goal of improving quality of care and service to our members.

12.30 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 physician 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 Complaints 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 physician education
- Educational seminars
- Request for a corrective action plan
- Site visit
- Freezing of patient panel and/or incentive payment
- Termination from the physician 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’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’s Credentialing department to place in the provider’s credentialing file.

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 5, and issue its decision, as described in Section 11, 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’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 physician, the National Practitioner Data Bank may need to be notified depending on the severity of the deficiency and the associated sanction and corrective action.

12.31 Termination

Specialty groups, primary care and specialty care physicians 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 Relations Department
210 Silvia Street
West Trenton, NJ 08628

Horizon NJ Health will notify members of the physician termination at least 30 days prior to the termination date.

Contractual obligations with Horizon NJ Health and New Jersey HMO regulations require that physicians provide continuity of care for patients for up to 120 days after termination when it is medically necessary, as determined by Horizon NJ Health, for the member to continue treatment by the terminated provider, except as set forth below:

- Pregnancy – services shall continue through postpartum evaluation up to six weeks after delivery.
- Postoperative - services shall continue up to six months after termination date.
- Oncological or psychiatric treatment - services shall continue up to one year after termination date.

Continuity of care services rendered after termination require prior authorization (except in the cases of pregnancy, as set forth above) and will be paid at the contract rate, except for care provided by primary care physicians under a capitation agreement. Primary care physicians are not entitled to capitation payments after the termination date and will be paid at the Horizon NJ Health fee schedule. Any capitation payments remitted to the physician after the termination date must be refunded to Horizon NJ Health.
13.1 Quality Improvement Program

13.1.1 Quality Improvement Program (QI)

Horizon NJ Health’s QI Program is designed to produce prospective, concurrent, and retrospective analyses of the plan’s activities in order to improve the quality of care and service members receive. The specific goals of the QI Program are to ensure that Horizon NJ Health is:

- Providing health care that is medically necessary with an emphasis on the promotion of health in a safe, effective and efficient manner
- Assessing the appropriateness and timeliness of the care and services being provided
- Promoting members’ ability to maintain themselves in the least restrictive, most integrate setting of their choice
- Optimizing care delivery for members with special and/or complex care needs
- Identifying members’ needs and coordinating care to address the needs of the member
- Focusing on the quality of medical care and services provided to all members
- Working to identify and reduce health care disparities within its membership
- Striving to improve member and provider satisfaction
- Maintaining oversight of delegated entities
- Maintaining oversight of the credentialing and re-credentialing of providers
- Meeting NCQA accreditation requirements
- Working to improve plan performance on HEDIS, STARS, CAHPS, HOS, and QIPs

Primary authority for the ongoing operation of the QI Program rests with the senior medical director. The day-to-day administrative management of the program is the responsibility of the director of Quality Management. The program is supported by the Quality Improvement Committee, which meets at least 10 times per year and is comprised of senior management, as well as Horizon NJ Health medical directors and network physicians. One of the functions of this committee is to present an annual evaluation of the QI Program and plan to the board of directors for feedback and approval. Annual evaluation includes the review of all quality improvement activities conducted during the year and progress toward our goals and objectives, as outlined in the program and plan descriptions. The committee also oversees annual revisions of the QIC plan and quarterly updates of progress toward improvements. Delegated entities present program evaluation, program description, goals and objectives annually to the QIC committee.

The specific components in place to support the QI Program goals include credentialing and recredentialing standards for providers and hospitals, office care and medical record review standards for PCPs, practice guidelines, ongoing education for providers and members, ongoing reviews of care provided and focused studies/audits to identify initiatives for quality improvement activities. In addition, internal policies and procedures are developed to communicate program objectives and inform staff of procedures.

13.1.2 Quality Improvement Program Performance Monitoring

Horizon NJ Health’s Quality Improvement (QI) Program is designed to assess and improve HEDIS and STARS scores, member satisfaction based on the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey and practitioner satisfaction based on a satisfaction survey and focus groups; to implement initiatives that improve the safety of our members in all settings; and to prepare for accreditation that requires evaluation of all processes and opportunities for improvement.

The Quality Improvement Program is intended to:

- Expand access and enhance the quality of health care
- Enhance customer satisfaction
- Maximize the safety and quality of health care delivered to members
- Improve efficiency and effectiveness
- Fulfill quality-related reporting requirements of accrediting bodies and other local, state and federal regulatory and external review organizations
The annual Quality Improvement Program Work Plan describes specific activities that Horizon NJ Health will assume to meet the established goals. The annual Quality Improvement Program evaluation assesses how well Horizon NJ Health performed at achieving goals in the work plan.

Horizon NJ Health’s Quality Improvement Program uses HEDIS (Healthcare Effectiveness Data and Information Set) measures that the National Committee for Quality Assurance (NCQA) established. The NCQA created HEDIS as a tool to collect data about the quality of care and services provided by the health plan. This set of standardized measures compares health plans’ performance on important dimensions of care and service.

Providers and Practitioners should use appropriate coding when submitting claims, visits or encounters. In addition, all visits, tests, or immunizations should be completed timely according to the recommended standard(s) of care. For more detailed information regarding HEDIS, please visit horizonnjhealth.com/for-providers.

13.2 Occupational Safety and Health Administration

The Occupational Safety and Health Administration (OSHA) has established certain standards and guidelines to ensure that the work environment remains safe, healthy, clean and sanitary. Our physicians must follow these guidelines so that all office employees are protected against potential health hazards resulting from exposure to blood and certain body fluids, including blood-borne pathogens.

13.3 Clinical Laboratory Improvement Act

All laboratory testing sites providing services to Horizon NJ Health members must have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. A physician with a certificate of waiver shall provide only the types of tests permitted under the terms of their waiver. The tests permitted under the certification of waiver are listed below.

1. Dipstick or tablet reagent urinalysis (non-automated) for the following: Bilirubin, Glucose, Hemoglobin, Ketone, Leukocyte, Nitrite, pH, Protein, Specific gravity, and Urobilinogen
2. Fecal occult blood
3. Ovulation test - visual color comparison tests
4. Urine pregnancy test - visual color comparison tests
5. Erythrocyte sedimentation rate, non-automated
6. Hemoglobin
7. Blood count; Spun Microhematocrit
8. Blood glucose (FDA-cleared home use devices)

All other tests of moderate to high complexity and provider microscopies require a certificate of registration, along with a CLIA identification number. For information on CLIA rules and regulations, the Centers for Medicare and Medicaid Services (CMS) hotline number is 1-877-267-2323.

13.4 Utilization Management Program and Controls

The HMO medical delivery system is designed to allow a smooth transition from the traditional medical care New Jersey Medicaid Fee-for-Service delivery system into managed health care service. An important component of Horizon NJ Health’s health care delivery system is the ability to provide a thorough and detailed mechanism to effectively review, monitor and manage the availability, accessibility, appropriateness, efficiency and quality of health care within the managed care delivery system. Identified are utilization management programs and initiatives, which represent primary elements of our Quality Improvement Program and Utilization Management Program (QIC-UM) for members.

The following programs and initiatives have been carefully developed and constitute fundamental aspects
of the Utilization Management program:

- Care coordination
- Concurrent review program
- Prior authorization process - DME, short procedure requests, etc.
- Discharge planning
- Drug utilization review program
- Patient hospital generic quality improvement guideline screens
- Retrospective review program
- Infectious disease program

13.5 Special Needs Program

Our Pledge to Special Needs Members

Horizon NJ Health strives to ensure that services provided to special needs members are equal in quality and accessibility to services provided to all Horizon NJ Health members.

Who are Horizon NJ Health’s Special Needs Members?

Adults with special needs are individuals who have complex/chronic medical conditions requiring specialized health care services. These individuals may have physical, mental, or developmental disabilities and/or substance abuse issues. Children with special needs are individuals who have or are at increased risk of having a chronic physical, developmental, behavioral or emotional condition and who require more health and related services than the general population.

Horizon NJ Health identifies special needs members through the following:

- State file of Division of Developmental Disabilities (DDD) members
- State file of Division of Child Protection and Permanency (DCPP) members
- Identified through the State file of Program Status Codes for the Aged
- Referrals from State agencies
- Referrals from specialists, PCPs and other community agency case managers for DDD, DCPP and the Aged, i.e., County-based care managers, Special Child Health Services
- Internal department referrals from Pharmacy, Disease Management, Utilization Review, etc.

How Can the Special Needs Program Help?

Case Management will be the primary contact for coordination of any services required by the special needs member. If you have a patient who is enrolled with Horizon NJ Health and has a physical and/or developmental disability or catastrophic illness, you may contact Case Management at 1-800-682-9094 to request an evaluation. A care manager (nurse/social worker) will conduct a Comprehensive Needs Assessment (CNA) by telephone. The screening will determine the level of care management the member requires.

Care management will provide assistance with:

- Referrals to special care facilities for highly specialized care
- Standing referrals for long-term specialty care
- Provisions for dental services for members with developmental disabilities

Transition planning is intended to transition the member into Horizon NJ Health. Transition planning includes, but is not limited to:

- Review of existing claims through the State Data Exchange Database
- A plan to ensure continuous care during the transfer of coverage
- Assurance that required durable medical equipment, e.g., wheelchair, ventilator etc., is delivered

Planning shall take no more than 45 business days from the effective date of enrollment and identification of a special need or within 30 days after special conditions are identified by a physician for an existing enrollee.

After a member has been determined as having special needs, a CNA will be performed by the care manager. This review is conducted by telephone and a form is completed with the information. The CNA includes, but is not limited to:
• Review of diagnoses to determine physical condition
• Review of psychosocial and developmental functioning
• Evaluation of existing medical/community relationships or linkages
• Review of pharmaceutical, dental, vision and other medical health needs
• Review of preventive health services

Horizon NJ Health will use the Health Risk Assessment to assign each identified special needs member to one of the following three levels:
• Level 1 - Low complexity
• Level 2 - Moderate complexity
• Level 3 - High complexity

All care plans typically involve coordination of services for DME, social issues, transportation, pharmacy, home health, etc.

The Case Manager (CM), in collaboration with the PCP or specialist, will develop a plan of care that addresses both the physical and psychosocial needs of the special needs member. The plan will also serve as a means of identifying appropriate community resources. The PCP/specialist will receive a copy of the care plan to use as a reference when making appointments with various providers.

Who Conducts Followup?
Once the care plan has been developed, the CM will follow up with the member/family to assess whether or not the member is achieving expected results and contact the PCP/specialist to discuss the case as needed. The care plan will be updated as the needs of the member change.

Can Nonparticipating Physicians Render Service?
Horizon NJ Health encourages the use of participating physicians; however, non-participating physicians may be used if the following conditions exist:
• An existing relationship has been established between the special needs member and a nonparticipating physician and;
• There is not an appropriate physician to render the needed service within the network.

Who Should You Contact?
The following telephone and fax numbers will enable you to directly access the CM:

Phone: 1-800-682-9094
Fax: 1-609-538-3035

Please keep in mind that the CM should be your primary point of contact and they are available to assist you in caring for your patients. For after-hours concerns, there is clinical staff available 24 hours a day, 7 days a week to address any urgent or emergent needs. This staff can be reached at 1-800-682-9094.

13.6 Medical Home
A medical home is an approach to providing health care services to ensure that differently-abled members receive care that is family-centered, accessible, continuous, comprehensive, coordinated, compassionate and culturally competent in a managed care environment. Horizon NJ Health is committed to educating and training network physicians, facilities, administrators and office staff on how to improve the delivery of services to members who are differently-abled by applying the concepts of a medical home.

The Horizon NJ Health Medical Home objectives are:
• To provide knowledge to network physicians and facilities on how to ensure that differently-abled members have medical homes in a managed care environment
• To enhance skills for developing sustainable medical homes
• To enhance skills for identifying and developing community resources and networks
• To illustrate the importance of a collaborative effort between Horizon NJ Health, network physicians, facilities, members, their families and community resources

NOTE – A refinement of this concept is the patient-centered medical home, which adds data management.
Diagram of the Medical Home

The Horizon NJ Health Medical Home Components

Family Centered: Horizon NJ Health and network physicians recognize that the family is the constant. The family is the principal caregiver and center of strength and support.

Accessible: Horizon NJ Health and network physicians ensure that care is personally, physically and geographically accessible.

Continuous: Horizon NJ Health and network physicians assist members and families with transition planning with home, school, adult services and other network physicians and facilities.

Coordinated: Horizon NJ Health and network physicians connect members and families with all needed services. These services can include specialty care and community-based services, as well as family support and advocacy groups.

Compassionate: Horizon NJ Health and network physicians demonstrate sincerity, respect and a caring attitude.

13.7 Case Management

Complex Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a member’s clinical and medical needs. The primary focus is the coordination of quality health care in the most cost-effective manner for members with complex medical conditions. The intensity of case management activities varies based on a multitude of factors including, but not limited to:

- Clinical features of the individual case as reported by a member or attending/treating provider
- Evaluation/treatment setting resources available
- The member’s clinical needs and situation
- The opportunity for case management intervention to have a positive impact on the member’s circumstances

The purpose of this program is to direct and coordinate the delivery of cost-effective, quality-driven health care services for complex medical cases. The main objectives of case management are:

- Assure timely access to appropriate levels of care
- Manage health care benefits effectively
- Identify needs that follow an acute care period
- Assist with interventions for long-term health problems
- Balance cost versus quality of care issues
- Maintain continuity of care

Horizon NJ Health is able to identify complex cases by utilizing the following tools:

- Concurrent review during inpatient hospital admissions
- Telephone requests from PCP or specialist
- Hospital inquiries for benefit or precertification information
- Member services telephone inquiries
- Reports from home health care providers
- Requests for durable medical equipment information

The case manager gathers information relative to the case, assesses requested services, suggests alternative care plans when appropriate, advocates for the members and monitors provision of services as needed. By continually evaluating each specific case, the case manager will make appropriate determinations regarding when the member no longer needs specific case management. To come to this conclusion, the case manager will review the member’s condition, the physician’s recommendations and anticipated future course of action and, if possible, personally contact members to review their medical situation with them.

To contact a case manager, please call 1-800-682-9094, ext. 89634.

13.7.1 MLTSS Care Management

Horizon NJ Health provides every MLTSS member with a Care Manager and care management team, including a clinical care coordinator. The Care Manager, usually a nurse or social worker, leads the coordination of all primary, acute, behavioral and long term services and supports for the member.

A Service Plan of Care is developed based on the member’s health status and health care needs. The role of the provider (Primary Care Physician, 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, what services the member may receive, frequency of service and name of provider decided upon by the member. MLTSS Services will be provided within 30 calendar days of enrollment, 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 preference. The provider may receive a copy of the plan of care via fax.

The Care Manager will make a face-to-face visit every 90 days or 180 days, depending on the member’s setting of residence. The Care Manager will periodically review the member’s plan of care at least every 90 days or sooner and make updates as warranted if there are changes in the member’s condition and service needs. 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.

13.8 Infectious Disease Program

The purpose of the HIV/AIDS Complex Case Management Program is to provide confidential case management specific to this disease process. All members with a diagnosis of HIV or AIDS are eligible for this program. Horizon NJ Health works in collaboration with Ryan White Care grantees to coordinate health care services and provide community linkages.

Goals

The goal of the HIV/AIDS Complex Case Management Program is to help enrollees regain and maintain functional health in a quality, cost-effective manner.

- Educate enrollees regarding appropriate preventative services
- Coordinate services for enrollees including, but not limited to:
  - PCP followup
  - Specialist referrals
  - Ancillary services
  - Pharmacy

- Community linkages/resources
- Mental health/substance abuse services
- Review and assist enrollees with compliance issues, including medication adherence and followup with specialist visits

Program Enrollment

2. Member identification will be multifaceted, utilizing self-referral, inpatient information, emergency room information, primary care physician or specialist outreach, etc.
3. Referrals will be accepted from both internal and external sources, including:
   - Member self-referrals
   - Utilization Management
   - Case Management
   - Pharmacy
   - Horizon NJ Health physicians and other health care providers

Stratification

A member receives an outreach call from an R.N./case manager to educate the member about the Complex Case Management Program. The member has the option of accepting or declining enrollment into the program. Enrollees are risk stratified, based on past and/or potential utilization.

Level 3: One or more inpatient or emergency room admissions within six months, with ICD-10 code B20
Level 2: Newly diagnosed HIV
Level 1: Well-controlled HIV

Confidentiality

To ensure confidentiality, all persons assessed will be asked to repeat their Social Security number or date of birth. Information for members identified with HIV/AIDS will be maintained with strict confidentiality and respect. No member’s medical information will be shared with any person who is not personally involved in their medical process. Members will identify persons who may speak on their behalf (e.g., case managers at clinics, caregivers and legally designated persons).

13.9 Disease Management

The Disease Management program has been established to coach and educate low- to moderate-risk members in the management and treatment of their disease.
Members referred through:

- Primary care physicians/specialists
- ER/IP reports
- Encounter claims
- Case Management/Utilization Review
- Pharmacy claims
- Complex Needs Assessment (CNA)

The Disease Management Education programs are:

- Diabetes (NCQA-identified)
- Congestive heart failure (CHF)
- Hypertension
- Asthma (NCQA-identified)
- Chronic obstructive pulmonary disease (COPD)
- HIV/Sickle cell/Hepatitis

The goals of the Disease Management programs are:

- To educate both members and providers in health management based on nationally recognized standards of care
- To promote an optimal, realistic level of an individual’s wellness and functionality
- To promote behavior modification and facilitate member and provider communication
- To enable the member/family to make independent, informed health care decisions
- To provide a disease prevention and wellness education program that will improve the quality of health for our members
- To promote the cost-effective utilization of financial and human resources
- To improve overall member and provider satisfaction with Horizon NJ Health

13.9.1 Congestive Heart Failure Disease Management Program

The Congestive Heart Failure (CHF) Disease Management Program has been implemented to better manage members with CHF through education and member support services.

This program is staffed with nurses who identify CHF members by inpatient admissions, physician referrals and member self-referrals. The nurses perform global health assessments of the member’s medical, psychosocial and pharmaceutical data. Individual care plans are then established for these members to track the progress of their disease management. All CHF members will receive member health education and services through the health educators via letters and phone calls. They may, if appropriate, receive a scale to empower the member to maintain weight control and detect unexplained weight gains that may lead to future complications. The program is not intended to replace any CHF instructions or education provided by primary care physician or specialists; rather, it is intended to manage the member’s care in a collaborative effort with the primary care physician and/or specialist.

Please call to enroll any Horizon NJ Health member who has been diagnosed with CHF in Horizon NJ Health’s CHF Disease Management Program. Also, please encourage members to call to enroll directly. The CHF Disease Management department can be reached at 1-800-682-9094.

13.9.2 Diabetes Disease Management

The program is based on ADA Clinical Practice Recommendations. A summary of revisions for the 2012 Clinical Practice Recommendations are:

Additions to the Standards of Medical Care in Diabetes

- A section on driving and diabetes has been added.
- A section and table on common co-morbidities of diabetes has been added.
- A table listing properties of non-insulin therapies for hyperglycemia in type 2 diabetes has been added.

Revisions to the Standards of Medical Care in Diabetes—2012

In addition to many small changes related to new evidence since the prior year, and to clarify recommendations, the following sections have undergone major changes:

- The introduction was revised to more clearly describe processes for systematic evidence review, to link to the evidence table for changes since 2011, and to link to opportunities for public comment on the Standards of Medical Care in Diabetes—2012.
• Section V.D.2. Therapy for Type 2 Diabetes was revised to include more specific recommendations for starting and advancing pharmacotherapy for hyperglycemia.
• Section X. Strategies for Improving Diabetes Care was revised to reflect growing evidence for the effectiveness of restructuring systems of chronic care delivery.

Revised Position Statement
• A revised position statement, “Diabetes Management at Camps for Children with Diabetes,” has been added.

New Position Statement
• A new position statement, “Driving and Diabetes,” has been added.

Current criteria for the diagnosis of diabetes
• A1C ≥6.5%. The test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP)-certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay; or
• fasting plasma glucose (FPG) ≥126 mg/dL (7.0 mmol/l). Fasting is defined as no caloric intake for at least eight hours; or
• Plasma glucose ≥200 mg/dL (11.1 mmol/l) during an oral glucose tolerance test (OGTT). The test should be performed as described by the World Health Organization using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water; or
• in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/l);
• in the absence of unequivocal hyperglycemia, the result should be confirmed by repeat testing.

The Horizon NJ Health Diabetes Disease Management team can be reached at 1-800-682-9094. References to these guidelines are available on the Horizon NJ Health website and in Appendix A in this Manual. The diabetes clinical guidelines can also be viewed at: http://care.diabetesjournals.org/content/vol30/suppl_1/.

13.9.3 Asthma Program
The Asthma Program is designed to identify people with asthma through medical and pharmacy claims data, and then provide educational interventions aimed at improving compliance and reinforcing the education provided by the clinician.

Program Enrollment
Upon identification of a person with asthma, an assessment of medical and pharmacy utilization is done to determine risk category. Horizon NJ Health staff perform telephonic education of members with asthma. A specialist referral is strongly recommended for high-risk members with asthma (see following criteria).

Horizon NJ Health recommends that a patient be referred to a pulmonologist or allergist when he/she:
• Has an ICU admission, intubation or life-threatening asthma exacerbation; or
• Has had two or more emergency room visits in the past six months; or
• Has had a hospital admission in the past six months; or
• Has poorly controlled asthma (i.e., there is an adequate medication regimen but the patient is still having recurring symptoms using a relief inhaler > 2 times per week, or has persistent nighttime awakening with symptoms) ; or
• Has a history of steroid dependency due to asthma of three months or more and/or > or = three trials of steroid “burst” therapy; or
• Has a high-risk pregnancy and a history of asthma; or
• Has complicating co-morbidities, such as severe rhinitis, severe sinusitis, sleep apnea, GERD, and/or a history of smoking. There are problems with differential diagnosis or atypical signs and symptoms.
• Has problems with differential diagnosis or atypical signs and symptoms.

Members with asthma who require self-monitoring are eligible for a peak flow meter through the provision of a prescription from the clinician. Peak flow meter use and peak flow zones can be taught by the clinician or the dispensing pharmacist. The optichamber spacer and masks may also be obtained from any participating pharmacy with a written prescription. Education
regarding the proper use of this equipment is essential to
the provision of these devices. Children who require
medication during school time may have a duplicate peak
flow meter and medication if the clinician provides a
prescription noting “duplicate needed for school use.”
An asthma treatment plan must be provided to the school
nurse to allow the child to have medication during school
time. Physicians are encouraged to order metered dose
inhalers (MDIs) with spacers versus nebulizers for those
members with asthma that are over the age of 5 and do
not have any cognitive and/or physical disabilities that
would prevent them from properly utilizing an MDI with
spacer. The physician is responsible for educating the
member/family of proper MDI/spacer technique.
An annual asthma intervention letter is sent to the
physician and member when pharmacy data has
determined that the member has been utilizing excessive
beta2-agonists.
The Asthma “Breathe Easy” Program will remind
members to inform their PCP when their symptoms are
worsening so they can be seen or reevaluated in an
attempt to stabilize their condition and prevent an
emergency room visit and/or inpatient hospitalization.

For more information on the Horizon NJ Health Asthma
“Breathe Easy” Program or to enroll your patients, please
call 1-800-682-9094.

Horizon NJ Health’s pharmacy benefits cover spacers,
peak flow meters, nebulizer equipment and supplies.

Medications covered by Horizon NJ Health
Quick-Relief Medications
• Albuterol MDI
• Ventolin HFA
• Xopenex Neb

Long-Term Control Medications
• Flovent
• Pulmicort Neb (age 8 and younger)
• Advair
• Cromolyn
• Nedocromil
• Serevent
• Sustained Release Theophylline
• Montelukast
• Prednisolone
• Prednisone
• Asmanex
• Qvar

13.9.4 COPD Disease Management
Horizon NJ Health established the Chronic Obstructive
Pulmonary Disease (COPD) Management Program to
improve the quality of life of members with COPD,
reduce hospitalizations and emergency room visits and
provide education about COPD and proper drug therapy.
The program was developed and is based on the Global
Strategy for the Diagnosis, Management and Prevention of
Chronic Obstructive Pulmonary Disease (December 2007).
The program focuses on the five components of effective
management: assess and monitor disease, reduce risk
factors, manage stable COPD, manage exacerbations and
recommendations in primary care. For further information,
please see www.goldcopd.com. References to these
guidelines are available on the Horizon NJ Health website
and in Appendix A in this Manual.
Members are identified for the program based on
claims/encounter data, pharmacy claims and member
and PCP referral. Risk stratification determines the
appropriate level of intervention for each member
eligible for the program based on their functional status
and PFT findings.
For more information on the Horizon NJ Health COPD
program or to enroll your patients, please call
1-800-682-9094.

13.9.5 Hypertension Disease Management
Horizon NJ Health established the Hypertension
Management Program to improve the quality of life of its
members with hypertension, reduce hospitalizations and
emergency room visits and provide education about
hypertension and proper drug therapy. The program was
developed and is based on the seventh report of the Joint
National Committee on Prevention Detection, Evaluation,
and Treatment of High Blood Pressure (2005). For further
information, please see www.nhlbi.nih.gov/guidelines/
hypertension. References to these guidelines are available
on the Horizon NJ Health website and in Appendix A
in this Manual.
For more information on the Horizon NJ Health
hypertension program or to enroll your patients,
please call 1-800-682-9094.
13.10 CHAMPS Program

CHAMPS stands for Children’s Health Assessment and Maintenance of Preventive Services. Its goal is to improve education about the importance of receiving immunizations on a timely basis and increase well-child visits for children between up to the age of 21. The CHAMPS program key components include:

- Helping primary care physicians remind members of the importance of immunizations and Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) visits through reminder calls to the member, conducted by a Horizon NJ Health representative
- Identifying the need for nurse case management to assist patients with any special needs and/or services
- Encouraging family compliance with maintaining EPSDT visits

If reminder calls are not successful because the member (or parent) cannot be reached by telephone, Horizon NJ Health sends "Unable To Reach" letters to the member and also mails the member or parent a comprehensive needs assessment to complete.

Children are automatically enrolled into the CHAMPS program upon enrollment with Horizon NJ Health. Parents/guardians may opt out of the program at any time.

13.10.1 EPSDT Program and Guidelines

Horizon NJ Health primary care physicians must furnish Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-equivalent services. EPSDT is a federally mandated, comprehensive child health program for Medicaid recipients from birth through 20 years of age. According to section 1905 of the Social Security Act (42 U.S.C. 1936(d)) and federal regulation 42 CFR 441.50 et seq., EPSDT services include the following:

Health Services
A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all diagnosis and treatment services that are medically necessary to correct or ameliorate a physical or mental condition are identified during a screening visit.

1. Comprehensive, unclothed physical examination including:
   - Vision and hearing screening
   - Dental inspection
   - Nutritional assessment

2. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. (See Appendix A Preventive & Clinical Guidelines). Physicians must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits; necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.

3. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided. The list of screening tests is not all-inclusive; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
   - Hemoglobin/hematocrit
   - Urinalysis
   - Tuberculin test – intradermal, administered annually and when medically indicated
   - Blood lead screening using blood lead level determinations must be completed for every Horizon NJ Health member younger than 6 years of age. (See Appendix A Preventive & Clinical Guidelines)

   Please refer to Section 3.18 Outpatient Laboratory Services.

4. Health education/anticipatory guidance

5. Referral for further diagnosis and treatment or followup of all correctable abnormalities, which are treatable/correctable or require maintenance therapy uncovered or suspected. (Referral may be to the physician conducting the screening examination or to another physician, as appropriate.)

6. EPSDT screening services shall reflect the age of the child and be provided periodically, according to the following schedule:
   - Neonatal exam
   - Under 6 weeks
   - 2 months
   - 4 months
   - 6 months
   - 9 months
   - 12 months
   - 15 months
   - 18 months
   - 24 months
   - Annually through age 20
At a minimum, the primary care physician must provide the following screenings and services to children from birth to age 21 in accordance with the EPSDT screening services schedule.

**Vision Services**
A vision screening includes diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant is defined as an eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment shall be done for each child beginning at age 3.

**Dental Services**
A dental screening is defined, at a minimum as observation of tooth eruption, occlusion pattern, and presence of cavities or oral infection. A referral to a dentist at or after 1 year of age is recommended. Referrals to a dentist are mandatory at 2 years of age and annually thereafter, up to age 21.

**Hearing Services**
A hearing screening includes the diagnosis and treatment of defects in hearing, including hearing aids. For infants identified as at risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to 3 months of age using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant’s response to auditory stimuli and audiogram for a child 3 years of age and older. Speech and hearing assessment shall be part of each preventive visit for an older child.

**Mental Health/Substance Abuse**
A mental health/substance abuse (MH/SA) screening includes an assessment documenting pertinent findings. When there is an indication of possible MH/SA issues, an MH/SA screening tool(s) shall be used to evaluate the member. Please refer to the Horizon NJ Health website for a copy of the Horizon NJ Health Mental Health and Substance Abuse Well-Being Screening Tool.

**Other Considerations**
The primary care physician must provide other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental/substance abuse illnesses and conditions discovered by the screening services.

**Lead Screening**
Verbal Risk Assessment: A verbal risk assessment shall be performed for lead toxicity at every periodic visit between the ages of 6 and 72 months, as indicated on the schedule (See Appendix A Preventive & Clinical Guidelines). The verbal risk assessment includes, at a minimum, the following types of questions:

- Does your child live in or regularly visit a house built before 1960? Does the house have chipping or peeling paint?
- Was your child’s day care center/preschool/babysitter’s home built before 1960? Does the house have chipping or peeling paint?
- Does your child live in a house built before 1960 with recent, ongoing or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? Examples include construction, welding, pottery or other trades practiced in your community.
- Do you give your child home or folk remedies that may contain lead?
- Did your child have an elevated blood lead level when last tested?

Providers are expected to surpass 80 percent compliance for two consecutive six-month periods for obtaining a lead screen prior to the child's second birthday. Generally, a child’s level of risk for exposure to lead depends on the answers to the above questions. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answers to any question are affirmative or “I don’t know,” a child is considered at high risk for high doses of lead exposure.
13.0 PROGRAMS

Important Lead Testing Reimbursement Facts
Horizon NJ Health reimburses $10 for the in-office collection of blood for lead screening. The current lead screening codes are as follows:

- 36416.EP Collection of capillary specimen for lead screening (finger, heel, ear)
- 36406.EP Venipuncture for lead screening for children under 3 years of age
- 36415.EP Venipuncture for lead screening for children 3 years of age and older

If your office has any difficulty submitting this claim electronically, leave out the decimal point. Use all the code numbers. Please call Horizon NJ Health with any questions or issues regarding reimbursement.

Relevant LabCorp Information
Please remember to use the correct form for LabCorp lead testing. Utilize the Heavy Metal Request form and indicate the source of the blood (venous or capillary). You can order these forms from the LabCorp Customer Service line at 1-800-631-5250.

LabCorp can customize this form with your provider information. LabCorp can also customize this form to include any other labs you may wish to include at your request. For example, if you routinely ask for a hemoglobin and hematocrit with a lead screen, you can ask LabCorp to add this test to the Heavy Metal Request form for you. You could also add CBC and urinalysis to coordinate your EPSDT lab requirements.

NOTE – For NJ FamilyCare B and C members, EPSDT coverage is limited to preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening and hearing services. The EPSDT examination includes only those treatment services identified through the examination that are a covered benefit under the Horizon NJ Health benefit package or the New Jersey Medicaid Fee-for-Service program. Other services identified through an EPSDT examination that are not a covered benefit under Horizon NJ Health or Medicaid Fee-for-Service are not covered.

NOTE – For NJ FamilyCare D members, EPSDT coverage is limited to well-childcare visits, including immunizations, lead screenings and treatments. Private-duty nursing, an EPSDT service, is included only with prior authorization.

13.11 New Jersey Vaccines for Children Program
The New Jersey Vaccines for Children (VFC) Program provides vaccines for children from birth through 18 years of age who are enrolled in Medicaid and NJ FamilyCare Plan A as well as uninsured children and children who are American Indian or Alaskan Native. The VFC program is a federally funded, state-operated vaccine supply program. The VFC program supplies most routinely recommended vaccines at no cost to all public and private health care physicians. Horizon NJ Health will reimburse physicians for the administration fee of covered vaccines.

For NJ FamilyCare A children, providers must enroll in the VFC program and use the free vaccine if it is covered by VFC. The State DHS will not pay Horizon NJ Health for the reimbursements it gives providers for any administration fees. For non-VFC vaccines, Horizon NJ Health will reimburse providers for vaccines and vaccine administrations.

Physicians participating in the VFC program must agree to comply with the following:

- Screen the parent/guardian of the child to determine VFC eligibility
- Maintain records of all children immunized with a VFC vaccine (these records must be made available to public health officials upon request)
- Comply with the recommended immunization schedule, as established by the Advisory Committee on Immunization Practices and state law
- No charge for VFC-supplied vaccines
- Provide vaccine information materials and maintain records in accordance with the National Vaccine Injury Compensation Act
- Comply with state ordering, accountability or quality assurance requirements through NJIIS

As of July 1, 2014, the VFC program no longer provides vaccines for children enrolled in NJ FamilyCare Plans B, C, or D. For these members, providers must obtain all vaccines from traditional market sources and administer them, and Horizon NJ Health will reimburse providers for the vaccines and the vaccine administration. If a provider office is not able to independently obtain the necessary vaccines, it can give a prescription to a member and administer the vaccine after obtaining it – only with prior authorization - through the member’s prescription coverage. For authorization, please contact the Pharmacy Department at 1-800-682-9094.

13.12 VFC Immunizations
Under the VFC program, the following CPT codes are to be used when billing for the administration fee for immunizations. The codes below are arranged to depict which vaccines and reimbursements are appropriate for patients under the age of 19 and which cover those over the age of 19. When billing for members over the age of 19 or if the immunization is not covered under the Vaccines for Children program, please note the appropriate codes on the table. (If the provider receives vaccines free of charge from a local health department or other finding source, none of this applies.)
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>Meningococcal recombinant protein and other</td>
</tr>
<tr>
<td>90621</td>
<td>Meningococcal recombinant lipoprotein vaccine</td>
</tr>
<tr>
<td>90630</td>
<td>Influenza virus vaccine, quadrivalent</td>
</tr>
<tr>
<td>90632</td>
<td>Hepatitis A, Adult</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A, Peds/Adolescent 2-dose schedule</td>
</tr>
<tr>
<td>90634</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90636</td>
<td>Hepatitis A and B, Adult</td>
</tr>
<tr>
<td>90647</td>
<td>Hib, PRP-OMP conjugate 3-dose schedule</td>
</tr>
<tr>
<td>90648</td>
<td>Haemophilus influenzae B (Hib) PRP-T</td>
</tr>
<tr>
<td>90649</td>
<td>Human papillomavirus (8-18 yrs. females only)</td>
</tr>
<tr>
<td>90650</td>
<td>Human papillomavirus (HPV) bivalent for intramuscular use</td>
</tr>
<tr>
<td>90651</td>
<td>Human papillomavirus 16,11,16,18,31,33,45,52,58 nonavalent 3-dose</td>
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<td>90654</td>
<td>Influenza virus vaccine, split virus, preservative free, for intradermal use</td>
</tr>
<tr>
<td>90655</td>
<td>Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, intramuscular use</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, intramuscular use</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza, 6-35 months, IM/jet injection</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza, 3 years and above, IM/jet injection</td>
</tr>
<tr>
<td>90660</td>
<td>Influenza virus (5-18 yrs.) Live, Intra-nasal</td>
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<td>90662</td>
<td>Influenza virus vaccine, split virus, preservative free</td>
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<tr>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13valent, for intramuscular use</td>
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<tr>
<td>90680</td>
<td>Rotavirus (2, 4, 6 mos. old ONLY)</td>
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<tr>
<td>90681</td>
<td>Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use</td>
</tr>
<tr>
<td>90685</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use (Code Price is per .25 ml) (Fluzone)</td>
</tr>
<tr>
<td>90687</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age</td>
</tr>
<tr>
<td>90688</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 7 years of age and older, for intramuscular use</td>
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<tr>
<td>90696</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 3 years of age and older, for intramuscular use</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenzae type B, and poliovirus vaccine, inactivated (DTaP, Hib, IPV), for intramuscular use</td>
</tr>
<tr>
<td>90700</td>
<td>DTaP</td>
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<tr>
<td>90707</td>
<td>MMR</td>
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<tr>
<td>90710</td>
<td>MMRV</td>
</tr>
<tr>
<td>90713</td>
<td>Inactivated IPV</td>
</tr>
<tr>
<td>90714</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, intramuscular use</td>
</tr>
<tr>
<td>90715</td>
<td>Tdap (11-18 yrs.)</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella virus vaccine</td>
</tr>
<tr>
<td>90717</td>
<td>Yellow fever vaccine</td>
</tr>
<tr>
<td>90723</td>
<td>DTaP-Hep B-IPV (Pediarix)</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal, Polysaccharide vaccine, 23 valent, adult or immunosuppressed patient for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
</tr>
<tr>
<td>90743</td>
<td>Hepatitis B, Adolescent (2-dose schedule)</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B, Peds/Adolescent dosage (3-dose schedule) intramuscular use</td>
</tr>
<tr>
<td>90746</td>
<td>Hepatitis B, Adult</td>
</tr>
<tr>
<td>G9142</td>
<td>Influenza A (H1N1) vaccine</td>
</tr>
<tr>
<td>Q2035</td>
<td>Influenza virus vaccine, split virus, 3 years and above, intramuscular use</td>
</tr>
<tr>
<td>Q2036</td>
<td>Influenza virus vaccine, split virus, 3 years and above, intramuscular use</td>
</tr>
<tr>
<td>Q2037</td>
<td>Influenza virus vaccine, split virus, 3 years and above, intramuscular use</td>
</tr>
<tr>
<td>Q2038</td>
<td>Influenza virus vaccine, split virus, 3 years and above, intramuscular use</td>
</tr>
<tr>
<td>Q2039</td>
<td>Influenza virus vaccine, split virus, 3 years and above, intramuscular use</td>
</tr>
</tbody>
</table>

For information regarding the Vaccines for Children Program call: 1-609-826-4862 Fax: 1-609-826-4867
### 13.13 **Immunizations After the Age of 19**

When billing for members over the age of 19 or if the immunization is not covered under the Vaccines for Children program, use the following CPT codes. (If the provider receives vaccines free of charge from a local health department or other finding source, this does not apply)

<table>
<thead>
<tr>
<th>Code</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>Hepatitis A, Adult</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage, 2-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90634</td>
<td>Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90636</td>
<td>Hepatitis A and B, Adult</td>
</tr>
<tr>
<td>90645</td>
<td>Hib vaccine Hb0C conjugate (4 dose) for intramuscular use</td>
</tr>
<tr>
<td>90646</td>
<td>Hib vaccine Hb0C conjugate (4 dose) for intramuscular use</td>
</tr>
<tr>
<td>90647</td>
<td>Hib, PRP-OMP conjugate 3-dose schedule</td>
</tr>
<tr>
<td>90648</td>
<td>Haemophilus influenza B (Hib) PRP-t</td>
</tr>
<tr>
<td>90649</td>
<td>Human papillomavirus (19-26 yrs., females only)</td>
</tr>
<tr>
<td>90650</td>
<td>Human papillomavirus (HPV) bivalent for intramuscular use</td>
</tr>
<tr>
<td>90654</td>
<td>Influenza virus vaccine, split virus, preservative free, for intradermal use</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza, 3 years and above, IM/jet injection</td>
</tr>
<tr>
<td>90660</td>
<td>Influenza virus vaccine live, intranasal</td>
</tr>
<tr>
<td>90662</td>
<td>Influenza virus vaccine, split virus, preservative free</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal conjugate vaccine, 13 valent, for intramuscular use</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live, for intranasal use (Code price is per dose) (Flumist)</td>
</tr>
<tr>
<td>90680</td>
<td>Rotavirus vaccine, tetravalent, live, for oral use</td>
</tr>
<tr>
<td>90681</td>
<td>Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use</td>
</tr>
<tr>
<td>90686</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use (Code Price is per 0.5mL)</td>
</tr>
<tr>
<td>90688</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use</td>
</tr>
<tr>
<td>90696</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)</td>
</tr>
<tr>
<td>90698</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenzae type B, and poliovirus vaccine, inactivated (DTaP, Hib, IPV), for intramuscular use</td>
</tr>
<tr>
<td>90701</td>
<td>DTP</td>
</tr>
<tr>
<td>90704</td>
<td>Mumps</td>
</tr>
<tr>
<td>90705</td>
<td>Measles virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90706</td>
<td>Rubella virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90707</td>
<td>MMR</td>
</tr>
<tr>
<td>90712</td>
<td>Poliovirus vaccine, (any type(s)) (OPV), live, for oral use</td>
</tr>
<tr>
<td>90713</td>
<td>Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90714</td>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90715</td>
<td>Tdap</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella</td>
</tr>
<tr>
<td>90718</td>
<td>Td, absorbed for use in individuals 7 years or older for intramuscular or jet injection</td>
</tr>
<tr>
<td>90720</td>
<td>DTP-Hib</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumococcal, Polysaccharide vaccine, 23 valent, adult or immunosuppressed patient for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90733</td>
<td>Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
</tr>
<tr>
<td>90736</td>
<td>Zoster (shingles) vaccine, live, for subcutaneous injection</td>
</tr>
<tr>
<td>90746</td>
<td>Hepatitis B, Adult</td>
</tr>
<tr>
<td>90747</td>
<td>Hepatitis B (Dialysis or HIV), immuno-suppressed patient dosage (4-dose schedule) for intramuscular use</td>
</tr>
<tr>
<td>90748</td>
<td>Hepatitis B and Hemophilus influenza b vaccine (Hep B-hib), for intramuscular use</td>
</tr>
</tbody>
</table>
Influenza virus vaccine, split virus, 3 years and above, intramuscular use

13.14 New Jersey Immunization Information System

The New Jersey Immunization Information System (NJIIS) is a mandated statewide, web-based immunization registry designed to capture immunization histories of all New Jersey children, regardless of where they receive their vaccinations. There are no software costs or user fees for physicians to use the NJIIS. Children are entered into the registry at birth through a linkage with the electronic birth record process. Health care providers can initiate a registry record in their practice when a vaccine is administered to a child. The benefits to health care providers are:

• Access real-time clinical immunization information and current vaccine recommendations
• Reduce paperwork and staff time in obtaining records and responding to record requests
• Instantly print a child’s official immunization record for school enrollment
• Consolidate immunizations from all providers to complete the child’s immunization history
• Enable accurate immunization assessment
• Help interpret the complex immunization schedule
• Electronic interfaces with health plans, WIC and the Child Lead Program
• Access child’s preventive health history, such as TB and lead test results
• Quick access to newborn hearing screening results
• Electronically submit newborn hearing “lost to follow-up” form
• Automated vaccine inventory adjusts each time a shot is administered
• Ability to electronically generate VFC eligibility form
• Online vaccine ordering and inventory management

For more information, visit NJIIS online at www.njiis.nj.gov.

13.15 Prenatal Program - Mom’s GEMS

Mom’s Getting Early Maternity Services (GEMS) prenatal program is available to all pregnant Horizon NJ Health members. This program is designed to improve birth outcomes for Horizon NJ Health members through the provision of appropriate maternity care services.

The key components to this program are:

• Medical care coordination
• Case and Care Management
• Health education
• Home visitation (if applicable)
• Outreach
• Social/psychological counseling referrals
• 24/7 on call GEMS nurse

Primary Care Physicians

Please notify the Physician & Health Care Hotline at 1-800-682-9091 of members identified as pregnant so that we can help them obtain the appropriate prenatal care.

OB-GYN Physicians

All members must receive prenatal care within their first trimester. All newly enrolled members must receive prenatal care within their first trimester or within 42 days of enrolling in Horizon NJ Health.

The postpartum visit must be completed on or between 21 and 56 days after delivery.

All OB-GYN physicians must notify Horizon NJ Health of members who present for prenatal care after the first contact and must receive precertification for the remainder of the services. Upon the initial prenatal visit with a Horizon NJ Health member, the physician is required to complete a pregnancy risk assessment (PRA). At Horizon NJ Health, the Pregnancy Risk Assessment (PRA) serves to:

• Coordinate care
• Obtain baseline information about the member
• Initiate case/care management with the goal of improving birth outcomes
• Provide OB-GYN physicians with a method to guarantee payment for eligible services
• Promote early and accurate identification of prenatal risk factors
• Reduce administrative burden on obstetric practices

In addition, the use of a common risk assessment tool will allow the Division of Medical Assistance and Health
Services/Medicaid to gather information and learn more about Medicaid-eligible pregnant women in New Jersey.

The (PRA) and the WIC referral form must be completed within 7 days of the initial prenatal visit. The completed PRA must be sent to Family Health Initiatives (FHI) at 1-856-675-5286. The preferred method is electronic submission. An updated PRA form must also be completed if there are changes or updates to the members' pregnancy.

The PRA is a state derived assessment form that is sent to Family Health Initiatives (FHI), a subsidiary of the Southern NJ Perinatal Cooperative, to collect state required information for provider reimbursement. FHI is responsible for form processing, data management and training. For questions about the PRA form or process, please contact the FHI at 1-856-675-5286 or pra@snjpc.org. You can view the PRA training manual at www.njperinatalriskassessment.org or request on site or virtual training by contacting FHI.

If the PRA is not received, Horizon NJ Health will not pay for any professional charges related to prenatal and/or postpartum visits. If the PRA is received after 7 days of the initial Horizon NJ Health visit, Horizon NJ Health will only pay for the subsequent care provided after the date that the PRA is received by Horizon NJ Health.

Horizon NJ Health will fax or mail a letter with an authorization number for all prenatal visits, delivery, post-partum visit and up to three (3) OB Ultrasounds may be authorized for each pregnancy to the physician within seven business days of receipt of the PRA from the FHI. Physicians who do not receive an authorization number within seven business days should contact the Horizon NJ Health Mom's GEMS department at 1-800-682-9094.

**Post-Partum**

*Well Mom/Well Baby Home Visit Referral Coordination*

Please contact your assigned GEMS Case Manager for assistance in requesting postpartum home and newborn visits. Postpartum visits need to occur within 21 and 56 days post-delivery for payment. If visits have not been scheduled, we ask that you assist the member in scheduling them.

If you need supplies or more information regarding the Mom's GEMS prenatal program, contact the Physician & Health Care Hotline at 1-800-682-9091.

If a member does not have a Mom’s GEMS authorization, please confirm that a PRA has been sent to FHI and if urgent authorization for OB/US services is needed, please contact the Prior Authorization Unit at 1-800-682-9094 and assistance will be provided.

If a member does not have a Mom’s GEMS authorization, please confirm that a PRA has been sent to FHI and if urgent authorization for OB/US services is needed, please contact the Prior Authorization Unit at 1-800-682-9094 and assistance will be provided.

- Fetal biophysical profile
- Professional delivery fees
- Non-stress test
- Perinatal consult
- Prenatal and Postpartum visit
- RhoGam
- Breast pumps
- Vaccines (clinically required)

All other procedures require a referral and authorization when performed by a participating physician and billed using a valid CPT or HCPC code.

- For non-obstetrical Radiology Tests please refer to NIA.

**Frequently Used Obstetrical Codes**

- 59425  Antepartum Care Only: 4-6 visits
- 59426  Antepartum Care Only: 7 or more visits
- 59409  Regular Vaginal Delivery
- 59430  Postpartum Care Visit Only
- 59514  Cesarean Section Delivery Only
- 59409, 59612  Vaginal After Cesarean Delivery (First Newborn)
- 59510, 59514, 59515, 59618, 59620, 59622  Vaginal After Cesarean Delivery (Subsequent Newborn)
<table>
<thead>
<tr>
<th>Disease</th>
<th>Guidelines</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attention-Deficit/Hyperactivity Disorder</strong></td>
<td>American Academy of Pediatrics, “Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents”</td>
<td><a href="http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654">http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654</a></td>
</tr>
<tr>
<td><strong>Congestive Heart Failure</strong></td>
<td>ACC/AHA Guideline “Update for the Diagnosis and Management of Congestive Heart Failure in the Adult” (2005) 2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults 2013 ACCF/AHA Guideline for the Management of Heart Failure A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines</td>
<td><a href="http://circ.ahajournals.org/cgi/content/full/112/12/e154">http://circ.ahajournals.org/cgi/content/full/112/12/e154</a> <a href="http://circ.ahajournals.org/content/119/14/e391.full.pdf">http://circ.ahajournals.org/content/119/14/e391.full.pdf</a> <a href="http://circ.ahajournals.org/content/128/16/e240.extract">http://circ.ahajournals.org/content/128/16/e240.extract</a></td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td>Department of Health and Human Services Centers for Disease Control and Prevention</td>
<td><a href="http://www.cdc.gov/hiv/guidelines/index.html">http://www.cdc.gov/hiv/guidelines/index.html</a></td>
</tr>
<tr>
<td>Disease</td>
<td>Guidelines</td>
<td>Website</td>
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<td></td>
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<td><a href="http://www.state.nj.us/health/fhs/newborn/lead.shtml#hcmLpe">http://www.state.nj.us/health/fhs/newborn/lead.shtml#hcmLpe</a></td>
</tr>
<tr>
<td><strong>Obesity Pediatric and Adult</strong></td>
<td>American Academy of Pediatrics Assessment of Child and Adolescent Overweight and Obesity National Institute of Health CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS</td>
<td><a href="http://pediatrics.aappublications.org/content/120/Supplement_4/S193.full?sid=5f44d3f5-82c-4f0a-a1d0-3d6514d62357">http://pediatrics.aappublications.org/content/120/Supplement_4/S193.full?sid=5f44d3f5-82c-4f0a-a1d0-3d6514d62357</a></td>
</tr>
<tr>
<td><strong>Perinatal Care</strong></td>
<td>Horizon BCBS of NJ, Clinical Practice Guidelines, Section on Preventive Health Guidelines: “Clinical Practice Guidelines for Perinatal Care” State of New Jersey Department of Health Prenatal Care</td>
<td><a href="https://services3.horizon-bcbsnj.com/hcm/Clinical.nsf">https://services3.horizon-bcbsnj.com/hcm/Clinical.nsf</a></td>
</tr>
<tr>
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<td><a href="http://www.state.nj.us/health/fhs/prenatal/prenatalcare.shtml">http://www.state.nj.us/health/fhs/prenatal/prenatalcare.shtml</a></td>
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<td>American Cancer Society: Cervical Cancer</td>
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<td></td>
<td>American Cancer Society: Colorectal Cancer Prevention and Early Detection</td>
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<td>American Cancer Society: Prostate Cancer</td>
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<tr>
<td></td>
<td>American Cancer Society: Skin Cancer Prevention and Early Detection</td>
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<tr>
<td></td>
<td>CDC Guidelines :Pneumococcal CDC Guidelines: Influenza CDC Guidelines: Childhood Vaccinations</td>
<td></td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>Treating Tobacco Use and Dependence from the U.S. Department of Health and Human Services, June 2008 and United States Preventive Services Task Force</td>
<td><a href="http://www.ahrq.gov/path/tobacco.htm">http://www.ahrq.gov/path/tobacco.htm</a></td>
</tr>
</tbody>
</table>
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 abuse, 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 abuse, 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 part. 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.

“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, initiation of referrals to specialty providers 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 smears and phlebotomy services; and
- 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 physician bound by this agreement.
2.0 Hospital

“Covered services” shall mean those medically necessary medical and hospital services and supplies as set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which Medicaid recipients are entitled under the New Jersey Medical Assistance Program, unless expressly provided in the Medicaid/NJ FamilyCare contract.

“Department” shall mean the Department of Human Services of the State of New Jersey.

“DOH” shall mean the Department of Health and Senior Services of the State of New Jersey.

“DOBI” shall mean the Department of Banking and Insurance of the State of New Jersey.

“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 abuse, 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.

“Fee-for-service payment” shall mean the provider’s billed charge or the fee-for-service rates set forth in Appendix B, which may be amended by HMO from time to time, whichever is less.

“Hospital,” “provider,” “provider/subcontractor” shall mean the contracting health care facility.

“Hospital services” shall mean those services set forth in Appendix A.

“Member” means an enrolled participant in the HMO relating to the Medicaid/NJ FamilyCare contract.

“Participating provider” means a 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 to provide covered services.

“Utilization management/quality improvement (UM/QI) protocols” means the programs established by Horizon NJ Health to monitor and enhance the quality of health care services provided to members and those methodologies used to improve the effective, efficient use of the health care delivery system and covered services including, but not limited to: pre-review, concurrent review and retrospective review, as well as discharge planning, as applicable, consistent with the Medicaid/NJ FamilyCare contract.

3.0 Ancillary

“Capitation” shall mean the method of payment for covered services that are set forth in Section 2 (B) of this agreement (“Capitated Health Care Services”), paid to provider at a predetermined monthly rate, as set forth in Appendix A, which is attached hereto and made a part hereof for those members who have selected or been assigned to provider. Capitation shall be the method of payment only for those providers who directly and actually provide health care.

“Covered services” shall mean those medical and hospital services set forth in the Medicaid/NJ FamilyCare contract, which shall be no broader or narrower than the services to which Medicaid recipients/NJ FamilyCare beneficiaries are entitled under the New Jersey Medical Assistance Program unless expressly provided in the Medicaid/NJ FamilyCare contract or set forth in Appendix A and shall include capitated health care Services and non-capitated health care services.

“Fee-for-service payment” shall mean the fee-for-service payments set forth in Appendix B for covered services that are ancillary services as set forth in Appendix A.

“Medical facility(ies)” means the health care facilities where a provider provides or arranges covered services for members.
“**Medically necessary**” means services or supplies received by a member whose HMO, through Horizon NJ Health, determines to be: (1) consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice within the community; (3) not primarily for the convenience of the member, his/her physician, hospital or other health care provider; and (4) the most appropriate supply or level of service that can be safely provided to the member in the least costly setting, or as otherwise provided in the Medicaid/NJ FamilyCare contract.

“**PCP**” means a physician who has entered into a primary care provider agreement with HMO.

“**Utilization management/quality improvement (UM/QI) protocols**” means the programs established by Horizon NJ Health to monitor and enhance the quality of health care services provided to members and those methodologies used to improve the effective, efficient use of the health care delivery system and covered services including, but not limited to, pre-review, concurrent review and retrospective review as well as discharge planning, as applicable, consistent with the Medicaid/NJ FamilyCare contract.
The State of New Jersey requires that any provider/subcontractor who agrees to serve Medicaid/NJ FamilyCare Members comply with all the following provisions.

The following language shall be included, verbatim, in all provider contracts and subcontracts (to the extent applicable to the provider contract/subcontract). Any changes made to the Required Language by the State of New Jersey, shall be posted on the Horizon NJ Health website and incorporated herein, by reference, without Amendment.

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. SUBJEC TION 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.

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.

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.

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 CONTRACT/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,” the 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/subcontractors 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/subcontractors 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

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 – 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, 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 [insert name of HMO] 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 [insert HMO name] 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.

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 provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider contract/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department’s External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

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, 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. RECORD 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.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or
2. Three (3) years after 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. 9:6-8.10a 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.

N. 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.

O. 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.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B 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.

Q. INDEMNIFICATION BY PROVIDER/ SUBCONTRACTOR

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 claim s, 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.
R. 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(g) and N.J.A.C. 10:49-9.4. 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 statues 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..

S. 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.
T. 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. All suspected fraudulent activity should be reported to the Horizon Blue Cross Blue Shield of NJ Fraud Hotline:

   Horizon BCBSNJ Fraud Hotline:
   1-855-FRAUD20 (855-372-8320)

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.

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.

U. 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.

V. 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 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), and/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)3.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 NJS.A 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.