FIDELIS CARE®

2023-24 New Jersey Medicaid Provider Manual

1-888-453-2534 (TTY: 711)
fideliscarenj.com

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Partners in Quality Care

Dear Provider/Partner:

At Fidelis Care we value everything you do to deliver quality care to our members – your patients. Through our combined efforts we ensure that our members continue to trust us to help them in their quest to lead longer and more satisfying lives.

We're committed to quality. That pledge demands the highest standards of care and service. We are constantly investing in people and programs, innovating, and working hard to remove barriers to care.

Fidelis Care's dedication to quality means that we are also committed to supporting you. We want to make sure that you have the tools you need to succeed. We will work with you and your staff to identify members with outstanding care gaps, and we will reward you for closing those gaps.

The enclosed provider manual is your guide to working with us. We hope you find it a useful resource. The areas highlighted to the right are sections of the manual that directly address our mutual goal of delivering quality care.

Thank you again for being a trusted Fidelis Care provider partner!

Sincerely,

Nancy Tham, MD

Nancy Tham, MD, MBA, FACOG

Chief Medical Officer – NJ State
Fidelis Care

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Section 1: Welcome to Fidelis Care

Overview

Fidelis Care is a wholly owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise offering both core Medicaid and specialty services. Fidelis Care provides managed care services targeted exclusively to government-sponsored healthcare programs focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. Fidelis Care's experience and exclusive commitment to these programs enables it to serve its Members and Providers as well as manage its operations effectively and efficiently. For the purposes of this Manual, Fidelis Care and/or its constituent health plan(s) may be referred to herein as "Fidelis Care," or, as applicable, "Health Plan."

Mission and Vision

Fidelis Care's vision is to be a leader in government-sponsored healthcare programs in partnership with the Members, Providers, governments and communities it serves. Fidelis Care will:

- Enhance its Members' health and quality of life
- Partner with Providers and governments to provide quality, cost-effective healthcare solutions
- Create a rewarding and enriching environment for its associates

Fidelis Care's Values are:

- *Partnership* — Members are the reason Fidelis Care is in business; Providers are Fidelis Care's partners in serving its Members; and regulators are the stewards of the public's resources and trust. Fidelis Care will deliver excellent service to its partners.
- *Integrity* — Fidelis Care's actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- *Accountability* — All associates must be responsible for the commitments Fidelis Care makes and the results it delivers.
- *Teamwork* — Fidelis Care and its associates expect – and are expected to – demonstrate a collaborative approach in the way they work.

Purpose of this Manual

This Provider Manual is intended for Fidelis Care-contracted (Participating) Medicaid Providers providing healthcare service(s) to Fidelis Care Members enrolled in a Fidelis Care Medicaid/NJ FamilyCare Managed Care plan. This Manual serves as a guide to the policies and procedures governing the administration of Fidelis Care's Medicaid/NJ FamilyCare plans and is an extension of and supplements the Provider Participation Agreement (the "Agreement") between Fidelis Care and healthcare Providers, who include, without limitation: physicians, hospitals and ancillary Providers (collectively, "Providers").

This Manual replaces and supersedes any previous versions dated prior to July 2, 2024, and is available on the website at fideliscarenj.com/providers/Medicaid. A paper

copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.

Participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to Fidelis Care's policies and procedures. As policies and procedures change, updates will be issued by Fidelis Care in the form of Provider Bulletins and will be incorporated into subsequent versions of this Manual. Provider Bulletins that apply to Fidelis Care's Medicaid/NJ FamilyCare Managed Care plan may override the policies and procedures in this Manual.

Unless otherwise provided in the Agreement, Fidelis Care will notify Providers of changes to this Manual through a Table of Revisions in the front of the Manual, Provider Bulletins posted to the Provider portal on Fidelis Care's website, and in the quarterly provider newsletter. For material changes, Fidelis Care will send formal notice in accordance with the terms of the Agreement.

Fidelis Care's Medicaid/NJ FamilyCare Managed Care Plan

Fidelis Care has contracted with the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services (DMAHS or "Agency") to provide Medicaid/NJ FamilyCare and CHIP managed care services to eligible Members. Fidelis Care serves adults and children eligible to participate in New Jersey's Medicaid/NJ FamilyCare program. Eligibility is determined solely by the Agency. These plans offer Members more benefits and coverage than traditional Medicaid at no additional cost. Members may choose their Primary Care Provider (PCP) from a network of Participating Providers, including family doctors, pediatricians and internists.

Covered Services

Note: All NJFC Members: Plans A, B, C, D, ABP, MLTSS and FIDE-SNP (dual-eligible Medicare/Medicaid) with dental benefits have a comprehensive dental package which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical and other adjunctive general services. Note that some procedures require Prior Authorization with documentation of Medical Necessity. Orthodontic services are age restricted and only approved with adequate documentation of handicapping malocclusion or Medical Necessity.

The NJFC Benefits Schedule is available by contacting LIBERTY Dental Provider Relations or on LIBERTY's website at **libertydentalplan.com/Secured-Documents.aspx**

- **Password:** 2020NJFC

A list of dental providers, including dental specialist can be found at: **findaprovider.fideliscarenj.com/.**

The following services are provided as Medically Necessary to eligible Fidelis Care Medicaid and NJ FamilyCare Plan A, B, and C Members:

Because FIDE-SNP and MLTSS Members receive Plan A coverage, these Member categories are not included in the chart below. Although there are age restrictions for some services, all

Medicaid/NJ FamilyCare Members with dental benefits have the same comprehensive dental benefit package.

Both NJ FamilyCare Plans C and D have a $5 co-pay for all dental visits except for diagnostic and preventative dental visits.

NJ FAMILYCARE BENEFIT PLAN COMPARISON CHART

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered by MCO.			
Autism Services	Covered by MCO and FFS. Only covered for Members under 21 years of age with Autism Spectrum Disorder. Covered Services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; developmental and relationship based interventions; and Applied Behavior Analysis (ABA) treatment.			
Blood and Blood Products	Covered by MCO. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered by MCO. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			
Cardiovascular Screenings	Covered by MCO. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.			
Chiropractic Services	Covered by MCO. Covers manipulation of the spine.			
Colorectal Screening	Covered by MCO. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• ***Barium Enema***	Covered by MCO. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.			
• ***Colonoscopy***	Covered by MCO. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.			
• ***Fecal Occult Blood Test***	Covered by MCO. Covered once every 12 months.			
• ***Flexible Sigmoidoscopy***	Covered by MCO. Covered once every 48 months.			
Dental Services	Covered by MCO. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of Medical Necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or Medical Necessity. Examples of Covered Services include (but are not limited to): oral evaluations (examinations); x-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary x-rays are covered twice per rolling year.		Covered by MCO. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of Medical Necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or Medical Necessity. Examples of Covered Services include (but are not limited to): oral evaluations (examinations); x-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary x-rays are	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	Additional diagnostic, preventive and designated periodontal procedures can be considered for Members with special healthcare needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of Medical Necessity.		covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for Members with special healthcare needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of Medical Necessity. **NJ FamilyCare C and D Members have a $5 copay per dental visit (except for diagnostic and preventive services).**	
Diabetes Screenings	Covered by MCO. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.			
Diabetes Supplies	Covered by MCO. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.			
Diabetes Testing and Monitoring	Covered by MCO. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for Members with diabetic peripheral neuropathy and loss of protective sensations.			
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered by MCO. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered by MCO.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Emergency Care	Covered by MCO. Covers emergency department and physician services.		Covered by MCO. Covers emergency department and physician services. **NJ FamilyCare C Members have a $10 copayment.**	Covered by MCO. Covers emergency department and physician services. **NJ FamilyCare D Members have a $35 copayment.**
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered by MCO. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, dental, vision, and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify	Covered by MCO. For NJ FamilyCare B, C, and D Members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. ***For NJ FamilyCare B, C, and D Members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.***		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	the need.			
Family Planning Services and Supplies	Covered by MCO. The MCO shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Covered Services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. ***Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).***			
Federally Qualified Health Centers (FQHC)	Covered by MCO. Includes outpatient and primary care services from community-based organizations.			
Hearing Services/Audiology	Covered by MCO. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.			
Home Health Agency Services	Covered by MCO. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.			
Hospice Care Services	Covered by MCO. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	and grief counseling. • Covered in the community as well as in institutional settings. • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. **NOTE:** **Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.**			
Immunizations	Covered by MCO. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.			
Inpatient Hospital Care	Covered by MCO. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental healthcare; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.			
• ***Acute Care***	Covered by MCO. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).			
• ***Psychiatric***	***For coverage details, please refer to the Behavioral Health chart.***			
Mammograms	Covered by MCO. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.			
Maternal and Child Health Services	Covered by MCO. Covers medical services for perinatal care, and related newborn care and hearing screenings, including midwifery care, Centering Pregnancy, immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.			
Medical Day Care (Adult Day Health Services)	Covered by MCO. A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	***Not covered for NJ FamilyCare B, C, or D Members.***		
Nurse Midwife Services	Covered by MCO.		Covered by MCO. **$5 copayment for each visit (except for prenatal care visits)**	
Nursing Facility Services	Covered by MCO. Members may have patient pay liability.	***Not covered for NJ FamilyCare B, C, or D Members.***		
• ***Long Term (Custodial Care)***	Covered by MCO. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	***Not covered for NJ FamilyCare B, C, or D Members.***		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• ***Nursing Facility (Hospice)***	Covered by MCO. Hospice care can be covered in a Nursing Facility setting. **See Hospice Care Services.*	***Not covered for NJ FamilyCare B, C, or D Members.***		
• ***Nursing Facility (Skilled)***	Covered by MCO. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	***Not covered for NJ FamilyCare B, C, or D Members.***		
• ***Nursing Facility (Special Care)***	Covered by MCO. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for Members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	***Not covered for NJ FamilyCare B, C, or D Members.***		
Organ Transplants	Covered by MCO. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered by MCO.			
Outpatient	Covered by MCO.		Covered by MCO.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Hospital/ Clinic Visits			**$5 copayment per visit (no copayment if the visit is for preventive services).**	
Outpatient Rehabilitation *(Occupational Therapy, Physical Therapy, Speech Language Pathology)*	Covered by MCO. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered by MCO. Covers physical, occupational, and speech/language therapy. ***For NJ FamilyCare B, C, and D Members, limited to 60 days per therapy per calendar year.***		
Pap Smears and Pelvic Exams	Covered by MCO. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.			
Personal Care Assistance	Covered by MCO. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	***Not covered for NJ FamilyCare B, C, or D Members.***		
Podiatry	Covered by MCO. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. ***Exceptions: Routine hygienic care of***		Covered by MCO. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. **$5 copayment per visit for NJ**	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.		**FamilyCare C and D Members.** ***Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.***	
Prescription Drugs	Covered by MCO. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.		Covered by MCO. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered. **For NJ FamilyCare C and D Members, there is a $1 copayment for generic drugs, and a $5 copayment for brand name drugs.**	
Physician Services - Primary and Specialty Care	Covered by MCO. Covers medically necessary services and certain preventive services in outpatient settings.		Covered by MCO. Covers medically necessary services and certain preventive services in outpatient settings. **$5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).**	
Private Duty Nursing	Covered by MCO. Private duty nursing is covered for Members who live in the community and whose			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to Members with MLTSS (of any age).**			
Prostate Cancer Screening	Covered by MCO. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.			
Prosthetics and Orthotics	Covered by MCO. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.			
Renal Dialysis	Covered by MCO.			
Routine Annual Physical Exams	Covered by MCO.		Covered by MCO. **No copayments.**	
Smoking/Vaping Cessation	Covered by MCO. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: • **NJ Quitline**: Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS** (**1-866-657-8677**) (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at https://www.nj.gov/health/fhs/tobacco/quitting/. • **NJ QuitNet**: Free peer support and trained counselors, available 24 hours a day, seven days a week at https://www.tobaccofreenj.com/quit-smoking**.** • **NJ Quitcenters**: Receive professional face-to-face counseling in individual or group sessions. Locate a center by calling **1-866-657-8677** (TTY **711**) or visit https://www.tobaccofreenj.com/quit-smoking.			
Transportation (Emergency) *(Ambulance, Mobile Intensive Care Unit)*	Covered by MCO. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Transportation (Non-Emergent) ***(Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)***	Covered by FFS. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by the health plan, PCP, or providers. **MovidCare, "Transportation services are a covered for NJ FamilyCare B, C, or D Members. All transportation including livery is available for all Members including B, C and D.**			
Urgent Medical Care	Covered by MCO. Covers care to treat a sudden illness or injury that isn't a medical emergency but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).		Covered by MCO. Covers care to treat a sudden illness or injury that isn't a medical emergency but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). **NOTE: There may be a $5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.**	
Vision Care Services	Covered by MCO. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are		Covered by MCO. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
	covered for Members with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for Members with age-related macular degeneration.		covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for Members with age-related macular degeneration. **$5 copayment per visit for Optometrist services.**	
• ***Corrective Lenses***	Covered by MCO. Covers 1 pair of lenses/frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.			

Non-Covered Services

- All services that are not Medically Necessary
- Cosmetic surgery except when Medically Necessary and approved
- Experimental organ transplants
- Services provided outside the United States and its territories

The following expanded benefits are available to Fidelis Care Members at no cost:	
Benefit	**Description/Limits**
SafeLink Cell Program	Provides one (1) free smartphone per household. Includes 350 minutes of talk time monthly, unlimited text messaging, and 3GB of data per month.
Stay Connected Program (High Risk Pregnancies/Chronic Conditions)	Provides one (1) free cell phone to Members who do not have a telephone and are engaged in a care management program for a high-risk pregnancy or chronic condition

Healthy Rewards Program	Provides rewards, such as gift cards and e-gift cards, to Members who complete specific preventive health, wellness and engagement activities
OTC4Me	Provides Member with discounts on more than 500 over-the-counter items. Members will receive a 20% discount on their first order and 10% on each order after that. Plus, shipping is free for each order of $25 or more.
Over-the-Counter (OTC)	Provides $10 worth of OTC items each month, per head of household. No prescription required.

Provider Services

Providers may contact Provider Services at **1-888-453-2534** Monday through Friday, 8 a.m. to 6 p.m. EST. There are over 50 agents available to assist with Provider inquiries. A link to the secure provider portal is listed on the bottom of each page in this Provider Manual. Providers may also find important Fidelis Care addresses, phone numbers, fax numbers and authorization requirements by referring to the *Quick Reference Guide* which may be found on Fidelis Care's website at **fideliscarenj.com**.

Fidelis Care Online Tools for Providers

Fidelis Care **offers robust technology options to save Providers time using the secure web portal, Chat and IVR (Interactive Voice Response System) self-service tools.**

These self-service tools help Providers do business with Fidelis Care. We want your interactions with us to be as easy, convenient and efficient as possible. Giving Providers and their staff self-service tools, and access is a way for us to accomplish this goal. Providers can access this information below or at **fideliscarenj.com**, then click on Medicaid from the drop-down menu under Providers.

Interactive Voice Response (IVR) System

IVR system

- Technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

Self-Service Features

- Ability to receive Member co-pay information
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials

- Automatic routing to the PCS claims adjustment team to dispute a denied claim
- Rejected claims information is now available through self-service
- Form retrieval and requests

TIPS for using IVR

- Providers should have the following information available with each call:
- Fidelis Care Provider ID number
- NPI or Tax ID for validation, if Providers do not have their Fidelis Care ID
- For claims inquiries – provide the Member's ID number, date of birth, date of service and dollar amount
- For authorization and eligibility inquiries – provide the Member's ID number and date of birth

Benefits of using Self-Service

- 24/7 data availability
- No hold times
- Providers may work at their own pace
- Access information in real time
- Unlimited number of Member claim status inquiries
- Direct access to PCS – No transfers

The *Phone Access Guide* is posted on **fideliscarenj.com/providers/Medicaid.**

Dental Vendor – LIBERTY Dental Plan

Provider Service Line **1-888-352-7924** Monday through Friday, 5 a.m. to 8 p.m. EST
libertydentalplan.com

Email Professional Relations at: **prinquiries@libertydentalplan.com**

Website Resources

Fidelis Care's website, **fideliscarenj.com/providers**, offers a variety of tools to assist Providers and their staff.

Available resources include:

- Provider Manuals
- Quick Reference Guides
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- Forms and documents
- Provider search tool (directories)
- Authorization look-up tool
- Training materials and job aids
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Dental Vendor-LIBERTY Dental Plan-Provider Reference Guide can be found online at:

libertydentalplan.com/Providers/Provider-Resource-Library.aspx

Secure Provider Portal: Key Features and Benefits of Registering

Fidelis Care's secure online provider portal offers immediate access to what Providers need most. All Participating Providers who create an account will be assigned permissions by a portal administrator and can use the following features:

- **Claims Submission, Status, Appeal, Dispute** – Submit a claim, check status, appeal or dispute claims, and download reports;
- **Member Eligibility, Co-Pay Information and More** – Verify Member eligibility, and view co-pays, benefit information, demographic information, care gaps, health conditions, visit history and more;
- **Authorization Requests** – Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization;
- **Pharmacy Services and Utilization** – View and download a copy of Fidelis Care's preferred drug list (PDL), access pharmacy utilization reports, and obtain information about Fidelis Care pharmacy services;
- **Visit Checklist/Appointment Agenda** – Download and print a checklist for Member appointments, then submit online to get credit for Fidelis Care's Partnership for Quality (P4Q) program, if available; and
- **Secure Inbox** – View the latest announcements for Providers and receive important messages from Fidelis Care.

Provider Registration Advantage

The secure provider portal allows Providers to have one username and password and be affiliated with multiple Providers/offices. Administrators can easily manage users and permissions. Once registered for Fidelis Care's portal, Providers should retain their username and password information for future reference.

How to Register

To create an account, please refer to the *Provider Resource Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**. For more information about Fidelis Care's web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service.

Using Chat: Get to Know the Benefits of Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application instead of calling and speaking with agents. Here are some ways our Chat support can help you and your staff: multi-session functionality; web support assistance; and real-time claim adjustments. Explore the benefits you will experience by using live Chat!

- **Convenience**
  Live Chat offers the convenience of getting help and answers without having to have a phone call.
- **No Waiting On Hold**

- **Documentation of Interaction**
  Chat logs provide transparency and proof of contact. When customers engage with customer support via phone, they don't typically receive a recording of the verbal conversation. Live Chat software gives you the option of receiving a transcription of the conversation afterward.
- **You can access Chat through the portal**
  The *Chat Support* Icon is located on our secure provider portal. From there, you can:

Log on to the provider portal at **fideliscarenj.com**

- Access the "Help" section
- Submit a Chat inquiry. The receiving Chat agent can assist with numerous complex issues
- If the Chat agent is unable to resolve the issue, the issue will be routed to the right team for further assistance.

Dental Vendor – LIBERTY Dental Plan

Provider web portal offers 24/7 real-time access to important information and tools through the secure online system. Please visit **libertydentalplan.com** to register as a new user and/or log in.

Additional Resources

The *New Jersey Medicaid Resource Guide* contains information about Fidelis Care's secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. For specific instructions on how to complete day-to-day administrative tasks, please see the *New Jersey Medicaid Resource Guide* found on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Provider Services (toll free): **1-888-453-2534**

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of the guidelines for which all Fidelis Care Medicaid/NJ FamilyCare Managed Care Participating Providers are accountable. Please refer to the Agreement or contact a Provider Relations representative for clarification on any of the following.

Participating Providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964 as amended, the Age Discrimination Act of 1975 as amended, the Americans with Disabilities Act of 1990 as amended, and the Rehabilitation Act of 1973 as amended
- Cooperate with Fidelis Care in its efforts to monitor compliance with its Medicaid/NJ FamilyCare contract(s) and/or the Agency rules and regulations, and assist Fidelis Care in complying with corrective action plans necessary for it to comply with such rules and regulations
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Fidelis Care Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) should provide direct Member care within the scope or practice established by the rules and regulations of the Agency and Fidelis Care guidelines
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender titles (examples: MD, DO, ARNP, PA) to Members and to other healthcare professionals
- Honor, at all times, any Member request to be seen by a physician rather than a physician extender
- Administer, within the scope of practice, treatment for any Member in need of healthcare services
- Maintain the confidentiality of Member information and records
- Allow Fidelis Care to use Provider performance data for quality improvement activities
- Respond promptly to Fidelis Care's request(s) for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all Fidelis Care's policies governing content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*
- Ensure that: (a) all employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Agreement between the Provider and Fidelis Care; (b) the physician maintains written agreements with contracted physicians, healthcare practitioners, or other Providers, employed

physicians and other healthcare practitioners and Providers, and that such agreements contain similar provisions to the Agreement

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Fidelis Care, the Member or the requesting party at no charge, unless otherwise agreed
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimens
- Not discriminate in any manner between Fidelis Care Medicaid/NJ FamilyCare Members and Members of other plans, commercial or otherwise
- Ensure that the hours of operation offered to Fidelis Care Medicaid/NJ FamilyCare Members is no less than those offered to commercial Members
- Not deny, limit or condition the furnishing of treatment to any Fidelis Care Member on the basis of any factor that is related to health status, including, but not limited to, the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of healthcare; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for the Member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services
- Identify Members who are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to Fidelis Care-sponsored or community-based programs
- Must document the referral to Fidelis Care-sponsored or community-based programs in the Member's medical record and provide the appropriate follow-up to ensure the Member accessed the services
- Assure the use of the most current diagnosis and treatment protocols and standards established by DHSS and the medical community

Excluded or Prohibited Services

Providers must verify Member eligibility and enrollment prior to service delivery. Fidelis Care is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.

Excluded services are services that Members may obtain under the Medicaid/NJ FamilyCare plan for which Fidelis Care is not financially responsible. Excluded services may be paid for by the Agency on a fee-for-service basis or another basis. In the event the service(s) is (are) an Excluded service, Providers must submit reimbursement for those services directly to the

Agency. In the event the service(s) is (are) prohibited, neither Fidelis Care nor the Agency is financially responsible.

Responsibilities of All Providers

The following is a summary of the responsibilities of all Providers who render services to Fidelis Care Members. These are intended to supplement the terms of the Participating Provider Agreement (the "Agreement") and not replace them. In the event of a conflict between this Provider Manual and the Agreement, the terms of the Agreement will govern.

Living Will and Advance Directive

All Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

Each Fidelis Care Member (age 18 years or older and of sound mind) should receive information regarding living will and advance directives. This allows Members to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living wills and advance directives should be made available in Provider offices and discussed with Members or their authorized representatives. Completed forms should be documented and filed in Members' medical records.

A Provider shall not, as a condition of treatment, require a Member to execute or waive an advance directive.

Provider Billing and Address Changes

Prior notice to a Provider Relations representative or Provider Services is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number

Failure to notify Fidelis Care prior to these changes will result in a delay in claims processing and payment.

Provider Termination

In addition to the Provider termination information included in the Agreement, Providers must adhere to the following terms:

- Contracted Providers must give at least 90 days prior written notice to Fidelis Care before terminating their relationship with Fidelis Care unless otherwise provided in the Agreement or otherwise agreed to in writing. This ensures adequate notice may be given to Fidelis Care Members regarding a Provider's participation status with Fidelis Care. Please refer to the Agreement for the details regarding the specific

required days for providing notice of termination since a Provider may be required by contract to give more or less notice than listed above.

- Unless otherwise provided in the termination notice, the effective date of termination will be on the last day of the month.
- Please refer to *Section 6: Credentialing* in this Manual for specific guidelines regarding rights to appeal plan termination (if any).
- The Company must notify DMAHS, in a data format defined by the State, at least 45 days prior to the effective date of suspension, termination, non-renewal of contract, voluntary withdrawal, or any other termination of a Provider's or subcontractor's participation in Fidelis Care's Provider network for the Medicaid/NJ FamilyCare program.
- If a termination is based on fraud, this must be reported to the NJ Medicaid Fraud Division. The Company will report the fraud, with the basis for the determination of fraud, to the appropriate administrative agency (that is, the Provider's licensing entity, such as the Board of Medical Examiners, the Board of Pharmacy, the Board of Chiropractic, and the Division of Criminal Justice).
- If the termination was based on a determination that the Provider represents an imminent danger to the patient or the public health, safety and welfare, the Company will report the determination to the appropriate State licensing board.

Out-of-Area Member Transfers

Providers should assist Fidelis Care in arranging and accepting the transfer of all Members receiving care out of the service area if the transfer is considered medically acceptable by the Participating Provider and the out-of-network attending provider.

Payment in Full/Prohibition on Balance Billing

Providers must accept Fidelis Care's payments for services, goods and supplies as payment in full on behalf of the Member. No additional amount can be charged to the Member, his or her family, representative or others on his or her behalf for the Covered Services, goods, and supplies furnished to the Member. Providers also may not seek reimbursement from Members for any missed appointments.

Providers may not seek reimbursement from Members because the services provided are determined not to be Medically Necessary. A Provider may seek reimbursement from a Member for services, goods or supplies that are not Covered Services only if the Provider (a) informs the Member of the specific items or services that are not Covered Services and that they will not be paid for by Fidelis Care, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider shall contact Fidelis Care for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

Individuals with Special Healthcare Needs (ISHCN)

Individuals with Special Healthcare Needs (ISHCN) include, but are not limited to, Members with serious or chronic physical, developmental, behavioral or emotional conditions such as:

- Developmental disabilities or related conditions

- Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes
- Children and adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care

The following is a summary of responsibilities specific to Providers who render Covered Services to Fidelis Care Members who have been identified with special healthcare needs:

- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care
- Coordinate treatment plans with Members, family and/or specialists caring for Members
- The plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards
- Allow Members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the Members' conditions or needs
- Coordinate with Fidelis Care, if appropriate, to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished
- Coordinate services with other third-party organizations to prevent duplication of services and share results on identification and assessment of the Member's needs
- Ensure the Member's privacy is protected as appropriate during the coordination process

Responsibilities of Primary Care Providers

The following is a summary of responsibilities specific to PCPs who render services to Fidelis Care Members. These are intended to supplement the terms of the Agreement, not replace them.

- Coordinate, monitor and supervise the delivery of primary care services to each Member
- See Members for an initial office visit and assessment within the time frames indicated in the *Access Standards* section below
- Provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, 7 days per week
- To ensure accessibility and availability, PCPs must provide one of the following:
    - A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP
    - An answering system with an option to page the physician for a return call within 30 minutes
    - An advice nurse with access to the PCP or on-call physician within 30 minutes
- Assure Members are aware of the availability of public transportation where available
- Provide access to Fidelis Care or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related

organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office

- Submit an Encounter for each visit where the Provider sees the Member or the Member receives a service related to a HEDIS® quality measure. For more information on Encounters, refer to *Encounters* in *Section 5: Claims*

Ensure Members use Fidelis Care's Participating Providers. If a Provider is unable to locate a Participating Provider, contact Provider Services for assistance. Refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** for contact information

- Comply with and participate in corrective action and performance improvement plan(s)

Primary Care Office Resources

PCPs provide comprehensive primary care services to Fidelis Care Members. Primary care offices participating in Fidelis Care's Provider network have access to the following services:

- Support of the Provider Relations, Provider Services, Health Services, Marketing and Sales departments, as well as the tools and resources available on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**
- Information on Fidelis Care Participating Providers for the purposes of referral management and discharge planning

Closing of Physician Panel

When requesting closure of the Provider's panel to new and/or transferring Fidelis Care Members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel
- Maintain the panel to all Fidelis Care Members who were provided services before the closing of the panel
- Submit written notice of the re-opening of the panel, including a specific effective date

Covering Physicians/Providers

In the event that Participating Providers are temporarily unavailable to provide care or referral services to Fidelis Care Members, Providers should make arrangements with another Fidelis Care-contracted and credentialed Provider to provide services on their behalf, unless there is an emergency.

Covering physicians are required to be credentialed by Fidelis Care and are required to sign an agreement which, among other terms and conditions, sets forth the negotiated rate prohibits the balance billing of Fidelis Care Members. For additional information, please refer to *Section 6: Credentialing* in this Manual.

In non-emergency cases, should Providers have a covering physician/Provider who is not contracted and credentialed with Fidelis Care, please contact Fidelis Care for approval. For

more information, refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/medicaid**.

Access Standards

Providers must adhere to standards of timeliness that take into consideration the immediacy of the Member's needs for appointments, in-office waiting times and telephone response times as set forth in the table below. Fidelis Care shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable time frames. Providers not in compliance with standards will be required to implement corrective actions set forth by Fidelis Care.

Type of Appointment	Access Standard
Emergency Services	Immediately upon presentation
Urgent Care	< 24 hours
Symptomatic Acute Care — An encounter with a healthcare Provider associated with the presentation of medical signs, but not requiring immediate attention	< 72 hours
Routine – Non-symptomatic visits, including annual gynecological examinations or pediatric and adult immunization visits	< 28 days
Specialist Referrals	< 4 weeks or shorter as medically indicated
Urgent Specialty Care	Within 24 hours of referral
Baseline physicals for new adult Members	Within 180 calendar days of initial enrollment
Baseline physicals for new children Members and adult clients of the DDD	Within 90 days of initial enrollment, or in accordance with EPSDT guidelines
Prenatal Care	• Within 3 weeks of a positive home or laboratory pregnancy test • Within 3 days of identification of high risk • Within 7 days of request in first and second trimester • Within 3 days of first request in third trimester
Routine Physicals	Within 4 weeks
Lab and radiology services – routine	Within 3 weeks
Lab and radiology services – urgent	Within 48 hours
Initial Pediatric appointments	Within 3 months of enrollment
Dental – emergency (including in an emergency room)	No later than 48 hours, or earlier if the condition warrants, of injury to sound natural teeth and surrounding tissue
Dental – urgent	Within 3 days of referral

Type of Appointment	Access Standard
Dental – routine	Within 30 days of referral
Mental Health/Substance Abuse – Emergency	Immediately upon presentation
Mental Health/Substance Abuse – Urgent	< 24 hours
Mental Health/Substance Abuse – Routine	< 10 days
Maximum Number of Intermediate/Limited Patient Encounters – Adult	4 per hour
Maximum Number of Intermediate/Limited Patient Encounters – Children	4 per hour

In-office wait times shall not exceed 45 minutes.

Providers are required to respond to telephone inquiries in a timely manner and to prioritize appointments. Providers should triage medical and dental conditions and special behavioral needs for non-compliant Members. When scheduling an appointment, Providers should identify any special needs of Members, such as interpretive linguistic needs. Providers should use their best efforts to contact each new Member or, where applicable, an authorized person, to schedule an appointment for a complete age/sex specific baseline physical.

Providers should schedule a series of appointments and follow-up appointments as the Member's needs dictate.

Providers should develop processes to identify and reschedule missed appointments.

Type of Telephone Call	Response Time
After-hours non-emergent, symptomatic issues	Within 30 to 45 minutes
Non-symptomatic concerns	Same day
Crisis situations	Within 15 minutes

Specialist Providers/Specialty Care Services

Selected specialty services by a specialist Providers or specialty care centers require a proper referral from the Member's PCP. The specialist may order diagnostic tests without PCP involvement by following Fidelis Care's referral guidelines (*Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)).* However, the specialist Provider may not refer the Member to other specialists or admit the Member to a hospital without the referral of a PCP, except in the case of an emergency. The specialist Provider must abide by Fidelis Care's Prior Authorization requirements when ordering diagnostic tests. The PCP should arrange for a standing referral to a specialist Provider for notification of specialty and referral services from Fidelis Care when a Member requires ongoing specialty care.

The specialist Provider must maintain contact with the Member's PCP. This could include telephone contact, written reports on consultations or verbal reports if an emergency situation exists.

All specialist Providers must:

- Obtain referral or Prior Authorization from the Member's PCP before providing services
- Coordinate the Member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24 hours a day
- Maintain confidentiality of the Member's medical information

Fidelis Care recognizes that in certain cases, it may be beneficial for a Member's specialist Provider to act as the Member's PCP. Members who have special needs that require very complex, highly specialized healthcare services over a prolonged period of time, a life-threatening condition or disease, or a degenerative and/or disabling condition or disease may be offered the option of selecting an appropriate specialist Provider or specialty care center (where available) instead of a traditional PCP. Such specialist Providers must have the appropriate clinical skills, capacity, accessibility and availability. They must be specially credentialed and are contractually obligated to:

- Assume the responsibility for the overall healthcare coordination of the Member
- Assure that the Member receives all necessary specialty care related to his or her special needs
- Provide for or arrange all routine preventive care and health maintenance services, even if they are not customarily provided by or are the responsibility of the specialist Provider

The specialist Provider acting as PCP must be available or provide on-call coverage 24 hours per day, seven days per week.

In-office wait times shall not exceed 45 minutes.

New Jersey's Early and Periodic Screening, Diagnosis, and Treatment Program

New Jersey's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a comprehensive preventive healthcare program designed to improve the overall health of Medicaid/NJ FamilyCare eligible infants, children and adolescents. The goal of the EPSDT program is to identify health problems and treat them early to reduce the risk of costly treatment or hospitalization later. Fidelis Care's Participating Providers who perform PCP services are required to participate in the EPSDT Program.

Medical check-ups must be performed in accordance with the Pediatric Preventive Health Standards Schedule that is based on the American Academy of Pediatrics (AAP) recommendations.

All initial screenings are to be performed by the Member's PCP and include at a minimum:

- Family history (physical and mental development)
- Comprehensive unclothed physical examination

Dental Services. Dental services may not be limited to emergency services. Dental screening by the licensed medical staff in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection and include completion of AAP caries risk assessment. A referral to a dentist by 1 year of age or soon after the eruption of the first primary tooth is mandatory. Follow up at well child visits through the age twenty (20) to determine at a minimum dental visit twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided. NJ Smiles program allows trained licensed medical staff to provide oral health services to children through the age of three (3) years old

A dental home should be established by 2 years of age through assignment of a PCD, dental referral or outreach. Comprehensive oral evaluation by a dentist should occur followed by periodic oral evaluations as needed. A caries risk assessment should be provided on an annual basis for all children and be used to determine and develop a treatment plan.

Preventive services should occur at least biannually and more frequently based on Medical Necessity. All diagnosed diseases should be documented and all needed treatment should be provided in a timely manner. A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty Provider.

- A Periodicity Table of Dental Services for NJ FamilyCare can be found at the Fidelis Care NJ website: **fideliscarenj.com**
- Measurements (height, weight and infant head circumference)
- Nutritional assessment
- Developmental assessment
- Mental health assessment
- Sensory screening (vision and hearing)
- Laboratory tests (including blood lead level assessments appropriate for age and risk factors)
- Tuberculosis test
- Lead screening
- Immunizations
- Health education
- Visual assessment
- Anticipatory guidance
- Referral services, i.e., family planning, and dental services

Any Provider attending the birth of a baby must require testing for phenylketonuria (PKU), galactosemia, hypothyroidism, homocystinuria, hemoglobinopathies (including sickle cell anemia), electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, and congenital adrenal hyperplasia on all newborns as required by New Jersey law.

NJ Smiles Program

The NJ Smiles Program is based on recommendations of the American Academy of Pediatrics Bright Future guidelines. A preventative program that allows non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of five (5).

Fluoride varnish may be applied by any trained medical staff. The physician must be trained and submit an attestation that all staff providing this service have been trained and will be supervised. Training and the attestation form can be found at:
fideliscarenj.com/providers/Medicaid/training.

- Fluoride varnish application will be combined with risk assessment, anticipatory guidance, and referral to a dentist that treats children under the age of 6 and will be linked to well-child visits for children through the age of five (5) years old.
- The caries risk asse must be provided at least once per year in conjunction with an oral evaluation service by a Primary Care Dentist (PCD), and is linked to the Provider, not the Member. It may be provided a second time with Prior Authorization and documentation of Medical Necessity. Caries risk assessment form access information is available in Addendum C.
- These three services will be reimbursed as an all-inclusive service billed using CPT code 99188 and ICD-10 code Z41.8 and can be provided up to four (4) times a year for children at moderate or high risk based on Medical Necessity. This frequency does not affect the frequency of this service by the dentist.
- Bidirectional Referral: Communication between medical and dental Providers is required. A referral to a dentist by twelve (12) months of age or soon after the eruption of the first primary tooth is mandatory. Collaboration between the medical and dental Providers is required to determine at a minimum dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided. Documentation of the referral and collaborative communication must be retained in the Member's records. The bidirectional form may be found at: **fideliscarenj.com/providers/Medicaid/forms**.
- PCP's and PCD's are responsible for prescribing fluoride supplements (based on access & use to fluoridated public water) and counseling parents/guardians of young children on oral health, age-appropriate oral habits and safety. Including what dental emergencies are, and the use of the emergency room for dental services. (*please see the Emergency Dental Condition definition in this manual) Reducing Pediatric Caries Risk Fluoride Supplement Q&A information is available in Addendum C.
- The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the Provider, not the Member. It may be provided a second time with Prior Authorization and documentation of Medical Necessity.
- Fidelis Care provides the following directories of dental Providers that we encourage to use as a resource for dental referrals:
    - The NJFC Directory of Dentists Treating Children under the Age of 6, and the Directory of Dentists Treating Members with Intellectual and Developmental Disabilities – Adults and Children can be found at **NJ FamilyCare (NJFC) Dental Directory - English/Spanish (PDF)**
    - Dental Directory of Providers who treat children with intellectual and developmental disabilities (I/DD), can be accessed on the web at **Dental_Directory:Child_Member-English/Spanish_(PDF)**. Dental Directory of

Providers who treat adults with intellectual and developmental disabilities (I/DD) can be accessed on the web at **Dental_Directory:Adult_Member-English/Spanish_(PDF).**

- All dental Providers including specialists can be found in Fidelis Care's Find a Provider/Pharmacy tool at **https://www.wellcare.com/new-jersey/Find-a-Provider?coverage=Medicaid#/Results.**
- All our dental directories are also found on our dental vendor, Liberty Dental Plan's website at **https://client.libertydentalplan.com/anthem/FindADentist**.

- PCP's: For more information on the NJ Smiles Program visit **fideliscarenj.com/providers/Medicaid/training**.

Member Notification

Fidelis Care informs all eligible Members of all testing/screenings due according to the federal periodicity schedule pursuant to State and federal agency contracts. Fidelis Care contacts Members to encourage them to obtain a health assessment and preventive care. Upon enrollment, all Members will receive a Member Handbook, which includes information about needed child health screenings, preventive services, age-appropriate immunizations and dental screenings (if applicable). Age-appropriate eligible Members are sent reminder notices when upcoming assessments or needed services are due. Fidelis Care offers scheduling assistance in order to assist Members in keeping appointments.

Fidelis Care will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child's age. Members are sent reminder notices according to the following schedule:

- Within 45 days of enrollment with Fidelis Care if there has been no visit to PCP for EPSDT visit
- Age 1 month
- Age 2 months
- Age 4 months
- Age 6 months
- Age 9 months
- Age 12 months
- Age 15 months
- Age 18 months
- Age 24 months
- Age 30 months
- Ages 3 through 21 years annually

Provider Notification and Responsibilities

Fidelis Care will send all Providers a monthly Membership list of EPSDT-eligible children, who have not had a screen within 120 days of enrolling in Fidelis Care or are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these Members' parents or guardians to schedule an appointment.

Providers are responsible for monitoring, tracking and following up with all Members who have not had a health assessment screening. Providers will ensure all Members receive the

proper referrals to treat any conditions or problems identified during the health assessment and tracking, monitoring and following up with all Members to ensure they receive the Medically Necessary services. Providers are to assist all Members with transition to other appropriate care for children who age out of EPSDT services.

Providers are required to follow up with all Members who miss EPSDT appointments, referrals for problems identified through EPSDT exams. Appropriate and reasonable outreach must consist of a minimum of three attempts to reach the Member through:

- Mailers
- Certified mail if necessary
- Telephone calls
- The use of the MEDM system provided by the State
- Contact with the Medical Assistance Customer Center (MACC), DDD, or Division of Youth and Family Services of the Department of Children and Families (DYFS/DCF) regional offices to confirm addresses and/or to request assistance in locating a Member
- Text messages and/or emails, if applicable

Documentation of the Provider's attempts to contact all Members and coordinate care must be in the medical record.

Medical record reviews are conducted to assess the quality of care delivered and services documented. The process includes, but may not be limited to, evaluation of adherence to EPSDT requirements. In general, documentation in the medical office record is reviewed for the following elements:

- Record of missed appointment follow-up, when applicable
- Compliance with professional practice standards, as well as any preventive health guidelines
- Appropriate and timely assessments
- Use of appropriate tools to identify early, timely and age-appropriate interventions
- Early and timely referrals to appropriate intervention programs in the Member's area
- Appropriate utilization of services
- Coordination of care and services
- Inclusion of the Member in the development of the treatment process
- General compliance with state and federal requirements

Vaccines for Children

For NJ FamilyCare A children, Providers must enroll with the New Jersey Department of Health's (DOH) Vaccines for Children (VFC) Program and use the free vaccines for all eligible Members if the vaccines are covered by VFC. Providers shall not receive from the Department of Human Services (DHS) any reimbursement for the cost of VFC-covered vaccines. PCPs can receive vaccines for immunizations free of charge through DOH. Providers must have a Provider Identification Number (PIN) to order. If a Provider is not enrolled, call **1-609-826-4862** for more information on how to enroll.

Fidelis Care requires all Members under the age of 18 to be immunized by their PCP unless medically contraindicated or against parental religious beliefs.

Providers must notify Fidelis Care if they are no longer enrolled in VFC by calling Provider Services at **1-888-453-2534**.

Blood Lead Screening

PCPs are required to perform a verbal risk assessment and screen for blood lead levels in children 6 months through 6 years of age as part of the EPSDT visit. This screening must be done through a blood lead level determination. The EP test is no longer acceptable as a screening test for lead poisoning, although it is still valid as a screening for iron deficiency anemia. PCPs must report all blood lead screening results, both positive and negative, to the County Lead Poisoning Center at the local health department. If a screening identifies a child with blood lead levels equal to or greater than 10 micrograms per deciliter, PCPs must immediately report the findings to the County Lead Poisoning Center.

Domestic Violence and Substance Abuse Screening

PCPs should identify indicators of substance abuse or domestic violence. The New Jersey Statewide Domestic Violence Hotline provides 24-hour, seven-days-a-week access to domestic violence victims and others seeking information about domestic violence. **1-800-572-SAFE (7233)**

Abuse, Neglect and Exploitation

PCPs should screen elderly and vulnerable Members for risk for abuse, neglect or exploitation. If the Member has any risk factors for abuse, neglect or exploitation, it would be prudent to investigate further. Fidelis Care's Care Management Department can help coordinate efforts to promote Member safety and can be reached at **1-888-453-2534.**

New Jersey's APS law (N.J.S.A. 52:27D-406 to 426) requires healthcare professionals who have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation to report that information to the county Adult Protection Services office. In addition, Providers must notify Fidelis Care and follow Fidelis Care Critical Incident reporting requirements for any Managed Long Term Services and Supports (MLTSS) Member that has been subjected to abuse, neglect or exploitation.

Please call Fidelis Care at **1-888-453-2534** and ask for the Care Management Department to coordinate efforts with a Care Manager. See also the Fidelis Care Policy and Procedure for Abuse and Neglect in the Aged (NJ23 CM-MD-13.1 and NJ23 CM-MD-13.1-PR-001), and report suspected abuse, neglect or exploitation to the appropriate agency.

Smoking Cessation

PCPs should direct Members who wish to quit smoking to call Member Services and ask to be directed to the Care Management Department. A care manager will educate the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through Fidelis Care.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of all Fidelis Care Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines located on Fidelis Care's website at **fideliscarenj.com/providers/tools/clinical-guidelines**.

Laboratory and Radiology Test Results

The Provider should notify all Members of laboratory and/or radiology test results within 24 hours of receipt of the results in urgent care or emergent care cases. The Provider should notify all Members of laboratory and/or radiology results within 10 business days of receipt of the results in non-urgent or non-emergent cases.

The Provider shall notify a Member's mental health/substance abuse Provider of physical examination and laboratory and/or radiology test results within 24 hours of receipt of the results in urgent care cases and within five business days in non-urgent cases.

Termination of a Member

A Fidelis Care Provider may not seek or request to terminate his or her relationship with a Member, or transfer a Member to another Provider of care, based upon the Member's medical condition, amount or variety of care required, or the cost of Covered Services required by Fidelis Care's Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. In the event that a Participating Provider desires to terminate her or his relationship with a Fidelis Care Member, the Provider should submit adequate documentation to support that although the Provider has attempted to maintain a satisfactory Provider and Member relationship, the Member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively.

If a satisfactory relationship cannot be established or maintained, the Provider shall continue to provide medical care for the Fidelis Care Member until such time that written notification is received from Fidelis Care stating, *"The Member has been transferred from the Provider's practice, and such transfer has occurred."*

Request for Transfer of Members should be submitted via Fidelis Care's secure provider portal by users who have administrator rights for their contract or subgroup. After logging in, Providers should access the *My Patients* area, search for the Member, select *Request Member Transfer* from the Select Action menu, then complete and submit the form.

Member Administrative Guidelines

Member Identification Cards

Member identification cards are intended to identify Fidelis Care Members, the type of plan they have, and facilitate their interactions with Providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, co-payment information, health plan contact information and

claims filing address. Possession of the Member identification card does not guarantee eligibility or coverage. Providers are responsible for confirming the current eligibility of the Member.

Member Eligibility Verification

A Member's eligibility status can change at any time. Therefore, all Providers should consider requesting and copying the Member's identification card, along with additional proof of identification such as a photo ID, and file them in the Member's medical record.

Providers may do one of the following to verify eligibility:

- Access the secure, online Provider portal of the Fidelis Care website at **fideliscarenj.com**.
- Access Fidelis Care's Interactive Voice Response (IVR) system
- Contact Provider Services

Providers will need their Provider ID number to access Member eligibility through the resources listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See the Agreement for additional details.

Member Rights and Responsibilities

Fidelis Care Members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

Fidelis Care Members have the right to:

- Receive information about Fidelis Care's plans, services, doctors and other healthcare Providers
- Receive information about appeals, including how to initiate an appeal, in a language they understand
- The Medicaid Fair Hearing Process for Medicaid enrollees and information about the method for obtaining a State hearing (Fair Hearing and/or IURO)
- Receive information about their rights and responsibilities
- Know the names and titles of the doctors and other health Providers caring for them
- Be treated with respect and dignity
- Have their privacy protected
- Choose their PCP from Fidelis Care's Participating Providers
- Decide with their Provider on the care they receive
- Have services provided that promote a meaningful quality of life and autonomy, and support independent living in both the Member's home and other community-based settings so long as such services are medically and socially feasible, and preserve and support the Members natural support systems
- Talk openly about the care they need, no matter the cost or benefit coverage, treatment options and the risks involved (this information must be given in a way they understand)

- Have the benefits, risks and side effects of medications and other treatments explained to them
- Know about their healthcare needs after they leave a Provider's office or the hospital
- Know how Fidelis Care's Providers are paid
- A second medical opinion
- Refuse care, as long as they agree to be responsible for their decision
- Refuse to take part in any medical research
- File an appeal or grievance about their plan or the care provided; also, to know that if they do, it will not change how they are treated
- A choice of Providers
- Call **911** in an emergency without Prior Authorization
- A medical screening exam in the emergency room (ER))
- Be free from balance billing
- Not be responsible for Fidelis Care's debts in the event of bankruptcy and not be held liable for:
    - Covered Services provided to them for which the government does not pay Fidelis Care
    - Covered Services provided to them for which the government or Fidelis Care does not pay the Provider who furnished the services
    - Payment of Covered Services under a contract, referral or other arrangement to the extent those payments are in excess of the amount they would owe if Fidelis Care provided the services directly
- Be free from hazardous procedures or any form of restraint or seclusion as a means of force, discipline, convenience or revenge
- Ask for and get a copy of their medical records from their Provider; also, to ask that the records be changed/corrected if needed (requests must be received in writing from the Member or the person they choose to represent them; the records will be provided at no cost; they will be sent within 14 days of receipt of the request)
- Have their records kept private
- Make their healthcare wishes known through advance directives
- Have a say in Fidelis Care's Member rights and responsibilities policies and recommend changes to other policies and services that Fidelis Care covers
- Appeal medical or administrative decisions by using Fidelis Care's appeals and grievances process
- Exercise these rights no matter their sex, age, race, ethnicity, income, education or religion
- A policy on the treatment of minors
- Have Fidelis Care staff observe their rights
- Have all of these rights apply to the person legally able to make decisions about their healthcare
- Be furnished quality services in accordance with 42 CFR 438.206 through 438.210, which include:
    - Accessibility
    - Authorization standards

- Availability
- Coverage
- Coverage outside of network

Fidelis Care Members also have certain responsibilities. These include the responsibility to:

- Read their Member Handbook to understand how Fidelis Care's healthcare plan works
- Carry their Member identification card and Medicaid/NJ FamilyCare card at all times
- Give information that Fidelis Care and their Providers need to provide care to them
- Follow plans and instructions for care that they have agreed on with their Provider
- Understand their health problems
- Help set treatment goals that they and their Provider agree upon
- Show their Member identification card to each Provider when they receive services
- Schedule appointments for all non-emergency care through their Provider
- Get a referral from their PCP for specialty care
- Cooperate with the people who provide their healthcare
- Be on time for appointments
- Tell their Provider's office if they need to cancel or change an appointment
- To pay their co-pays to Providers
- Respect the rights and property of all Providers
- Respect the rights of other patients
- Not be disruptive at their Provider's office
- Know the medicines they take, what they are for and how to take them the right way
- Make sure their Provider has copies of all of their previous medical records
- Let Fidelis Care know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care
- Be responsible for cost sharing only as specified under Covered Services co-pays

Disruptive Behaviors in Medical Practitioners Office

The Care Management Team will coordinate with the Provider to accompany to appointments those Members with special needs or who are disruptive and are exhibiting inappropriate and threatening behaviors in a medical practitioner's office. The Member will be co-managed by a Behavioral Health (BH) Care Manager. The Provider can contact the Care Management Department at **1-855-642-6185** 8 a.m. to 5 p.m. or the Behavioral Health Crisis Line at **1-800-411-6485** 24/7 for immediate assistance.

Assignment of Primary Care Provider (PCP)

Fidelis Care ensures that Members are informed and have access to enroll with traditional and safety net Providers. Fidelis Care makes every effort to ensure that Members are assigned to their existing PCP.

If the Member does not choose a PCP within 10 calendar days of the Member's effective date of enrollment, the Member will be assigned to her or his PCP of record, based on prior information, if that Provider is in Fidelis Care's network. Otherwise, the Member will be assigned a PCP based on proximity to the Member and the Member's language and/or cultural needs (if known).

Fidelis Care has policies and procedures allowing a PCP to request reassignment of a Member, e.g., for irreconcilable differences, for when a Member has taken legal action against the Provider, or if a Member fails to comply with healthcare instructions and such noncompliance prevents the Provider from safely and/or ethically proceeding with that Member's healthcare services. Fidelis Care shall approve any reassignments and require documentation of the reasons for the request for reassignment. For example, if a PCP requests reassignment of a Member for failure to comply with healthcare instructions, Fidelis Care shall take into consideration whether the Member has a physical or developmental disability that may contribute to the noncompliance, and whether the Provider has made reasonable efforts to accommodate the Member's needs.

In the case of DCP&P/DCF-eligible children, copies of such requests shall be sent to:

Division of Child Protection and Permanency/Department of Children and Families
c/o Medicaid Liaison
P.O. Box 729
Trenton, NJ 08625-0729

Women's Health Specialists

PCPs may also provide routine and preventive healthcare services that are specific to female Members. If a female Member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to Fidelis Care Members through Member Services. PCPs should coordinate these services for Fidelis Care Members and contact Member Services if assistance is needed. Please refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** for the Provider Services telephone numbers.

Section 3: Quality Improvement

Quality Improvement

Overview

Fidelis Care's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare services. The QI Program applies to all Member demographic groups, care settings, and types of services afforded to Medicaid Members, including special needs, behavioral health, Managed Long Term Services and Supports (MLTSS) and Dual Special Needs Plan (DSNP). The QI Program addresses the quality of clinical care and non-clinical aspects of service including MLTSS and D-SNP that can be expected to have a beneficial effect on health outcomes, enrollee satisfaction and enrollee choice in determining healthcare setting. Strategies are identified

and activities are implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that includes, but is not limited to:

- Quantitative and qualitative improvement in Member outcomes
- Coordination and continuity of care with seamless transitions across healthcare settings/services
- Cultural competency
- Reducing health disparities
- Quality of care/service
- Patient safety
- Critical incidents (including abuse, neglect and exploitation)
- Preventative health
- Service utilization
- Grievances
- Network adequacy/practitioner availability and accessibility
- Appropriate service utilization
- Disease and case/care management
- Member and Provider satisfaction
- Components of operational service
- Regulatory/federal/State/accreditation requirements
- Integration of behavioral and dental health

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS® measures, and/or medical record audits. Fidelis Care's Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

Medical Records

Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to medical charts, prescription files, hospital records, Provider specialist reports, consultant and other healthcare professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided. Medical records must be signed and dated.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted only to authorized personnel. Access to records should be granted to Fidelis Care, or its representatives without a fee to the extent permitted by State and federal law. Records remaining in the care, custody and control of the Provider

shall be maintained for a minimum of 10 years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to Fidelis Care upon request at no cost to Fidelis Care. Information from the medical record review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including, but not limited to, confidentiality of Member information and release of records, refer to *Section 8: Compliance* in this Manual.

Provider Participation in the Quality Improvement Program

Participating Providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys, grievances, and calls to Member Services. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report on progress in meeting goals. Fidelis Care evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that address the quality of clinical care and service, trends measured to assess performance in quality of clinical care and quality of service identifies any corrective actions implemented or corrective actions which are recommended or in progress, and any modifications to the QI Program. This report is available as a written document and is posted to the provider portal annually.

Member Satisfaction

On an annual basis, Fidelis Care conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality and access is evaluated. The results are compared to performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS)

Programs promoting patient safety are a public expectation, a legal and professional standard and an effective risk-management tool. As an integral component of healthcare delivery by all inpatient and outpatient Providers, Fidelis Care supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues, and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular check-ups
- Immunizations
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, Pap smears and mammograms

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and the Member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from Participating Providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools, and ongoing monitoring and measuring of outcomes. While Fidelis Care can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

Clinical Practice Guidelines

Fidelis Care adopts validated evidence-based *Clinical Practice Guidelines* (*CPGs*) and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede *CPGs*, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The *CPGs* are based on peer-reviewed medical evidence and are relevant to the population served. *CPGs* are approved by the Quality Improvement Committee and include Preventative Health Guidelines. CPGS may be found on Fidelis Care's website at **fideliscarenj.com/providers/tools/clinical-guidelines**.

New Jersey specific preventive cancer screening requirements:
Fidelis Care complies with the New Jersey requirements to ensure the provision of preventive cancer screening services including, at a minimum, mammography and prostate cancer screening. The program includes the following components:

1. Measurement of Provider compliance with performance standards.
2. Education outreach for both enrollees and practitioners regarding preventive cancer screening services.
3. Mammography services for women ages 65 to 75 offered at least annually
4. Screen for prostate cancer scheduled for enrollees aged 65 to 75 at least every two years.
5. Documentation on medical records of all tests given, positive findings, and actions taken to provide appropriate follow-up care.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®)) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool is comprised of 92 measures across six domains of care, including:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

HEDIS is a mandatory process that occurs annually. The results of Fidelis Care's compliance with the measures are reported annually to the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services (CMS) and the State of New Jersey. Providers can request a copy of the results. The HEDIS process is an opportunity for Fidelis Care and its Providers to demonstrate the quality and consistency of care that is available to Members. Medical records and claims data are reviewed to ensure the required data are captured. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Members benefit from the quality and effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Diamond Designation™ Program

The Diamond Designation ™ Program provides ratings on the quality and efficiency of care across 14 different specialty areas; however, specialties vary per market. The specific specialties included for New Jersey Medicaid are listed below. The Program emphasizes quality over efficiency. Provider ratings are determined and reported at a medical practice/group level based on Tax Identification Number.
We aim to update the Diamond Designation™ Program at least every two years with the Program Year 2024 update becoming effective during the first half of 2024.

Specialty Types Included in Program Year 2024 for New Jersey Medicaid

Specialty Types	
Gastroenterology	Neurology
General Surgery	Ophthalmology
Nephrology	Podiatry

Some primary care providers want to understand more about the quality and efficiency of specialty physicians and other clinicians. Rating results from the Program are made available to our primary care providers to potentially consider as they refer patients to specialty care. Individuals are advised to consider all relevant factors and that Program ratings should not be the sole basis of their decision-making.

The Diamond Designation™ Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians as well as members. The health plan seeks to produce evaluation results that are as accurate as possible. Ratings from the Diamond Designation™ Program are only a partial evaluation of quality and efficiency and should not solely serve as the basis for specialist provider selection (as such ratings have a risk of error). Other factors may be important in the selection of a specialist. The Program and its results are not utilized to determine payment under pay-for-performance programs. Specialty Provider groups evaluated within the Program have the opportunity to request a change or correction to information used in determining their efficiency or quality scores.

For additional information regarding the Diamond Designation™ Program, please visit **DiamondDesignation.com.** This site includes a description of the most current methodology used in determining Program ratings and specific instructions for Providers to submit requests for reconsideration of their results. The health plan values Provider feedback and welcomes comments and questions. Please send them by email to **ContactUs@DiamondDesignation.com**.

Web Resources

Fidelis Care periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the Fidelis Care website. Please check Fidelis Care's website frequently for the latest news and updated documents at **fideliscarenj.com/providers/Medicaid**.

Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

Overview

Fidelis Care's Utilization Management (UM) Program is designed to meet contractual requirements with federal regulations and the Agency while providing Members access to high quality, cost-effective, Medically Necessary care.

The focus of the UM program is on:

- Evaluating requests for services by determining the Medical Necessity, efficiency, appropriateness and consistency with the Member's diagnosis and level of care required.
- Providing access to medically appropriate, cost-effective healthcare services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers.
- Reducing overall expenditures by developing and implementing programs that encourage preventive healthcare behaviors and Member partnership.
- Facilitating communication and partnerships among Members, families, Providers, Delegated Entities and Fidelis Care in an effort to enhance cooperation and appropriate utilization of healthcare services.
- Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology.
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical healthcare services.

Medically Necessary Services

In order for services to be considered Covered Services, the service(s) must meet Medical Necessity criteria. Please see *Section 12: Definitions* for the definition of Medically Necessary services.

The fact that a Provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services Medically Necessary or a Covered Service.

In accordance with 42 CFR 440.230, each Medically Necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

Fidelis Care's UM Program includes components of Prior Authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on the Fidelis Care Member's coverage, the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.

Fidelis Care does not reward its associates or any practitioners, physicians, other individuals or entities performing UM activities for issuing denials of coverage, services or care. Fidelis Care does not provide financial incentives to encourage or promote underutilization.

Criteria for Utilization Management Decisions

Fidelis Care's UM Program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license and professional knowledge and/or clinical expertise in the related healthcare specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM Program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Milliman Clinical Guidelines (MCG)
- Fidelis Care *Clinical Coverage Guidelines*
- American Society of Addiction Medicine (ASAM) Criteria for Substance Use Disorders
- State Medicaid/NJ FamilyCare contract
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid/NJ FamilyCare and Medicare guidelines
- Hayes health technology assessment

The clinical reviewer and/or Medical Director involved in the UM process will apply Medical Necessity criteria in context with the Member's individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member's needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services. The phone number is listed on the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Utilization Management Process

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by NCQA® requirements, contractual requirements or a combination of both.

Fidelis Care forms for the submission of notifications and authorization requests can be found on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/forms**.

Notification

Notifications are communications to Fidelis Care with information related to a service rendered to a Member or a Member's admission to a facility. Notification is required for:

- Prenatal services. This enables Fidelis Care to identify pregnant Members for inclusion into the Care Coordination Program. Obstetrical Providers are required to notify Fidelis Care of a Member's pregnancy via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite care management and claims reimbursement.
- A Member's admission to a hospital. This enables Fidelis Care to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name and admitting diagnosis.

Referrals

A referral is a request by a PCP for a Member to be evaluated and/or treated by a Participating specialty Provider. A written or faxed script to the specialist is required. The specialist must document receipt of the request for a Consultation and the reason for the referral in the medical record. No communication with Fidelis Care is necessary. A copy of the medical Consultation and diagnostic results should be submitted to the Member's mental health or substance abuse Provider, if applicable. Fidelis Care does not require authorization for the initial or subsequent visits when the Member is evaluated by a Participating Provider. Referral to a non-participating provider requires authorization by Fidelis Care.

Providers in the NJFC Program are not required to submit referrals to LIBERTY Dental for approval and there is no reimbursement for referrals. General dentists are not required to attempt specialty care services that are outside of their scope of practice, prior to referral. In the event a general or specialty care dentist submits a referral to LIBERTY, the referring dentist is not required to supply diagnostic documentation as part of the referral request.

Any PCP or PCD may refer a Member to a Participating dental specialist. A list of dental specialists can be found on Fidelis Care's website at **findaprovider.fideliscarenj.com/ and on our dental vendor, Liberty Dental Plan's website at: Liberty Dental Plan**

All final decisions regarding denials of referrals to non-participating dental providers for dental services shall be made by a licensed New Jersey dentist/dental specialist.

Prior Authorization

Prior Authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care, within the most appropriate setting. Prior Authorization may be obtained by the Member's PCP, treating specialist or facility. Reasons for requiring Prior Authorization may include:

- Review for Medical Necessity
- Appropriateness of rendering Provider

- Appropriateness of setting
- Care and disease management considerations
- Review out of network Provider requests

Prior Authorization is **required** for elective, non-urgent or non-emergency services as designated by Fidelis Care. Prior Authorization requirements by service type may be found on the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** or on the searchable Authorization Look-up Tool.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the Member and Provider demographic information, the diagnosis to be treated and the CPT code describing the anticipated procedure, and any pertinent clinical information to support the request.
- A Prior Authorization may be given for a series of visits or services related to an episode of care. The Prior Authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective, non-urgent or non-emergency admission and late submission of a request for Prior Authorization will result in a denial.

Prior Authorization requirements by service type may be found on the *Quick Reference Guide* **fideliscarenj.com/providers/Medicaid** or on the searchable authorization Look-up Tool at **wellcare.com/New-Jersey/Providers/Authorization-Lookup**.

MLTSS Prior Authorization

To check the status of a Prior Authorization (medical, behavioral, pharmacy, dental) or changes to a Prior Authorization, please visit the secure provider portal at **fideliscarenj.com** or call Provider Services at **1-888-453-2534**.

For information regarding the status of a Prior Authorization for LTC (PCA, Medical Day Care, PDN, or HCBS), please call **1-855-642-6185**.

Fidelis Care's process for Prior Authorization acknowledgement includes a response to the request and/or a request for additional information. There is no formal acknowledgement policy in place. However, Providers may call Provider Services at **1-888-453-2534** to inquire on Prior Authorization requests not received within 15 days.

Dental Prior Authorization

Consideration for Prior Authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the

dentist may sequentially submit several Prior Authorization requests, one for each of the various stages of the treatment.

All final decisions regarding denials for non-emergency dental Prior Authorizations shall be made by a licensed New Jersey dentist/dental specialist. Prior Authorization decisions for non-emergency dental services shall be made within 14 calendar days or sooner as required by the needs of the enrollee.

Also note that if the documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service (s) may approve the service (s) which are supported by the submitted documentation.

Prior Authorization Guidelines for Treatment In the Operating Room and Ambulatory Surgical Center for Members with Special Healthcare Needs (SHCN) and children under the age of 5 years old.

Care for Members with Special Healthcare Needs ("SHCN") and children under the age of 5 years old may require treatment to be performed in a hospital setting/operating room ("OR") or ambulatory surgical center ("ASC") facility setting as an outpatient service.

Providers must notify LIBERTY during the credentialing and contracting process of all hospital privileges. For payment purposes, completion of a Site Application Form must be completed by the Provider for each OR/ASC location. These forms are available by contacting LIBERTY's Provider Relations Department or by download from LIBERTY Dental Plan's Resource Library: **libertydentalplan.com/Providers/Provider-Resource-Library.aspx.**

Providers should follow the same guidelines as indicated in the Member's plan benefit schedule when submitting a request for Prior Authorization and/or payment when dental treatment is performed in an OR ASC setting. Fidelis Care Member plan benefit schedules include the covered CDT codes, Prior Authorization requirements, benefit limitations and the specific documentation required for approval. Plan benefit schedules may change from time to time. The most current plan benefit schedules for a specific Member can be requested by contacting LIBERTY's Member Services Department at **1-888-352-7924** and are also available on the provider portal, on the "Member Eligibility" Screen. LIBERTY is responsible for payment of all covered dental procedures, while Fidelis Care is responsible for payment of all approved facility charges (room, board and anesthesia).

LIBERTY offers care management services for SHCN Members and children under the age of 5 years old. These can be requested by contacting our Member Services Department. Our Care Managers are trained to help Members and Providers arrange services. They'll work one-on-one to help coordinate oral healthcare needs.

To do this, they:

- May ask questions to get more information about a Member's health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help Members understand their illness;

- Will provide information to help Members understand how to care for themselves and how to access services, including local resources; and
- Will coordinate authorizations for dentally required hospitalizations by consulting with Fidelis Care's dental and medical consultants in an efficient and time-sensitive manner.

Submission Guidelines

Claims and requests for Prior Authorization when services are rendered in a facility setting can be submitted to LIBERTY in one of the following ways:

- Via provider portal: **libertydentalplan.com**
- Via third party clearinghouse

Liberty EDI Vendor	Phone Number	Website	Payer ID
Dentalxchange	1-800-576-6412	**Dentalxchange.Com**	CX083
Change Healthcare	1-877-363-3666, Prompt 1	**Changehealthcare.Com**	Cx083
Tesia	1-800-724-7240 Ext. 6	**Tesia.Com**	CX083

- Via mail

  LIBERTY Dental Plan ATTN: Claims Department
  PO Box 401086
  Las Vegas, NV 89140

Claims billed to LIBERTY with CDT code D9420 (Hospital or ambulatory surgical center call) must include the correct Place of Service Code as indicated by CMS. For a comprehensive Place of Service Code Set List, please visit: **cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.**

Place of Service Code(s)	Place of Service Name	Place of Service Description
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or

		institutionalization. (Description change effective January 1, 2016)
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Additionally, all claims billed with CDT code D9420 must include the address of where the treatment was actually rendered (the address of the facility) in box 56 on the standard ADA claim form.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X_____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

When to Request Prior Authorization from Fidelis Care:

LIBERTY recommends that Providers coordinate with the OR/ASC setting directly in order to obtain approval from Fidelis Care for the facility charges. Fidelis Care's Authorization Intake Department will process requests for room, board and anesthesia by phone **1-888-453-2534** or fax **1-888-339-6339**.

Clinical Criteria for Medical Exception

When submitting a request to Fidelis Care for the facility charges, the following must be included:

- Authorization Type – OPH (hospital setting) or AMS (ambulatory surgery center)
- Date of Request
- Date the services are to be completed
- Requesting Provider
- Facility Name
- Place of Service (22 or 24)
- Service Detail: Room, board and anesthesia "Pay Facility Charges Only"
- CPT Codes are usually 00170 and 41899
- Appropriate ICD-10 Code

The codes that relate to clinical criteria for medical exceptions/disabilities/special needs are listed below:

E75-E756, F03-F0391, F06-F068, F07-F079, F09, F48-F489, F53, F60-F609, F70, F71, F72, F73, F78, F79, F84-F849, F88, F89, F90-F909, F91-F919, G10, G25-G259, G31-G319, G40-G409, G71-G719, G72-G729, G73-G737, G80-G809, G93-G939, P04-P049, Q86, Q90-Q99, R56-R569, S06-S069X9, F819, I6783, P154, P158, P159.

Resubmission of Denied Services
Providers have 365 days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for missing documentation, incorrect coding and/or processing errors.

In cases where Prior Authorization is denied, the denial documentation contains a detailed explanation of the reason(s) for denial; indicates whether additional information is needed and the process for reconsideration. Additionally, denial documentation includes the name and contact information of the LIBERTY Staff Dentist or Dental Consultant that reviewed and denied the treatment request which will allow the Provider an opportunity to discuss the case.

NJ FamilyCare Dental Services Clinical Criteria Policy/Grid

The NJFC program has established a clinical criteria policy for dental services. Please see the link below for a full description of the clinical criteria policy/guidelines and grid.

- **libertydentalplan.com/Providers/Provider-Resource-Library.aspx**

Medical Versus Dental Services:
Medical conditions may exist that can exhibit one or more dental components. Examples of medical procedures that have dental components but are covered under the Fidelis Care medical benefit are serious medical conditions such as cleft palate and cleft lip; underdeveloped upper or lower jaw (maxillary/mandibular micrognathia); overdeveloped lower jaw (extreme mandibular prognathism); severe asymmetry (craniofacial anomalies); jaw does not move (ankylosis of the temporomandibular joint); and other significant skeletal deformities (dysplasias).

Dental services that are covered through Fidelis Care's dental benefit via LIBERTY Dental Plan include all common CDT codes outlined in the LIBERTY benefit schedules for Fidelis Care, e.g., diagnostic, preventive, restorative, prosthodontic, endodontic, periodontic and oral surgery.

For additional information regarding dental Prior Authorizations, go to LIBERTY Dental Plan's website at **libertydentalplan.com.**

Authorization Request Forms
Fidelis Care requests that Providers use Fidelis Care's standardized Prior Authorization request forms to ensure receipt of all pertinent information and to enable a timely response to Provider requests, including:

- *Inpatient Authorization Request Form* is used to request Prior Authorization for elective/non-urgent inpatient, observation, skilled nursing facility and rehabilitation admissions
- *Outpatient Authorization Request Form* is used to request Prior Authorization for services such as genetic testing, select outpatient hospital procedures, out-of-network services and transition of care. Prior Authorization requirements by service type may be found on the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** or on the searchable authorization Look-up Tool at **wellcare.com/New-Jersey/Providers/Authorization-Lookup**
- *Durable Medical Equipment (DME) Ancillary Services Request Form* is used to request Prior Authorization for durable medical equipment, orthotics and prosthetics, and items such as motorized wheelchairs, insulin pumps and Dynasplint® systems
- *Skilled Therapy Services Request Form* is used to request Prior Authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services
- *Home Health Services Request Form* is used to request Prior Authorization for home health services including skilled nursing, physical therapy and other services rendered in a home setting
- *Personal Care Assistant/Medical Day Care Request Form* is used to request Prior Authorization for PCA services, Adult Medical Day Care, Pediatric Medical Day Care services

To ensure timely and appropriate Prior Authorization processing and claims payment, all forms must:

- Have all required fields completed
- Be typed or printed in black ink for ease of review
- Contain a clinical summary or have supporting clinical information attached

Incomplete forms are not processed and will be returned to the requesting Provider. If Prior Authorization is not granted, all associated claims will not be paid.

All forms are located on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/forms**. All forms should be submitted via fax to the number listed on the form.

In no instance may the limitations or exclusions imposed by Fidelis Care be more stringent than those specified in the Medicaid/NJ FamilyCare Handbooks.

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic or on-site chart review and communication with the attending physician, hospital Utilization Manager, Care Management staff, or hospital clinical staff involved in the Member's care.

Concurrent review is initiated as soon as Fidelis Care is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan, and discharge planning activity. The continued length of stay authorization will occur concurrently based on nationally recognized criteria (e.g. Milliman Clinical Guidelines [MCG], InterQual™) for appropriateness of continued stay to:

- Ensure services are provided in a timely and efficient manner
- Make certain that established standards of quality care are met
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify cases appropriate for Care Management

Reviews are performed by licensed clinical reviewers under the direction of the Fidelis Care Medical Director.

To ensure the review is completed in a timely manner, Providers must submit notification and clinical information on the next business day after the admission, as well as upon request of the Fidelis Care review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The concurrent review nurse works with the attending physician, hospital discharge planner, ancillary Providers, and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to Care Management for in-facility outreach.

Retrospective Review

A Retrospective review is any review of care or services that have already been provided. There are two types of Retrospective reviews which Fidelis Care may perform:

- Retrospective review initiated by Fidelis Care:
  - Fidelis Care requires periodic documentation including, but not limited to, the medical record (UB and/or itemized bill) to complete an audit of the Provider submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Fidelis Care to support accurate coding and claims submission.
- Retrospective review initiated by Providers:
  - Fidelis Care will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with Fidelis Care retroactively or in cases of emergency treatment and the payer is not known at the time of service.
  - The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the Member's needs at the time of service.

Fidelis Care will also identify quality issues, utilization issues and the rationale behind failure to follow Fidelis Care's Prior Authorization/pre-certification guidelines.

Fidelis Care will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If Fidelis Care is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the UM Department via Provider Services. Refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Peer-to-Peer Discussion of Adverse Determination

In the event Medical Necessity is not established with clinical information provided, a peer-to-peer discussion is offered to the treating and/or requesting Provider. The peer-to-peer review may be conducted prior to rendering a Medical Necessity decision, or in the event of an adverse determination following a Medical Necessity review, offered to the treating physician on the Notice of Action Communication (reconsideration).The Notice of Action includes a toll-free number to the Medical Director Hotline to request a discussion with a Fidelis Care Medical Director. The reconsideration peer-to-peer discussion is offered within seven business days following the receipt of the faxed adverse determination notification.

The review determination notification contains instructions on how to use the peer-to-peer process.

Services Not Requiring Authorization

Fidelis Care has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members, including:

- Many routine services do not require Prior Authorization. A searchable authorization look-up tool is available on Fidelis Care's Provider website.
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories, and Provider offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require Prior Authorization regardless of place of service:
    - Reproductive laboratory tests
    - Molecular laboratory tests
    - Cytogenetic laboratory tests
- Certain tests described as CLIA-waived may be conducted in the Provider's office if the Provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to Fidelis Care

All services performed without Prior Authorization are subject to Retrospective Review by Fidelis Care.

Fidelis Care Adverse Actions

An adverse action is an action taken by Fidelis Care to deny a request for services. In the event of an adverse action, Fidelis Care will notify the Member and the requesting Provider in writing of the adverse action. The notice will contain the following:

- The action Fidelis Care has taken or intends to take
- The reason(s) for the action
- The Member's right to appeal
- The Member's right to request a State hearing
- Procedures for exercising the Member's rights to appeal or file a grievance
- Circumstances under which an expedited resolution is available and how to request it
- The Member's rights to have services continue pending the resolution of the appeal, how to request that services be continued and the circumstances under which the Member may be required to pay the costs of these services

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any Member of the healthcare team, including a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified Participating Provider, or Fidelis Care shall arrange for the Member to obtain one outside the network if there is not a Participating Provider with the expertise required for the condition. The second opinion shall be provided at no cost to the Member.

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex, and/or chronic medical or dental conditions.

LIBERTY Dental Plan has a Second Opinion Program that can be used at the enrollee's option for diagnosis and treatment of dental conditions for elective surgical procedures, when a dentist recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the dentist failed to diagnose. The program can also be used at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the LIBERTY network or LIBERTY may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. Network Dentist(s) should refer these Members to the Member Services Department at **1-888-352-7924**, Monday through Friday, 8 a.m. to 5 p.m. PST.

Additional Services

Fidelis Care will provide additional services for Members who have special needs. Fidelis Care will allow:

- Methods to identify those at risk who should be referred for a Complex Needs

Assessment;
    - Methods to identify those at risk for nursing home level of care such as increased assistance with activities of daily living and behavioral issues such as wandering and inappropriate social behaviors including verbal and physical abuse;
    - Methods and guidelines of determining specific needs of referred individuals such as review of the Initial Health Screening, completion of the Complex Needs Assessment and creation of the Individualized Care Plan;
- Assure required services are furnished;
    - Allow for continuation of existing relationships with non-participating providers when single case agreements are needed;
    - Referrals to special care facilities for highly specialized care;
- Standing referrals for long-term specialty care;
    - Responding to crisis situations after hours for Members with special needs by using the 24-hour Nurse Advice Line and the 24-hour Behavioral Health Crisis Line;
    - Provision for dental services for enrollees with developmental disabilities to ensure that the Members receive proper treatment up to 4 visits annually are allowed without the need for Prior Authorization.
    - A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider.
- A notice that a Member with (i) a life-threatening condition or disease or (ii) a degenerative and/or disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist or specialty care center responsible for providing or coordinating the Member's medical care and the procedure for requesting and obtaining such a specialist or access to the center.
- Reimbursement for initial and follow-up dental visits which typically require up to 60 minutes to allow for a comprehensive dental examination and other relevant services (including, but not limited to: radiographs, prophylaxis, nonsurgical periodontal treatment, the application of fluoride and dental sealants, thorough inquiries regarding patient medical histories, and consultations with caregivers to ensure a thorough understanding of proper dental management during visits).
- To ensure that the Member receives proper treatment, up to four visits annually are allowed without Prior Authorization.
- Home visits are allowed when Medically Necessary and where available.
- Reimbursement for the costs of pre-operative and post-operative evaluations associated with dental surgery performed on patients with developmental disabilities. Preauthorization is not required for dental procedures performed during surgery on these patients for dental appropriate restorative care provided under general anesthesia. Informed consent, signed by the enrollee or authorized person, must be obtained prior to the surgical procedure. Fidelis Care's dental vendor, LIBERTY Dental, may review these procedures as part of a post- payment review process.
- Reimbursement for the cost of providing oral hygiene instructions to caregivers to maintain a patient's overall health between dental visits. In situations where the treating dentist recommends a non-standard, specialized toothbrush to improve a

Member's oral hygiene, the device will be included as a benefit. These provisions will include the design and implementation of a "dental management" plan, coordinated by the Care Manager for overseeing a patient's oral health.

- The health plan's Care Manager will be responsible to coordinate authorizations for dentally required hospitalizations with the dental and medical consultants in an efficient and time-sensitive manner.

Care plans will be developed to address the specific service requirements (such as durable medical equipment, skilled therapy services, home healthcare and transportation) of Members identified as having complex needs.

The specific needs of referred Members are assessed during the CNA, including condition-specific issues. The CNA includes the following:

- Initial assessment of the Member's medical, dental and behavioral health status, including condition specific issues
- Assessment of comorbidities
- Documentation of clinical history including current and past medications, disease onset, key events such as acute phases, inpatient stays and treatment history
- Documentation of frequency and quantity of drug and/or alcohol use
- Initial assessment of the activities of daily living such as eating, bathing and mobility
- Initial assessment of mental health status, including cognitive functions and psychosocial factors such as the ability to communicate, understand instructions and process information about their illness
- Initial assessment of life-planning activities (if the Member is more than 18 years old)
- If expressed life-planning activities are not on record, the Care Manager determines if such a decision is appropriate during the first contact, based on the Member's circumstances and provides life-planning information if appropriate
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of dental, visual and hearing needs, preferences or limitations
- Evaluation of caregiver resources and involvement, such as involvement in and decision making about the care plan
- Evaluation of available benefits within the organization and from community resources
- Assessment of care gaps

Fidelis Care will identify Members at risk for unnecessary or inappropriate nursing facility admission using its Initial Health Screen, and Comprehensive Needs Assessment or the NJ Choice Assessment System. Additionally, Fidelis Care will use other referral sources such as State agencies, self-referrals, network Providers and algorithms.

The following conditions/diagnoses place an aged Member at risk for long-term institutionalization and will be referred to Care Management (this is not an all-inclusive list):

- Cognitive disorders

- Division of Developmental Disabilities (DDD) Members
- Progressive neuromuscular disorders
- Multiple comorbid conditions
- Non-compliance
- Lack of social/caregiver support
- Frequent Emergency Department/inpatient utilization
- Homelessness

Fidelis Care works with the Member's Primary Care Provider, formal and informal caregivers as well as the Member once the risk for institutionalization is identified to develop and implement a comprehensive plan to avoid institutionalization when not Medically Necessary. Ongoing efforts to assist in avoiding institutionalization will be monitored quarterly and results shared with individual Providers.

Members will be referred to Behavioral Healthcare Management based on the outcome of the Patient Health Questionnaire (PHQ-9) screening. Members with a PHQ-9 score of 15 or greater are referred to Behavioral Healthcare Manager for anticipated referral to psychiatrist for an evaluation, if Member is not currently under treatment by a psychiatrist. The Care Manager will conduct the CNA in the medical management system.

Care Managers will collaborate with Providers, Members, parents, caregivers, or guardians to ensure that access to all Covered Services are available for Members with special needs whose disabilities substantially impeded activities of daily living.

Care Management will follow all policies and procedures to allow for the continuation of existing relationships with non-participating providers, when appropriate Participating Providers are not available within network, or it is otherwise considered by the contractor to be in the best medical interest of the Member with special needs.

If Fidelis Care or the PCP, in Consultation with Fidelis Care's Medical Director and a specialist, if any, determines that the Member's care would most appropriately be coordinated by such specialist/specialty care center, Fidelis Care shall refer the Member. Care Managers will collaborate in order to facilitate the Member's care by a specialty care center.

Care Managers will assist Members, parents, caregivers or guardians in scheduling dental appointments with a dental Provider with expertise in the dental management of Members with developmental disabilities. Fidelis Care will consider all current Providers of dental services to Members with developmental disabilities to be Participating Providers.

For all children, including children with Special Healthcare Needs, the Care Managers will collaborate with the child's Providers, parent, caregivers or guardian to ensure access to health promotion, disease prevention, well-child care and specialty care. Further, Care Management will follow all policies and procedures to allow for the continuation of existing relationships with non-participating providers, when appropriate Participating Providers are not available within network, or it is otherwise considered by the Care Manager to be in the best medical interest of the child with special needs.

Nurse Advice Line

Members, parents, caregivers, or guardians are provided the Nurse Advice Line, **1-800-919-8807** 24 hours a days, 7 days a week. This number is provided in Member letters, Member Handbooks, the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** and Care Management correspondence.

The Nurse Advice Line will be available to answer phone calls of Members, guardians, parents or caregivers who need to speak with a nurse. The Care Management team is sent referrals from the Nurse Advice Line to follow up and assess Care Management needs.

Behavioral Health Crisis Line

In the event of a crisis, Providers and Members can call the toll-free Behavioral Health Crisis Line 24 hours a day at **1-800-411-6485**.

During a call to the crisis line, the crisis staff:

- Assesses the nature of the presenting problem
- Determines the level of urgency to the problem according to Fidelis Care's acuity standards: emergent, urgent or routine
- Provides service intervention that is relevant to the level of risk of the problem, including organizing immediate emergency response
- Refers any caller who needs local response or intervention to the local contracted Providers
- Stays on the line to ensure that a solid hand-off of the call has been made or ensure that local **911** responders are able to coordinate an intervention

Conditions Considered to be Both Medical and Dental

Precertification submission is required from network specialty Providers (oral maxillofacial surgeons, physician specialist or prosthodontists) for surgical cases with appropriate diagnostic medical and/or dental necessity. For procedures that may be considered either medical or dental such as surgical procedures involving fractured jaw removal of cysts, tumors, and maxillofacial prosthetics, we have established written policies and procedures that clearly and definitively describe whether physician specialist or oral surgeon for all Providers and administrative staff, indicating that either a physician specialist, maxillofacial oral surgeon or prosthodontist may perform the procedure and when, where and how authorization, if needed shall be promptly obtained.

All services performed at an inpatient facility for oral surgery require Prior Authorization. To verify if a Prior Authorization is necessary or to obtain a Prior Authorization for outpatient services, please refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

A Provider's medical staff bylaws requiring that an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute Medical Necessity, nor is reimbursement guaranteed when the Member or family requests an assistant surgeon be present for the procedure. Coverage and subsequent

reimbursement for an assistant surgeon's service is based on the Medical Necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure.

Service Authorization Decisions

To ensure all service authorization policies are adhered to, the timeframes outlined below will be followed. These provisions are in effect if the Member did not have an emergency situation where immediate care was required and/or the health and well-being of the Member was not compromised.

Determination	Timeframe	Details
Routine determinations	Within 14 calendars days	Prior authorization determinations for non-urgent services are made and communicated via telephone or in writing to the Provider within fourteen (14) calendar days (or sooner as required by the needs of the Member) of receipt of necessary information sufficient to make an informed decision. **Prior authorization denials and limitations are provided in writing.**
Urgent determinations	Within 24 hours	Prior authorization determinations for urgent services are made within twenty-four (24) hours of receipt of the necessary information, but no later than seventy-two (72) hours after receipt of the request for service. Written notification is provided.
Post Service determinations	Within 30 days	Determinations involving healthcare services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.
Continued/Extended determinations	1 business day/Within 24 hours	Prior authorization determination involving continued or extended healthcare services, or additional services for continued services/treatments will be determined and communicated by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of hospital service or emergency room care, the determination involving continued or extended healthcare services is made within 24 hours.

Standard Service Authorization

Fidelis Care will provide a service authorization decision as expeditiously as the Member's health condition requires and within the State-established time frame which will not exceed 14 calendar days. Fidelis Care will provide an authorization response to the Provider verbally or in writing by faxing the response to the fax number(s) included on the Prior Authorization request form.

Expedited Service Authorization

In the event the Provider indicates, or Fidelis Care determines, that following the standard time frame could seriously jeopardize the Member's life or health, Fidelis Care will make an expedited authorization determination and provide notice within 24 hours of receipt of necessary information but no later than 72 hours of the request.

Members and Providers may file a verbal request for an expedited decision. Requests for expedited decisions for Prior Authorization should be requested by telephone, not fax, or Fidelis Care's online Provider portal. Please refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid** to contact the UM Department via Provider Services.

Urgent Concurrent Authorization

A Prior Authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within 24 hours of receipt of the request.

Emergency/Urgent Care and Post-Stabilization Services

Emergency services, including both medical and dental services, are not subject to Prior Authorization requirements and are available to Members 24 hours a day, seven days a week. Urgent care services should be provided within one day. See *Section 12: Definitions* for definitions of "Emergency Services" and "Urgent Care." Urgent Care services are provided as necessary and are not subject to Prior Authorization or pre-certification.

If a Provider calls Fidelis Care's Provider Services Department to obtain Prior Authorization for emergency medical and/or dental services, Fidelis Care will inform the Provider Prior Authorization is not required. Providers may contact the Provider Services Department by referring to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Post-stabilization services are services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member's condition. Post-stabilization services are covered without Prior Authorization up to the point Fidelis Care is notified that the Member's condition has stabilized.

Continuity of Care

Fidelis Care will allow Members in active treatment to continue care with a terminated treating Provider, when such care is Medically Necessary, in accordance with N.J.A.C 11:24-

3.5, as amended, and the terms of the Agreement. The PCP is responsible for the overall clinical direction and coordination of the Member's healthcare, including initiating referrals for specialty care and other Medically Necessary services, both in network and out of network and maintaining the Member's comprehensive medical record. If Fidelis Care's network is unable to provide necessary covered services, Fidelis Care will support referrals to an out of network provider to ensure Members receive needed care in a timely manner.

Transition of Care

During the first 30 days of enrollment, Prior Authorization is not required for certain Members with previously approved services by the State or another managed care plan. Fidelis Care will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside Fidelis Care's network until such time as Fidelis Care can reasonably transfer the Member to a service and/or Participating Provider without impeding service delivery that might be harmful to the Member's health. However, notification to Fidelis Care is necessary to properly document these services and determine any necessary follow-up care.

When relinquishing Members, Fidelis Care will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider.

For MLTSS Members, when Fidelis Care becomes aware that a covered Member will be disenrolled from Fidelis Care and will transition to another managed care plan, a Fidelis Care Review Nurse/Care Manager who is familiar with that Member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program. For all Fidelis Care Members receiving care management services at the time of disenrollment, Fidelis Care will arrange for the transfer of electronic care management records to the receiving plan or the provider assuming responsibility for care management services of the Member within 14 days of request by the Member, the Member's representative, the receiving plan or the care management Provider. Fidelis Care will ensure that network Providers furnishing authorized care to Members are notified within 14 days of the Member's disenrollment and are provided contact information for the receiving plan and/or the provider assuming responsibility for care management services.

If a Provider receives an adverse claim determination which they believe was a Transition of Care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation of Agency/CMO approval for reconsideration. Providers can refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid** for the Appeals Department contact information.

Care Management Program

Overview

Care Management refers to a set of Member-centered, goal-oriented and culturally relevant steps to assure that a Member receives needed healthcare services. The Care Management Program emphasizes prevention, health promotion, continuity of care and coordination of

care, as necessary across Providers and settings to achieve the least restrictive and most integrated setting of care. The goals of the Care Management Program include:

- Provide access to timely, appropriate, accessible, and Member-centered healthcare
- Improve the quality of care and health outcomes for Members
- Tailor care to the Members' needs by using evidence-based treatment, best practices and practice-based evidence to manage services by duration, scope and severity
- Ensure health plans involve Members and their family in the care process
- Reduce emergency room visits and avoidable hospitalizations
- Promote effective and ongoing health education and disease prevention activities
- Provide cost-effective care
- Promote information sharing and transparency

In an effort to achieve optimal Member outcomes, the aim of the Care Management Program is to provide supportive, effective, resourceful and timely service coordination in the most cost-efficient manner available. Therefore, the following Care Management functions are provided:

- Early identification of Members who have or may have special needs
- Assessment of a Member's risk factors, utilizing the New Jersey specific tools for assessment of Members
- Development of an individualized plan of care
- Referrals and assistance to ensure timely access to Providers
- Coordination of care linking the Member to Providers, medical services, dental services, residential, social, behavioral and other support services where needed
- Monitoring; continuity of care; follow-up and documentation

Role of the Care Manager

The Interdisciplinary Care Team (ICT) is a group comprised of individuals and Providers who have an impact on the health and well-being of the Member. The team is comprised of the Member, Care Manager, PCP, and other caregivers, specialists, and home care Providers. The role of the Care Manager is to provide communication and collaboration among the healthcare team for optimal coordination of care and goal attainment. As the facilitator, the Care Manager will:

- Conduct a Comprehensive Needs Assessment (CNA) that identifies Member needs and barriers to care
- Develop an individualized care plan with the Member/caregiver and the PCP, establish and prioritize self-management goals, and identify needed resources, plan interventions and review outcomes
- Coordinate with the ICT to facilitate seamless communication, coordination and delivery of services with all relevant participants in the care of the medically fragile Member
- Appropriately generate referrals to healthcare professional services such as behavioral health, pharmacy, medical, dental and other specialized practitioners when needed
- Coordinate transitions of care for Member by assisting with navigating today's complex healthcare system and accessing Provider, public and private community-

based resources
- Educate and assist Members with understanding diseases/conditions and resources necessary to address medical needs
- Assess and monitor Member's adherence with the Provider's plan of care

Care Management

Care Management activities, a component of Care Management, is a set of activities tailored to meet a Member's situational health-related needs. Situational health needs are time-limited episodes of instability. Care Managers will expedite access to services, both clinical and non-clinical, by connecting the Member to resources that support him/her in playing an active role in the self-direction of his/her healthcare needs.

Care Management activities also emphasize prevention, continuity of care, and coordination of care. Care Management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased Member satisfaction; adherence to the care plan; improved Member safety; and, to the extent possible, increased Member self-direction.

Individuals with Special Healthcare Needs (ISHCN)

Children with Special Healthcare Needs – Those children who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Enrollee with Special Needs – For adults, special needs include complex/chronic medical conditions requiring specialized healthcare services and persons with physical, mental/Substance Use Disorder, and/or developmental disabilities, including persons who are eligible for the MLTSS program. See also "Children with Special Healthcare Needs".

ISHCN are adults and children/adolescents who face physical, mental or environmental challenges daily that place their health and ability to fully function in society at risk. Factors include:

- Individuals with intellectual disabilities or related conditions
- Individuals with serious chronic illnesses, such as HIV, schizophrenia or degenerative neurological disorders
- Individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes
- Children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care

ISHCN Members will be identified for referral for a Comprehensive Needs Assessment (CNA) by a review of hospital and pharmacy utilization. Additionally, Providers can refer Members and Members can self-refer.

Providers who render services to Members who have been identified as having chronic or life-threatening conditions should:

- Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member's condition or needs:
    - To obtain a standing authorization, the Provider should complete the appropriate authorization request form and document the need for a standing authorization request under the pertinent clinical summary area of the form.
    - The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care.
- Coordinate with Fidelis Care to ensure each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the Member.
- Ensure that Members requiring specialized medical care over a prolonged period of time have access to a specialty care Provider. Members will have access to a specialty care Provider through standing authorization requests, if appropriate.

Member Identification and Referral

All Members, with the exception DDD Membership, will receive the NJ Initial Health Screening (IHS) within 90 days of enrollment. Members who score 5 or more on the screening tool will be referred to Care Management for additional outreach and completion of the CNA. Additional triggers which may indicate the need for a CNA may be obtained from the following data sources:

- Claims and/or encounter data
- SNP Member identification from enrollment reports
- Hospital discharge
- Pharmacy
- Utilization Management
- Data supplied by Member and/or caregiver (Health Risk Assessments)
- Data supplied by practitioners, if applicable

Referral sources for identification and consideration of Members appropriate for Care Management services include, but are not limited to, the following:

- Utilization Management
- Disease Management
- BH and SUD
- Intake
- Practitioners/Provider
- Members or their caregivers (self-referral)
- Hospital Discharge Planners
- Health Information Line
- State Regulators

Fidelis Care's dental vendor, LIBERTY Dental Plan, offers Care Management services to children and adults with special healthcare needs. A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD

requires a consultation for services by that specialty Provider. Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the Provider conducting the screening examination, or to another Provider, as appropriate.)

All Fidelis Care Members have access to care management services. Members appropriate for care management referral may include, but are not limited to Members who:

- Are developmentally disabled.
- Are homebound.
- Are identified as needing assistance in accessing or using services.
- Have long-term or complex health conditions, like asthma, diabetes, HIV/AIDS and high-risk pregnancy.

Care Managers are trained to help Providers, children and adults to arrange services (including referrals to special care facilities for highly- specialized care) that are needed to manage treatment. LIBERTY'S goal is to help Members with special needs understand how to take care of themselves and maintain good oral health.

Fidelis Care's dental vendor, LIBERTY Dental Plan's Care Management Program offer children and adults a Care Manager and other outreach workers. They will work one-on-one to help coordinate oral healthcare needs. To do this, they:

- May ask questions to get more information about a Member's health conditions.
- Will work with PCPs and PCDs to arrange services needed and to help Members understand their illness.
- Will provide information to help Members understand how to care for themselves and how to access services, including local resources.

Additional dental diagnostic, preventive and periodontal services shall be allowed every three months to enrollees with special needs when Medical Necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

Prior Authorization Guidelines for Treatment In the Operating Room and Ambulatory Surgical Center for Members with Special Healthcare Needs (SHCN) and children under the age of 5 years old

Care for Members with Special Healthcare Needs ("SHCN") and children under the age of 5 years old may require treatment to be performed in a hospital setting/operating room ("OR") or ambulatory surgical center ("ASC") facility setting as an outpatient service.

Providers must notify LIBERTY during the credentialing and contracting process of all hospital privileges. For payment purposes, completion of a Site Application Form must be completed by the Provider for each OR/ASC location. These forms are available by contacting LIBERTY's Provider Relations Department or by download from LIBERTY Dental Plan's Resource Library: **libertydentalplan.com/Providers/Provider-Resource-Library.aspx.**

Providers should follow the same guidelines as indicated in the Member's plan benefit schedule when submitting a request for Prior Authorization and/or payment when dental treatment is performed in an OR ASC setting. Fidelis Care Member plan benefit schedules include the covered CDT codes, Prior Authorization requirements, benefit limitations and the specific documentation required for approval. Plan benefit schedules may change from time to time. The most current plan benefit schedules for a specific Member can be requested by contacting LIBERTY's Member Services Department at **1-888-352-7924** and are also available on the provider portal, on the "Member Eligibility" Screen. LIBERTY is responsible for payment of all covered dental procedures, while Fidelis Care is responsible for payment of all approved facility charges (room, board and anesthesia).

LIBERTY offers care management services for SHCN Members and children under the age of 5 years old. These can be requested by contacting our Member Services Department. Our Care Managers are trained to help Members and Providers arrange services. They'll work one-on-one to help coordinate oral healthcare needs.

To do this, they:

- May ask questions to get more information about a Member's health conditions;
- Will work with PCPs and PCDs to arrange services needed and to help Members understand their illness;
- Will provide information to help Members understand how to care for themselves and how to access services, including local resources; and
- Will coordinate authorizations for dentally required hospitalizations by consulting with Fidelis Care's dental and medical consultants in an efficient and time-sensitive manner.

Submission Guidelines

Claims and requests for Prior Authorization when services are rendered in a facility setting can be submitted to LIBERTY in one of the following ways:

- Via Provider Portal: **libertydentalplan.com**
- Via third party clearinghouse

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	**1-800-576-6412**	**dentalxchange.com**	CX083
Change Healthcare	**1-877-363-3666, prompt 1**	**changehealthcare.com**	CX083
Tesia	**1-800-724-7240 ext. 6**	**www.tesia.com**	CX083

- Via mail at:

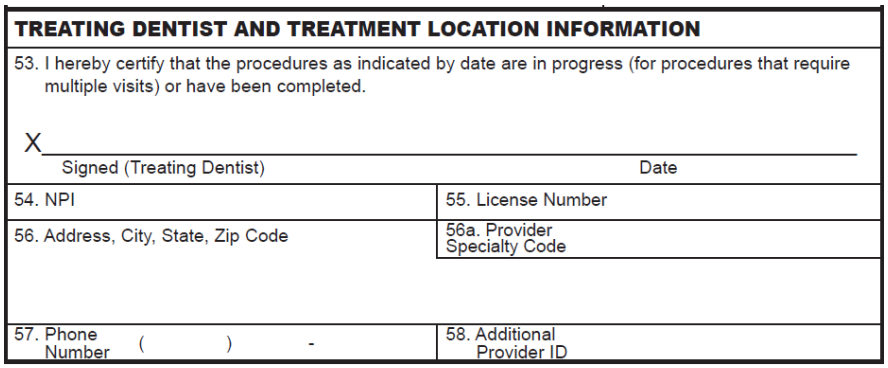
LIBERTY Dental Plan ATTN: Claims Department
PO Box 401086

Las Vegas, NV 89140

Claims billed to LIBERTY with CDT code D9420 (Hospital or ambulatory surgical center call) must include the correct Place of Service Code as indicated by CMS. For a comprehensive Place of Service Code Set List, please visit: **cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set**

Place of Service Code(s)	Place of Service Name	Place of Service Description
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Additionally, all claims billed with CDT code D9420 must include the address of where the treatment was actually rendered (the address of the facility) in box 56 on the standard ADA claim form.



TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X_____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

When to Request Prior Authorization from Fidelis Care

LIBERTY recommends that Providers coordinate with the OR/ASC setting directly in order to obtain approval from Fidelis Care for the facility charges. Fidelis Care's Authorization Intake Department will process requests for room, board and anesthesia by phone **1-888-453-2534** or fax **1-888-339-6339**.

Clinical Criteria for Medical Exception
When submitting a request to Fidelis Care for the facility charges, the following must be included:

- Authorization Type – OPH (hospital setting) or AMS (ambulatory surgery center)
- Date of Request
- Date the services are to be completed
- Requesting Provider
- Facility Name
- Place of Service (22 or 24)
- Service Detail: Room, board and anesthesia "Pay Facility Charges Only"
- CPT Codes are usually 00170 and 41899
- Appropriate ICD-10 Code

The codes that relate to clinical criteria for medical exceptions/disabilities/special needs are listed below:

E75-E756, F03-F0391, F06-F068, F07-F079, F09, F48-F489, F53, F60-F609, F70, F71, F72, F73, F78, F79, F84-F849, F88, F89, F90-F909, F91-F919, G10, G25-G259, G31-G319, G40-G409, G71-G719, G72-G729, G73-G737, G80-G809, G93-G939, P04-P049, Q86, Q90-Q99, R56-R569, S06-S069X9, F819, I6783, P154, P158, P159.

Resubmission of Denied Services
Providers have 365 days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for missing documentation, incorrect coding and/or processing errors.

In cases where Prior Authorization is denied, the denial documentation contains a detailed explanation of the reason(s) for denial; indicates whether additional information is needed and the process for reconsideration. Additionally, denial documentation includes the name and contact information of the LIBERTY Staff Dentist or Dental Consultant that reviewed and denied the treatment request which will allow the Provider an opportunity to discuss the case.

Please refer to Fidelis Care NJFC Provider Reference Guide for more detailed information at: **libertydentalplan.com/Resources/Documents/NJ%20FamilyCare%20PRG.pdf**

Care Monitoring
Care Monitoring allows the Care Management Team member to follow the Member's status throughout the continuum of care without the Member's participation. Care monitoring affords the Care Manager the ability coordinate the Member's care with the ICT and to

monitor the Member's status for trigger events (i.e., frequent emergency room visits, claims, pharmacy trends, and other predictive model indicators) and identify potential health plan resources to the PCP, specialist, and/or community agencies involved in the care of the Member. Care Monitoring involves outreach to the Member's PCP and other Providers as necessary to coordinate Provider services and ensure continuity of care. Members identified for care management through a score of 5 + of the NJ IHS who are unable to reach or refuse/decline consent for Care Management as well as Members required to be in Care Management by program or contractual requirements (such as DDD, HIV, lead toxicity, cognitively impaired, Department of Children Protection and Permanency (DCP&P) Members) and refuse to actively engage in Care Management activities, may be placed in "Care Monitoring" status.

Transition of Care

Fidelis Care may receive referrals to assist Members with the Transition of Care between clinical settings, levels of care, health plans or Providers. Provider engagement and cooperation is essential in supporting the Member's plan of care. Care Managers and coordinators are in place to assist the Interdisciplinary Care Teams in facilitating these transition efforts. To do so, they will outreach to the most appropriate person, Provider, agency or entity to secure the information required for Utilization Management, Care Management or resource planning. For assistance in transitional planning, the Provider may contact the Care Management toll-free line.

Provider Engagement

Fidelis Care seeks to engage Providers and raise awareness regarding the services available to Members. This includes informing Providers of the availability of the Care Management Program via the Provider Manual, Provider newsletter articles, and the Fidelis Care Website and Portal. Additionally, the Care Management Program engages Providers by sharing Care Plans and ensuring active communication within the Interdisciplinary Care Team.

Referrals

If Providers would like to refer a Member to the Care Management Program, please call **1-855-642-6185**, 8 a.m. to 5 p.m. or refer to the *Quick Reference Guide* which is available on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

Disease Management Program

Overview

Disease Management (DM) is a population-based strategy that involves consistent care across the continuum for Members with certain disease states. Elements of the program include education of the Member about the particular disease and self-management techniques, monitoring of the Member for adherence to the treatment plan and the consistent use of validated, industry-recognized evidence-based *Clinical Practice Guidelines* by the treatment team as well as the Disease Manager. Fidelis Care's Disease Management Program is an Opt-Out Program; therefore all Members with the diagnoses listed below are automatically assigned to the Program. Once a Member is assigned to the Disease

Management Program, Fidelis Care begins Member outreach to provide Disease Management education.

The DM Program targets the following conditions:

- Asthma – adult and pediatric
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes – adult and pediatric
- Hypertension
- Depression
- Smoking Cessation

Fidelis Care's DM Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid and appropriate medication management. The program also focuses on educating the Provider regarding the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs. In addition, Fidelis Care makes available to Providers and Members general information regarding health conditions on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/quality**.

Candidates for Disease Management

Fidelis Care encourages referrals from Providers, Members, hospital discharge planners and others in the healthcare community.

Interventions for Members identified vary depending on the Member's level of need and stratification level. Interventions are based on industry-recognized *CPGs.* Members identified at the highest stratification levels receive a Comprehensive Needs Assessment (CAN) by a DM nurse, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific *CPGs* adopted by Fidelis Care are on Fidelis Care's website at **fideliscarenj.com/providers/tools/clinical-guidelines**.

Access to Care and Disease Management Programs

If a Provider would like to refer a Fidelis Care Member as a potential candidate to the CM Programs or the DM Program or would like more information about one of the programs, the Provider may call the Care Management Referral Line or complete and fax the *Care Management Referral Form* on Fidelis Care's Provider website. Members may self-refer by calling the Care Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY/TTD available).

For more information on the Care Management Referral Line, refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

Section 5: Claims

Overview

The focus of the Claims Department is to process claims in a timely manner. Fidelis Care has established toll-free telephone numbers for Providers to access a representative in Fidelis Care's Provider Services Department. For more information on claims submission, refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

Fidelis Care (in partnership with PaySpan®) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed.

Register online using the simplified, enhanced Provider registration process at **payspanhealth.com** or call **1-877-331-7154**.

PaySpan Health Support can be reached via email at **providersupport@payspanhealth.com**, by phone at **1-877-331-7154** or on the web at **payspanhealth.com.**

Timely Claims Submission

Unless otherwise stated in the Agreement, Provider must submit claims (initial and voided) within 180 calendar days from the date of service or the date of discharge for inpatient services. Providers must submit corrected claims within 365 calendar days from the date of service or the date of discharge for inpatient services. Unless prohibited by New Jersey State law or the Agency, Fidelis Care may deny payment for any claims that fail to meet Fidelis Care's submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof if a "Clean" Claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Fidelis Care
- A Provider's electronic submission sheet with all the following identifiers:
    - Patient name

- Provider name
- Date of service to match Explanation of Benefits (EOB)/claim(s) in question
- Prior submission bill dates
- Fidelis Care product name or line of business

The following items are not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter
- A copy of the Provider's billing screen

Tax Identification (TIN) and National Provider Identification (NPI) Requirements

Fidelis Care requires the payer-issued Tax Identification Number (Tax ID/TIN) and National Provider Identifier (NPI) on all claim submissions, with the exception of atypical Providers. Atypical Providers must pre-register with Fidelis Care before submitting claims to avoid NPI rejections. Fidelis Care will reject claims without the Tax ID and NPI. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the Centers for Medicare & Medicaid Services (CMS) website at **cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.**

Taxonomy

Providers should submit claims with the correct taxonomy code consistent with Provider Demographic Information for the Covered Services being rendered in order to be reimbursed at the appropriate rate. Fidelis Care may pay the claim at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

Preauthorization Number

If a preauthorization number was obtained, Providers must include this number in the appropriate data field on the claim.

National Drug Codes (NDC)

Fidelis Care follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process

All claims and encounter transactions submitted via paper, Direct Data Entry (DDE), or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.

If a claim is rejected for lack of compliance with Fidelis Care's claim and encounter submission requirements, the rejected claim should be resubmitted as a new submission within timely filing limits. For more information on Encounters, see the *Encounters* section of this Manual.

Claims Submission Requirements

Fidelis Care requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. Fidelis Care requires all diagnosis coding to use ICD-10, or its successor, as mandated by CMS. Refer

to *Compliance Section* for additional information. In addition, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis (is) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be used rather than reporting the tests or procedures individually.

When presenting a claim for payment to Fidelis Care, the Provider understands that:

- The Provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services identified on the claim form
- The Provider must supervise and be responsible for preparation and submission of the claims
- The Provider must present a claim that is true and accurate and that it is for Covered Services that:
    - Have actually been furnished to the Member by the Provider prior to submitting the claim
    - Are Medically Necessary

Providers using electronic submission shall submit all claims to Fidelis Care or its designee, as applicable, using the HIPAA compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or Non-Covered Services. Covered Services are established by the Member's benefit plan. For more information on paper submission of claims, refer to the *Quick Reference Guide* which is on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Electronic Claims Submissions

Fidelis Care accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Fidelis Care must be in the ANSI ASC X12N format, version 5010A or its successor. For more information on EDI implementation with Fidelis Care, refer to the Fidelis Care *Companion Guides* on the Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/claims**.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a Fidelis Care contracted clearinghouse, to establish EDI with Fidelis Care. For a list of Fidelis Care contracted clearinghouse(s), for information on the unique Fidelis Care Payer Identification (Payer ID) numbers used to identify Fidelis Care on electronic claims submissions or to contact Fidelis Care's EDI team, refer to the *Provider*

Resource Guide or *Quick Reference Guide* available on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Electronic Visit Verification

Fidelis Care is in compliance with CMS regulations concerning Electronic Visit Verification (EVV). EVV is currently in place for certain Provider types as CMS rolls out the process to eventually cover most at home services or services where the Provider travels to the Member. Check with your Fidelis Care Provider Relations Representative for more information about your potential need for participation in this program.

Fidelis Care works with a third party EVV aggregator who handles the registration, scheduling of visits, clock in and out of the Provider on-site, and the claims generation once the visit is verified. Fidelis Care cannot accept any claims directly from a Provider who falls under the EVV mandate by CMS. All claims for Covered Services must come through the EVV system.

Providers included by CMS will be required to go through EVV training in order to utilize the scheduling/verification/billing system.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as Fidelis Care, as well as Providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

Specific Fidelis Care requirements for claims and encounter transactions, code sets and SNIP validation are described herein. *To promote consistency and efficiency for all claims and encounter submissions to* Fidelis Care*, it is* Fidelis Care*'s policy that these requirements also apply to all paper and DDE transactions.*

For more information on EDI implementation with Fidelis Care, refer to the Fidelis Care *Companion Guides* on the Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/claims**.

Paper Claims Submissions

For timely processing of claims, Providers are encouraged to submit claims electronically. Claims not submitted electronically may be subject to penalties in outlined the Agreement. For assistance in creating an EDI process, contact Fidelis Care's EDI team by referring to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

- Paper claims must only be submitted on an original (red ink on white paper) claim forms
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly
- Per CMS guidelines, the following process should be used for Clean Claims submission:

- **The information must be aligned within the data fields and must be:**
  - On an original red-ink-on-white-paper claim forms
  - Typed. Do not print, handwrite or stamp any extraneous data on the form
  - In black ink
  - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type
  - In capital letters
- **The typed information must not have:**
  - Broken characters
  - Script, italics or stylized font
  - Red ink
  - Mini font
  - Dot matrix font

CMS Fact Sheet about CMS-1500
cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

CMS Fact Sheet about UB-04
cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

Sterilization and Hysterectomy Claims
Federally prescribed documentation regulations for sterilization procedures are extremely rigid.

A **Consent for Sterilization** form (7473-M ED 3-81) must be attached to every sterilization claim including tubal ligation, vasectomy or similar procedures which are intended to permanently prevent pregnancy. The individual who has given voluntary consent for a sterilization procedure must sign the form at least 30 days prior to the procedure, be at least 21 years old at the time the consent is obtained and must be mentally competent.

Hysterectomy claims are required to have a **Hysterectomy Receipt of Information** form (FD-189) attached. Hysterectomy procedures must have a primary indication other than sterilization. The claim can be paid without a FD-189 signed by the patient prior to the procedure only if the physician certifies that the Member was already sterile at the time of the hysterectomy, or that the procedure was due to a life-threatening emergency and prior acknowledgement was not possible.

See **fideliscarenj.com/providers/Medicaid/forms** on the Fidelis Care Provider website for copies of these forms.

Claims Processing

Readmission

Fidelis Care may choose to review claims if data analysis deems it appropriate. Fidelis Care may review hospital admissions on a specific Member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the Provider), Fidelis Care will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by Fidelis Care, may be subject to a recoupment.

Disclosure of Coding Edits

Fidelis Care uses claims editing software programs to assist in determining proper coding for Provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and State-specific regulations. These software programs may result in claim edits for specific procedure code combinations. They may also result in adjustments to the Provider's claims payment or a request for review of medical records, prior to or subsequent to payment, that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to Fidelis Care. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service, and thus Providers must not bill or collect payment from Members for such reductions in payment.

Prompt Payment

Fidelis Care will pay Clean Claims within 30 days after receipt when submitted electronically, or 40 days after receipt when submitted in a manner other than electronically, in accordance with New Jersey Department of Banking and Insurance Regulation (N.J.A.C.11:22-1.1, et. seq.). Note that a healthcare Provider's submission of a Clean Claim to Fidelis Care's billing agent or clearinghouse does not constitute receipt by Fidelis Care.

Coordination of Benefits

Fidelis Care shall coordinate payment for Covered Services in accordance with the terms of a Member's benefit plan and applicable State and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Fidelis Care. Any balance due after receipt of payment from the primary payer should be submitted to Fidelis Care for consideration, and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the EOB. Fidelis Care may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Fidelis Care policies and procedures regarding subrogation activity.

The following applies for Members covered under more than one insurance policy at a time:

- If a claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. Fidelis Care has the capability of receiving EOB

information electronically. To submit other insurance information electronically, refer to the Fidelis Care *Companion Guides* which may be found on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/claims**.

- If Fidelis Care has information on file to suggest the Member has other insurance, Fidelis Care may deny the claim
- If the primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. In the event a claim was denied for other coverage, the Provider must resubmit the claim with proof that coverage was terminated
- If benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds Fidelis Care's liability, no additional payment will be made
- If the primary carrier pays less than Fidelis Care's liability, Fidelis Care will pay the difference up to the allowed amount, not to exceed any amount that constitutes the Member's responsibility

Encounters Data

Overview

This section is intended to provide delegated vendors and Providers (IPAs) with the necessary information to allow them to submit Encounter data to Fidelis Care. If Encounter data does not meet the Service Level Agreements (SLA) for timeliness of submission, completeness or accuracy, federal agencies have the ability to impose significant financial sanctions on Fidelis Care. Fidelis Care requires all delegated vendors and delegated Providers to submit Encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission

Unless otherwise stated in the Agreement, vendors and Providers should submit complete and accurate Encounter files to Fidelis Care as follows:

- Encounters submission will be weekly;
- Capitated entities will submit within 10 calendar days of service date; and
- Non-capitated entities will submit within 10 calendar days of the paid date.

The above requirements apply to both corrected claims (error correction Encounters) and cap-priced Encounters.

Accurate Encounters Submission

All Encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP Levels 1 through 5 shall be maintained. Once Fidelis Care receives a delegated vendor's or Provider's Encounters, the Encounters are loaded into Fidelis Care's Encounters system and processed. The Encounters are subjected to a series of SNIP edits to ensure that the Encounter has all the required information, and that the information is accurate.

More information on WEDI SNIP Edits can be found at the WEDI™ white paper link at **wedi.org/knowledge-center.**

For more information on submitting Encounters electronically, refer to the Fidelis Care *Companion Guides* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/claims**.

Vendors are required to comply with any additional Encounters validations as defined by New Jersey and/or CMS, as applicable.

Encounters Data Types

There are four Encounter types that delegated vendors and Providers are required to submit to Fidelis Care. Encounter records should be submitted using the HIPAA standard transactions for the appropriate service type. The four Encounter types are:

- Dental – 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

This document is intended to be used in conjunction with Fidelis Care's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides.

Encounters submitted to Fidelis Care from a delegated vendor or Provider can be a new, voided or a replaced/overlaid Encounter. The definitions of the types of Encounters are as follows:

- New Encounter: an Encounter that has never been submitted to Fidelis Care previously
- Voided Encounter: an Encounter that Fidelis Care deletes from the Encounter file and is not submitted to the State
- Replaced or Overlaid Encounter: an Encounter that is updated or corrected within the Fidelis Care system

Encounters Submission Methods

Delegated vendors and Providers may submit Encounters using several methods: electronically, through Fidelis Care's contracted clearinghouse(s), via DDE or using Fidelis Care's Secure File Transfer Protocol (SFTP) process. SFTP is the preferred submission method.

Submitting Encounters Using Fidelis Care's SFTP Process (Preferred Method)

Fidelis Care accepts electronic Encounters submission through EDI as its preferred method of submission. Encounters may be submitted using Fidelis Care's SFTP process. Refer to Fidelis Care's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit Encounters electronically using SFTP. For more information on EDI implementation with Fidelis Care, refer to Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/claims**.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a Fidelis Care contracted clearinghouse, to establish EDI with Fidelis Care. For a list of Fidelis Care contracted clearinghouse(s), for information on the unique Fidelis Care Payer Identification (Payer ID) numbers used to identify Fidelis

Care on electronic claims submissions, or to contact Fidelis Care's EDI team, refer to the *New Jersey Medicaid Provider Resource Guide*, which may be found on Fidelis Care's website.

Submitting Encounters Using Direct Data Entry

Delegated vendors and Providers may submit their Encounter information directly to Fidelis Care using Fidelis Care's DDE portal. The DDE tool can be found on the secure online provider portal at **provider.fideliscarenj.com**. For more information on free DDE options, refer to the *New Jersey Medicaid Provider Resource Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Balance Billing

Providers shall accept payment from Fidelis Care for Covered Services provided to Fidelis Care Members in accordance with the compensation terms outlined in the Agreement. Payment made to Providers constitutes payment in full by Fidelis Care for Covered Services, with the exception of Member expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Fidelis Care's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and Members are to be held harmless for Covered Services.

Provider-Preventable Conditions (PPCs)

Fidelis Care follows CMS guidelines regarding "Hospital Acquired Conditions," "Never Events," and other "Provider-Preventable Conditions (PPCs)." Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure on the wrong patient

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/06_Hospital-Acquired_Conditions.**

Healthcare Providers may not bill, attempt to collect from, or accept any payment from Fidelis Care or the Member for PPCs or hospitalizations and other services related to these non-covered procedures.

Reopening and Revising Determinations

A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the Provider to submit the requested documentation within 90 days of the denial to reopen the case.

All decisions to grant reopening are at the sole discretion of Fidelis Care.

Disputed Claims

The claims appeal process is designed to address claim denials for issues related to:

- Payment disputes or any other administrative dispute
- Untimely filing
- Incidental procedures
- Bundling
- Unlisted procedure codes
- Non-covered codes
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a healthcare Provider
- Inappropriate or unapproved referrals initiated by a Provider
- Any other reason for billing disputes
- No action or payment is required of the enrollee due to any of the disputes listed on this page.

The provider will have the right to contest the denial of any claim in accordance with N.J.A.C. 11:22-1.6. Claim payment disputes must be submitted to Fidelis Care in writing within 90 calendar days of the date of denial on the EOP. Any appeal or grievance between a Provider and Fidelis Care requires no action of the Member.

Such procedures shall not be applicable to any disputes that may arise between Fidelis Care and any Provider regarding the terms, conditions, or termination or any other matter arising under contract between the Provider and Fidelis Care.

Documentation must include:

- Date(s) of service
- Member name
- Member Fidelis Care ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN
- Total billed charges
- Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

To initiate the process, please refer to the Quick Reference Guide located on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** or mail to:

Fidelis Care
Attn: Claim Payment Disputes
P.O. Box 31370

Tampa, FL 33631-3370

Note: Any appeals related to claim denial for lack of Prior Authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in *Section 7: Appeals* and noted below:

Medical Appeals:
Fidelis Care
Attn: Medical Appeals Dept.
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

Examples include exclusion codes listed on the Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE. However, this is not an all-encompassing list of codes addressed by the medical Appeals Department. Anything else related to authorization, or Medical Necessity that is in question should be sent to the Appeals P.O. Box, noted above, with all substantiating information like a summary of the appeal, relevant medical records and Member-specific information.

Corrected Claims or Voided Claims

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

How to submit a corrected or voided claim electronically:

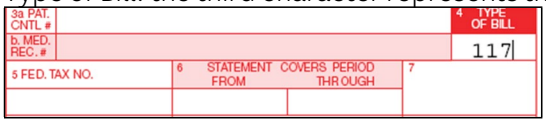
- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8'– indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be 'the original claim number'– the control number assigned to the original bill (original claim reference number for the claim intended to be replaced.)
- Example: REF✻F8✻ Fidelis Care Claim number here~

These codes are not intended for use for original claim submission or rejected claims.

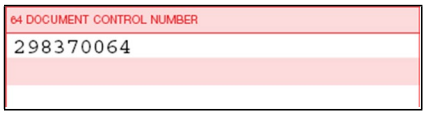
To submit a corrected or voided claim via paper:

- For Institutional claims, the Provider must include the original Fidelis Care claim number and bill frequency code per industry standards.

Example:
Box 4 – Type of Bill: the third character represents the "Frequency Code"



Box 64 – Place the Claim number of the Prior Claim in Box 64



- For Professional claims, the Provider must include the original Fidelis Care claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible) – and noted "*Payment lost/voided/missed*." This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted "*Adjusted per corrected bill*." This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The Payment Reversal for this process may generate a negative amount, which will appear on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

The Member has no responsibility and is not to be involved in in corrected and voided claim disputes. For more information on corrected and voided claim disputes, refer to "Provider Appeals" in *Section 7*.

Reimbursement

Fidelis Care applies the CMS site-of-service payment differentials in its fee schedules for Current Procedural Terminology (CPT) codes based on the place of treatment (physician office services versus other places of treatment).

Surgical Payments

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications –** A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by the Fidelis Care Medical Director regarding whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination –** One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges –** Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on Agency policy.
- **Multiple Procedures –** Payment for multiple procedures is based on current CMS or Agency percentages methodologies, as applicable. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon –** Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. Fidelis Care uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.
- **Co-Surgeon –** Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report her or his distinct, operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.

Modifiers

Fidelis Care follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Allied Health Providers

Fidelis Care follows the Agency's reimbursement guidelines regarding Allied Health Professionals. If the Agency does not have such reimbursement guidelines, Fidelis Care will follow CMS reimbursement guidelines for Allied Health Providers.

Recoupment Policy and Procedures – Overpayment Recoveries

Fidelis Care strives for 100% payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

Fidelis Care will proactively identify and attempt to correct inappropriate payments. In situations where the inappropriate payment caused an overpayment, Fidelis Care will adhere to New Jersey Law, L. 2005, c. 352 (**njleg.state.nj.us/2004/Bills/PL05/352_.HTM**) and limit its notice of retroactive denial to 18 months from the original payment date. These time frames do not apply to fraudulent or abusive billing for which there is no deadline for Fidelis Care to seek recovery from the Provider. Fidelis Care or its designee will provide a written notice to the Provider identifying the specific claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address Fidelis Care has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 days for the Provider to send in the refund, request further information, appeal or dispute the retroactive denial.

Failure of the Provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by Fidelis Care, or its designee, to arrange payment.

If the Provider independently identifies an overpayment, Fidelis Care requires the Provider to: 1) report that an overpayment has been received; 2) return the overpayment within 60 calendar days of the date the overpayment was identified; and 3) notify Fidelis Care in writing as to the reason for the overpayment to:

Fidelis Care
P.O. Box 31584
Tampa, FL 33634

For more information on contacting Fidelis Care Provider Services, refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

Benefits during Disasters and Catastrophic Events

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Fidelis Care will:

- Waive in full requirements for Prior Authorization or pre-notification
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts
- Waive the 30-calendar day notification requirement to Members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the Member

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed 30 calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, Fidelis Care should resume normal operations 30 calendar days from the initial declaration.

For institutional claims, the condition code will be DR or modifier CR. For professional claims, the modifier will be CR Code.

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate Fidelis Care staff evaluates the credentials and training qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this credentialing section, all references to "practitioners" shall include Providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations.

The credentialing review includes (as applicable to practitioner type):

- Background
- Education
- Postgraduate training
- Certification(s)
- Experience
- Work history and demonstrated ability
- Patient admitting capabilities
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide healthcare
- Accreditation status, as applicable to non-individuals

Practitioners are required to be credentialed prior to being listed as Participating Providers of care or services to Fidelis Care Members.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner's credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with State and federal regulatory agencies, accreditation and Fidelis Care policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be Participating Providers of services to Fidelis Care Members
- Satisfactory site inspection evaluations are required to be performed in accordance with State and federal accreditation requirements
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider

Credentialing may be done directly by Fidelis Care or by an entity approved by Fidelis Care for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Fidelis Care's criteria to ensure that the credentialing capabilities of the Delegated Entity clearly meet federal and State accreditation (as applicable) and Fidelis Care requirements. The Delegated Entity's contract may be subject to review and approval by the Agency prior to the entity performing any delegated services.

All Participating Providers or entities delegated for credentialing are to use the same standards as defined in this section and as set forth in the Agreement. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

Practitioner Rights

Practitioner Rights are listed below and are included in Fidelis Care's credentialing application and re-credentialing application and cover letter.

Practitioner's Right to Be Informed of Credentialing/Re-Credentialing Application Status

Upon receipt of a written request, Fidelis Care will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/Re-Credentialing Application

The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any Fidelis Care restrictions. Fidelis Care, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or re-credentialing.

The Provider may not review peer review information obtained by Fidelis Care.

Practitioner's Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Fidelis Care, the practitioner has the right to review the information that was submitted in support of her or his application, and to correct the erroneous information. Fidelis Care will provide written notification to the practitioner of the discrepant information.

Fidelis Care's written notification to the practitioner includes:

- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source
- The format for submitting corrections
- The time frame for submitting the corrections
- The addressee in the Credentialing Department to whom corrections must be sent
- Fidelis Care's documentation process for receiving the correction information from the Provider
- Fidelis Care's review process

Baseline Criteria

The baseline criteria for practitioners to qualify for Provider network participation are:

- **License to Practice**: Practitioners must have a current, valid, unrestricted license to practice
- **DEA Certificate**: Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the State where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for MD/DO/DPM) Dentists must have, or have confirmations of application submission of, valid DEA and CDS certificates
- **Work History**: Practitioners must provide a minimum of five years of relevant work history as a health professional
- **Board Certification**: Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for Fidelis Care or must have verifiable educational/training from an accredited training program in the specialty requested. Dental specialists must have met the NJ Board requirements for that specialty and have a current specialty permit. A dentist with certification in the following specialties: Endodontics, Oral Maxillofacial Surgery, Periodontics, and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any Provider that holds a valid DEA or CDS certificate must submit it.
- **Hospital-Admitting Privileges**: Specialist practitioners shall have hospital-admitting privileges at a Fidelis Care -participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Fidelis Care Participating Provider who has admitting privileges at a Fidelis Care -participating hospital, for the admission of Members
- **Ability to Participate in Medicaid/NJ FamilyCare and Medicare**: Providers must have the ability to participate in Medicaid/NJ FamilyCare and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Fidelis Care Company plan. Existing Providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with Fidelis Care policy and procedure.

Liability Insurance

Fidelis Care Participating Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits required by the State of New Jersey and as set forth in the Agreement, unless otherwise agreed by Fidelis Care in writing.

Providers must furnish copies of current professional liability insurance certificate to Fidelis Care, concurrent with expiration.

Fidelis Care will make an exception to its Professional Liability Insurance guidelines for Board Certified physicians who reside in rural areas or if there is a network deficiency. The exception still requires $1 million/$2 million instead of $1 million/$3 million.

Site Inspection Evaluation

Site Inspection Evaluations (SIEs) are conducted in accordance with federal, State and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:

- Office-site criteria
- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment record keeping criteria

SIEs are conducted for:

- Unaccredited facilities without a State or CMS SIEs to provide
- When a grievance is received relative to office-site criteria

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of Member grievances. SIEs are conducted for those sites where a grievance is received relative to the office-site criteria listed above. SIEs may be performed for an individual grievance or quality of care concern if the severity of the issue is determined to warrant an on-site review.

Covering Physicians

Primary Care Providers in solo practice must have a covering physician who also participates with, or is credentialed with, Fidelis Care.

Allied Health Professionals

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Fidelis Care.

Dependent AHPs include the following, and are required to provide collaborative practice information to Fidelis Care:

- Advanced Registered Nurse Registered Nurse Practitioners (ARNPs)
- Certified Nurse Midwife (CNMs)
- Physician Assistant (PAs)
- Osteopathic Assistant (OAs)

Independent AHPs include, but are not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapist
- Audiologist
- Speech/language therapist/pathologist

Ancillary Healthcare Delivery Organizations

Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. Fidelis Care is required to verify accreditation, licensure, Medicaid/NJ FamilyCare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a Fidelis Care Provider.

Re-Credentialing

In accordance with applicable federal and State laws, rules, and regulations, accreditation organizations, and Fidelis Care's policies and procedures, re-credentialing is required at least once every three years.

Updated Documentation

In accordance with contractual requirements, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to Fidelis Care prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, Fidelis Care or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against the network of Providers. If Providers are identified as being currently sanctioned, such Providers are subject to immediate termination and notification of termination of contract, in accordance with Fidelis Care policies and procedures.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, Fidelis Care, or its designee, contacts State licensure agencies to obtain the most currently available information on sanctioned Providers. This information is cross-checked against the network of Fidelis Care Providers. If a Participating Provider is identified as being currently under sanction, appropriate action is taken in accordance with Fidelis Care policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Fidelis Care policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the

Credentialing/Peer Review Committee. The committee makes a determination as to whether the Provider should continue participation or whether termination should be initiated.

Provider Appeal through the Dispute Resolution Peer Review Process

Fidelis Care may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the Medical Director, is engaging in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of Members. In such instances, the Medical Director will investigate on an expedited basis.

Fidelis Care has a Participating Provider dispute resolution peer review panel process in the event Fidelis Care chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies. The Participating Provider dispute resolution peer review panel process does not apply to credentialing and re-credentialing decisions.

Delegated Entities

All Participating Providers or entities delegated for credentialing are to use the same standards as defined in this section and the terms of the Agreement. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. For further details, please refer to *Section 9: Delegated Entities*.

Section 7: Grievances and Appeals

Overview

Fidelis Care offers a telephone help line for Providers to call and initiate a grievance, ask questions and get resolution to problems. The toll-free help line will be available during business hours, and the number can be found on the *Quick Reference Guide* available on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**. Help line staff are trained and educated on how to accept grievances, resolve complex issues, and address standard inquiries related to Member eligibility, claims and authorization status inquiries.

Actions

Action, at a minimum, means any of the following:

- 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 Member costs in connection with an approved clinical trial
- Denial of access to needed drugs
- 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
- 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

Grievances

Provider Grievances

Providers have the right to file a formal written grievance in the following circumstances:

- Disagree with claim management and standards on drug utilization review
- Are not satisfied with Fidelis Care's policies and procedures, or with a decision made by Fidelis Care
- Disagree with Fidelis Care as to whether a service, supply or procedure is:
    - A covered benefit
    - Medically Necessary
    - Performed in the appropriate setting

Fidelis Care's Grievance Department will resolve Provider grievances and provide written notification within 45 days of receipt.

Providers may not file a grievance on behalf of a Member without written consent from the Member as the Member's representative. The Member grievance process and Member appeals process are listed below this section.

The formal Provider grievance process is in place for in-network Providers and non-participating providers who may complain in writing. This process is not applicable to any disputes that may arise between Fidelis Care and any Provider regarding the terms, conditions or termination or any other matter arising under the Agreement between the Provider and Fidelis Care.

Formal Provider Grievance Submission

A formal Provider grievance must be submitted in writing (within 30 days of the occurrence) to:

Fidelis Care
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

Member Grievances

Members or the Member's representative have the right to file grievances. A grievance may be filed by contacting Fidelis Care's Member Services Department at **1-888-453-2534**. TTY users may call **711**.

To write us, mail to:

Fidelis Care
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

Additional assistance is available for the handling of grievances. Fidelis Care provides Members with reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Providers shall not discriminate against, or attempt to disenroll, a Member for filing a grievance. Within 5 business days of getting a grievance, Fidelis Care will mail the Member a letter. The letter will advise the Member that Fidelis Care received their grievance. If additional information is needed, a letter will be mailed to the Member outlining the additional information required and the reason for the additional information.

Fidelis Care shall coordinate its efforts with the Department's Health Benefits Coordinator (HBC) to refer Members to HBC for assistance as needed in the management of grievance procedures.

A Member or Member's representative acting on the Member's behalf may file a grievance. Examples of grievances that can be submitted include, but are not limited to:

- Provider service including, but not limited to:
    - Timely access issues
    - Rudeness by Provider or office staff
    - Refusal to see a Member (other than in the case of patient discharge from office)
    - Office conditions
- Services provided by Fidelis Care including, but not limited to:
    - Coverage issues
    - Drug utilization review
    - Hold time on telephone
    - Rudeness of staff
    - Involuntary disenrollment from Fidelis Care
    - Unfulfilled requests
- Access availability including, but not limited to:
    - Difficulty getting an appointment
    - Wait time in excess of one hour
    - Accommodations for persons with disabilities

A written description or summary of the appeals and grievances policy and procedure is available upon request to any Member, Provider or facility rendering service. Fidelis Care will not discriminate against a Member or attempt to disenroll a Member for filing a grievance.

A Member or a Member's representative may file a standard grievance request either verbally or in writing.

If the Member wishes to use a representative, then she or he must complete an *Appointment of Representative* (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement. The form is located on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/forms**.

Member Grievance Resolution

A Member or Member's representative shall be notified of the decision as expeditiously as the case requires, based on the Member's health status, but no later than (30 calendar days after the date Fidelis Care receives the verbal or written grievance, consistent with applicable laws and regulations. Fidelis Care will send a written decision letter upon completion of the Member's grievance (within 30 calendar days).

The Grievance Department will inform the Member of the determination of the grievance. All grievances submitted, either verbally or in writing, will be responded to in writing.

Fidelis Care provides all Members with written information about the grievance and appeal procedures/processes available to them. Fidelis Care also provides written information to Members and/or their appointed representative(s) about the grievance procedure at:

- Initial enrollment
- Upon involuntary disenrollment initiated by Fidelis Care
- Upon the denial of a Member's request for an expedited review of a determination or appeal
- Upon the Member's request
- Annually thereafter

Fair Hearings

Medicaid/NJ FamilyCare Plan A and New Jersey FamilyCare ABP Members have the right to request a fair hearing pursuant to 42 CFR Part 431, Subpart E in the event the Member believes her or his Medicaid/NJ FamilyCare benefits have been erroneously terminated, reduced or suspended.

Providers may request a fair hearing on any valid grievance or issue arising out of the Medicaid/NJ FamilyCare claims payment process, exclusive of Fidelis Care's claims processing procedures or issues arising under the Agreement between Fidelis Care and the Provider. A request for a fair hearing must be made within 60 days from the date of the notice of the decision by Fidelis Care or within 120 days to the Department of Human Services from the date of the notice of action letter following an adverse determination resulting from an internal appeal.

If a Member requests a Fair Hearing and wishes to request a continuation of benefits, he or she must do so in writing within 10 days of the date of the denial letter. If the Member requests continuation of benefits under the Medicaid Fair Hearing process and the appeal is denied, the Member may be required to pay for the cost of these services.

A Member's or Provider's written request for a fair hearing should be mailed to:

Department of Human Services
Division of Medical Assistance and Health Services
Fair Hearing Section
PO Box 712
Trenton, NJ 08625-0712

Provider Appeals

Medicaid/NJ FamilyCare Provider Appeals Process

A Provider may request a claim denial reconsideration on his or her own behalf through the secure provider portal at **provider.fideliscarenj.com,** or by mailing or faxing a letter of appeal and/or an appeal form with supporting documentation, such as medical records, to Fidelis Care. Appeal forms are located on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/forms**. Appeals between a Provider and Fidelis Care require no action of the Member. Fidelis Care (neither the Plan's UM committee nor its

utilization review agent) shall take any action with respect to a Member or a healthcare Provider that is intended to penalize or discourage the Member or the Member's healthcare Provider from undertaking an appeal, dispute resolution or judicial review of an Adverse Benefit Determination. Additionally, Fidelis Care shall not take any punitive actions against a Provider who requests an expedited resolution or supports a Member's request for an appeal.

Providers have 90 calendar days from the original utilization management or claim denial to file a Provider appeal. Cases appealed after that time will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, they may submit documentation showing proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Fidelis Care, or similar receipt from another commercial delivery service.

Fidelis Care has 30 calendar days to review the case for Medical Necessity and conformity to Fidelis Care guidelines.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the Provider to submit the requested documentation within 60 calendar days of the denial to reopen the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

Medical records and patient information shall be supplied at the request of Fidelis Care or appropriate regulatory agencies when required for appeals. The Provider is not allowed to charge Fidelis Care or the Member for copies of medical records provided for this purpose.

Dental Provider non-utilization management appeals should be directed to LIBERTY Dental Plan Professional Relations Team Monday through Friday, 5 a.m. to 5 p.m. EST at **1-888-352-7924**, press option 4, or email **prinquiries@libertydentalplan.com.**

Reversal of Adverse Provider Claim Determination

Once all of the relevant information is received, Fidelis Care will make a determination within 30 calendar days. If it is determined during the review that the Provider has complied with Fidelis Care protocols and that the appealed services were Medically Necessary, the denial will be overturned. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal if one has not already been submitted. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision has been made to overturn the denial. Fidelis Care will ensure that claims are processed and comply with federal and State requirements, as applicable.

Affirmation of Adverse Provider Claim Determination

If it is determined during the review that the Provider did not comply with Fidelis Care protocols and/or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing within 30 calendar days.

For denials based on Medical Necessity, the criteria used to make the decision may be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter. The written determination will also include notice to the Provider of the Provider's right to submit to binding arbitration of the matter that was the subject of the formal claim resolution procedure. The Provider must submit this request within 30 calendar days of the receipt of Fidelis Care's written determination.

In the event Fidelis Care fails to deliver a written determination to the Provider within 30 days of the initial receipt of the appeal, such failure on the part of Fidelis Care shall have the effect of a denial by Fidelis Care. The Provider will then have the right to submit the matter to binding arbitration (external review alternative dispute resolution).

Binding Arbitration – External Review Alternative Dispute Resolution

Binding arbitration or an external review alternative dispute resolution (ADR) must be conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the State of New Jersey N.J.A.C. 11:22-10.8, unless the Provider and Fidelis Care mutually agree to some other binding resolution process.

The Provider must submit a written request for an ADR review within 30 calendar days of the receipt of the adverse determination letter.

A claim that is finally determined through Fidelis Care's claim resolution procedure (including ADR) to contain sufficient supporting documentation shall be processed by Fidelis Care within 30 days after the final determination. A claim that is finally determined through Fidelis Care's claim resolution procedure (including ADR) to lack sufficient supporting documentation shall be processed by Fidelis Care within 30 days after the Provider submits to Fidelis Care the requisite supporting documentation. The Provider shall have 30 days after receipt of written notice of the final determination establishing that the claim lacked sufficient supporting documentation to submit the requisite supporting documentation. If supporting documentation is not received within the established timelines, the denial will be upheld and final.

Fidelis Care will maintain a log of all formally filed Provider claim disputes. The logged information will include a Provider's name, date of dispute, nature of dispute and disposition. Fidelis Care will submit to the Department of Human Services regarding the number and type of Provider disputes.

Member Appeals

Appeal Process for UM Determinations

Fidelis Care has policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of a Member who is receiving a service (from Fidelis Care, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, Fidelis Care will continue to provide the same level of service while the determination is in appeal.

1. Fidelis Care (as per the definition in 42 CFR §435.923) will:
    - provide a Member
    - a Provider acting on behalf of a Member with the Member's written consent
    - or an authorized representative acting on behalf a Member

Any UM decision resulting in a denial, termination, or other limitation in the coverage of and access to healthcare services in accordance with the NJ Medicaid Contract may be appealed.

Fidelis Care (neither the Plan's UM committee nor its utilization review agent) shall take any action with respect to a Member or a healthcare Provider that is intended to penalize or discourage the Member or the Member's healthcare Provider from undertaking an appeal, dispute resolution or judicial review of an adverse benefit determination. Additionally, Fidelis Care shall not take any punitive actions against a Provider who requests an expedited resolution or supports a Member's request for an appeal.

Fidelis Care uses State-mandated Notice of Action template letters. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. Members and Providers will be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

Notice of Action

2. Action means, at a minimum, any of the following:
    - 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; and
    - Denial of a service based on lack of Medical Necessity.

Hearings

3. If Fidelis Care provides a hearing to the Member on the appeal, the Member will have the right to representation. Fidelis Care will permit the Member to be accompanied by a representative of the Member's choice to any proceedings and grievances. Hearings will take place in community locations convenient and accessible to the Member.

Fidelis Care will provide the Member with a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Fidelis Care will inform the Member of the limited time available for this sufficiently in advance of the resolution time frame for appeals, including in cases where expedited resolution has been requested.

Fidelis Care will inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. Fidelis Care will inform Members sufficiently in advance of resolution time frames for appeals.

Fidelis Care will provide the Member or their authorized representative the Member's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by Fidelis Care) in connection with the appeal of the Adverse Benefit Determination. The case file will be provided free of charge, and sufficiently in advance of the resolution time frames for standard and expedited appeals.

Utilization Management Appeal Process: Service Denial/Limitation/Reduction/Termination based on Medical Necessity

The Provider, on behalf of the Member, should receive a notification letter within two business days of any decision to deny, reduce, or terminate a service or benefit. If the Member disagrees with the decision, the Provider, on behalf of the Member (with the Member's written permission) can challenge it by requesting an appeal. See the summary below for the timeframes to request an appeal.

Stages	Timeframe for Member/Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached	FamilyCare Plan Type
Internal Appeal The **Internal Appeal** is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by healthcare professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.	60 calendar days from date on initial notification/denial letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the notification letter, ***whichever is later***	30 calendar days or less from health plan's receipt of the appeal request	A /ABP B C D
External/IURO Appeal The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO).	60 calendar days from date on Internal Appeal notification letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, ***whichever is later***	45 calendar days or less from IURO's decision to review the case	A /ABP B C D
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	• ***Whichever is the latest of the following:*** • On or before the last day of the current authorization; ***or***	A final decision will be reached within 90 calendar days of the Fair Hearing request.	A /ABP ***only***

Stages	Timeframe for Member/Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached	FamilyCare Plan Type
		• Within 10 calendar days of the date on the Internal Appeal notification letter, ***or*** • Within 10 calendar days of the date on the External/IURO appeal decision notification letter		

4. The appeal process will consist of an internal review by Fidelis Care and an optional external review by an independent utilization review organization (IURO) administered by the DOBI. Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members also have access to the Fair Hearing process.

    - The Member, Provider acting on behalf of a Member with the Member's written consent, or authorized representative acting on behalf of the Member, will have 60 days from receipt of the notification of Adverse Benefit Determination to request an internal appeal. Appeals may be requested orally or in writing. Appeals requested orally will be followed by a written, signed appeal (except for expedited appeal requests, for which this is not required).

    - The internal appeal process will consist of an internal review wherein physicians and/or other healthcare professionals selected by Fidelis Care who are trained in or who practice in the same specialty as would typically manage the case at issue (who have not been involved in the Adverse Benefit Determination and are not subordinates of the individuals involved in the initial determination) review the facts of the case and render a decision. All such internal appeals will be concluded as soon as possible in accordance with the medical exigencies of the case. Which in no event will exceed 72 hours from Fidelis Care receipt of the appeal request in the case of appeals from determinations regarding:
        - Urgent or emergency care
        - An admission
        - Availability of care
        - Continued stay
        - Healthcare services for which the claimant received emergency services

but has not been discharged from a facility

- In addition, appeals wherein Fidelis Care determines (based on a Member's request) or the Provider demonstrates (while making the request on the Member's behalf or in supporting the Member's request) that expedited resolution is Medically Necessary, immediate action is necessary because taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function. There is a 30-calendar day time frame in the case of all other appeals. If Fidelis Care denies a request for expedited appeal, it will transfer the appeal to the standard resolution time frame, which cannot exceed 30 calendar days from receipt of the appeal request (with the possibility of an extension of up to 14 calendar days).

- Any Member, Provider acting on behalf of a Member with the Member's written consent, or authorized representative acting on behalf of the Member, may appeal an adverse internal appeal determination to an independent utilization review organization (IURO). There will be a 60-day time frame which will begin upon receipt of the adverse internal appeal determination to file a written request for an external (IURO) appeal.

If Fidelis Care fails to adhere to notice requirements (format and content of notifications) or timing requirements (resolution time frames for the Internal Appeal stage), the Member is deemed to have exhausted Fidelis Care's appeal process, and will have immediate access to the External (IURO) appeal and Fair Hearing.

Fidelis Care may extend the resolution time frame for an expedited appeal by up to 14 calendar days if a Member requests an extension or if Fidelis Care shows (upon DMAHS's request) that additional information is necessary, and that the delay is in the Member's interest. Fidelis Care will need to demonstrate to DMAHS's satisfaction that an adequate determination cannot be made without additional information.

In the event that Fidelis Care extends the resolution time frame for an expedited appeal not at the request of the Member, it will:

- Make reasonable efforts to give the Member prompt oral notice of the delay;

- Give the Member written notice (within 2 calendar days) of the reason for the decision to extend the time frame, as well as inform the Member of the right to file a grievance if he or she disagrees with that decision; and

- Resolve the appeal as expeditiously as the Member's condition requires, but no later than the expiration date of the extension.

External (IURO)

The external (IURO) appeal process is administered by DOBI and is used for the review of the appropriate utilization and Medical Necessity of covered healthcare services. The services below may not be eligible for the external (IURO) appeal process.

- Adult Family Care
- Assisted Living Program
- Assisted Living Services – when the denial is not based on Medical Necessity
- Caregiver/participant training
- Chore services
- Community Transition Services
- Home Based Supportive Care
- Home Delivered Meals
- PCA
- Respite (Daily and Hourly)
- Social Day Care
- Structured Day Program -- when the denial is not based on Medical Necessity
- Supported Day Services -- when the denial is not based on the diagnosis of TBI

Utilization Management Appeals

Appropriate clinical personnel will be involved in the investigation and resolution of all UM appeals. The processing of all such appeals will be incorporated in Fidelis Care's quality management activities and will be reviewed periodically (at least quarterly) by the Medical Director/Dental Director.

Continuation of Benefits

The MCO will automatically continue the Member's benefits during internal and external (IURO) appeals if all of the following conditions are met:

- The Member, Provider or authorized representative files the appeal timely;
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider (e.g., a network Provider); and
- The appeal request is made on or before the final day of the previously approved authorization, or within 10 calendar days of Fidelis Care sending the notification of Adverse Benefit Determination, whichever is later.

In the event that Fidelis Care fails to meet its obligation to send the notification of Adverse Benefit Determination at least 10 calendar days prior to the final day of the previously approved authorization, Fidelis Care will automatically extend the authorization to a date 10 calendar days after the date on which the notification was sent.

If the Member or Provider does not satisfy the conditions listed above, they may not be eligible for continuation of benefits. However, the Member or Provider will still have 60 days from receipt of the notification of Adverse Benefit Determination to request an internal appeal.

Fair Hearings

Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members can request a Fair Hearing within 120 days from the date of the notice of action letter following an adverse determination resulting from an internal appeal.

For Members who request the Fair Hearing Process, continuation of benefits will be requested in writing within 10 calendar days of the date of the notice of action letter following an adverse determination resulting from an internal or external (IURO) appeal, or on or before the final day of the previously approved authorization, whichever is later.

If a Member requests continuation of services while his or her Fair Hearing is pending and the outcome is not in their favor, the Member may be required to pay for the cost of the services furnished while the Fair Hearing was pending.

Duration of Continued or Reinstated Benefits

Fidelis Care will continue the Member's benefits while an appeal or Fair Hearing is pending until one of the following occurs:

- The Member withdraws the appeal or request for Fair Hearing;
- The Member fails to request a Fair Hearing and continuation of benefits within 10 calendar days after Fidelis Care sends the notification of adverse resolution of the Member's external appeal; or
- A Fair Hearing results in a decision adverse to the Member.

Effectuation of Reversed Appeal Resolutions

For services furnished while the appeal is pending, if Fidelis Care or the State Fair Hearing officer reverses a decision to deny authorization of services, and the Member receives the disputed services while the appeal is pending, Fidelis Care will pay for those services, in accordance with the NJ Medicaid Contract.

If the final resolution of the Internal Appeal, External (IURO) Appeal or Fair Hearing reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, Fidelis Care will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

Expedited Resolution of Appeals

Fidelis Care will establish and maintain an expedited review process for appeals.

Fidelis Care e will ensure that the expedited resolution of an appeal and notice to affected parties is no longer than 72 hours after Fidelis Care receives the appeal.

This language shall not be interpreted as removing any legal rights of Members under State or federal law, including the right to file judicial actions to enforce rights or request a Fair Hearing for Medicaid Members in accordance with their rights under State and federal laws and regulations.

All written notices to Medicaid/NJ FamilyCare A and NJ FamilyCare ABP Members will include a statement of their right to access the Fair Hearing process within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal.

You can file an Internal Appeal by:

1. Calling Fidelis Care at **1-888-453-2534** (TTY **711**); AND

2. Writing to:
   Fidelis Care
   Attn: Appeals Department
   P.O. Box 31368
   Tampa, FL 33634

   Or

   Fidelis Care
   Attn: Medication Appeals
   P.O. Box 31398
   Tampa, FL 33634

If you call first, you must follow up your phone request by writing to Fidelis Care at one of the address in #2 above.

In your letter, you should include an explanation for the reason you are appealing our decision and then sign your request for an appeal.

Additional assistance is available for the handling of appeals. Fidelis Care provides Members with reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Right to Representation

You have the right to represent yourself, have someone else represent you, or have legal representation. If you would like legal representation and are not able to pay for it, you can contact one of the following:

- Legal Services of New Jersey at **LSNJLawHotline.org** or call Legal Services of New Jersey at **1-888-576-5529**;
- Disability Rights New Jersey (DRNJ) at **disabilityrightsnj.org** or call DRNJ at **1-800-922-7233** (TTY **711**) for free legal and advocacy services for people with disabilities; or
- Community Health Law Project (CHLP) at **chlpinfo@chlp.org** or call CHLP at **1-973-275-1175** to be directed to the appropriate office serving your county. A list

of CHLP offices can also be found at **chlp.org**.

Medicaid Fair Hearings can be requested via mail at:

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

Faxed along with required information to **1-609-588-2435**.

Section 8: Compliance

Fidelis Care's Compliance Program

Overview

Fidelis Care's Corporate Ethics and Compliance Program, as may be amended from time to time, includes information regarding Fidelis Care's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Fidelis Care, Fidelis Care employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider subcontractors and their employees, are required to comply with Fidelis Care compliance program requirements. Fidelis Care's compliance-related training requirements include, but are not limited to, the following initiatives:

- HIPAA Privacy and Security Training
    - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA
    - Training includes, but is not limited to, discussion on:
        - Proper Uses and Disclosures of Protected Health Information (PHI)
        - Member Rights
        - Physical and technical safeguards
- Fraud, Waste, and Abuse (FWA) Training
    - Must include, but is not limited to:
        - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.)
        - Obligations of the Provider, including Provider employees and Provider subcontractors and their employees, to have appropriate policies and procedures to address fraud, waste and abuse
        - Process for reporting suspected fraud, waste and abuse
        - Protections for employees and subcontractors who report suspected fraud, waste and abuse
        - Types of fraud, waste and abuse that can occur
- Cultural Competency Training
    - Develop programs to educate and identify the diverse cultural and linguistic needs of the Members they serve
- Disaster Recovery and Business Continuity
    - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services

Providers, including Provider employees and/or Provider subcontractors, must report to Fidelis Care any suspected fraud, waste or abuse, misconduct or criminal acts by Fidelis Care, or any Provider, including Provider employees and/or Provider subcontractors, or by Fidelis Care Members. Reports may be made anonymously through the Fraud, Waste and Abuse Hotline at **1-866-685-8664.**

Details of the Corporate Ethics and Compliance Program may be found at **centene.com/who-we-are/ethics-and-integrity.html**.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). Fidelis Care uses ICD for diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at **cms.gov**, and the ICD-10 Lookup Tool at **cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx** for specific codes.

Information on the ICD-10 transition and codes can also be found at **wellcare.com/New-Jersey/Providers/ICD10-Compliance.**

Code of Conduct and Business Ethics

Overview

Fidelis Care has established a **Code of Conduct and Business Ethics** that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Fidelis Care's Code of Conduct and Business Ethics policy can be found at **centene.com/who-we-are/ethics-and-integrity.**

The Code of Conduct and Business Ethics is the foundation of iCare, Fidelis Care 's Corporate Ethics and Compliance Program. It describes Fidelis Care 's firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All Providers should familiarize themselves with Fidelis Care's **Code of Conduct and Business Ethics**. Participating Providers and other contractors of Fidelis Care are encouraged to report compliance concerns and any suspected or actual misconduct. Providers can report suspected fraud, waste and/or abuse by calling the Fraud, Waste and Abuse Hotline at **1-866-685-8664.**

In addition to reporting to Fidelis Care's Fraud Hotline, you may also report your concern directly to the New Jersey Medicaid Fraud Division Hotline at **1-888-937-2835** or by going directly to the New Jersey Medicaid Fraud Division website and filling out the requisite form at the following location: **nj.gov/comptroller/about/work/Medicaid.**

Fraud, Waste and Abuse (FWA)

Fidelis Care is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and State statutory, regulatory and contractual requirements. Fidelis Care has developed an aggressive and proactive fraud and abuse program designed to collect, analyze, and evaluate data in order to identify suspected fraud

and abuse. Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, up-coding, misuse of modifiers, and other activities designed to manipulate codes contained in the ICD-10 or its successor, CPT-4, the HCPCS, and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement.

Federal and State regulatory agencies, law enforcement, and Fidelis Care vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including, but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to fraud, waste and abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid** or call the confidential and toll-free Fidelis Care Compliance Hotline. Details of the Corporate Ethics and Compliance Program, and how to contact the Fidelis Care FWA Hotline, may be found on Fidelis Care's website at **fideliscarenj.com/privacy-legal**.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable State and federal laws, rules and regulations. All Consultations or discussions involving the Member or his or her case should be conducted discreetly and professionally in accordance with all applicable State and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996, as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable State and federal law.

Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with information regarding their privacy practices and, to the extent required by law, with their Notice of Privacy Practices (NPP). The NPP informs the patient or Member of their Member rights under HIPAA and how the Provider and/or Fidelis Care may use or disclose the Members' PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Member. Employees who have access to Member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to, the following:

- Medical records
- Communication between a Member and a physician regarding the Member's medical care and treatment
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other State or federal laws
- Any communication with other clinical persons involved in the Member's health, medical and mental care
- Information about a Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem
- Identifiable information relating to any communicable disease, such as AIDS or HIV (including HIV testing), that is protected under federal or State law

Medical Records

Member medical records must be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Records are to be maintained in a secure, timely, legible, current, detailed and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be signed and dated. Complete medical records include, but are not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare professionals' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of services provides under the Contract
- A signature by the Provider of service

Confidentiality of Member information must be maintained at all times. The Member's medical record is the property of the Provider who generates the record. However, each

Member or her or his representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

Each Provider is required to maintain a primary medical record for each Member, which contains sufficient medical information from all Providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact, name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of Encounter
- Documentation of late entries should include the date and time of the occurrence and the date and time of documentation
- Provider identification by name and profession of the rendering Provider (e.g., M.D., D.O., O.D.)
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location;
- Documentation of past medical history, including serious accidents, operations, illnesses
- Identification of current problems
- Documentation of the Consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering Provider's initials or other documentation indicating review
- Current list of immunizations pursuant to 42 CFR 456
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 42 CFR 456
- Documentation of follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advanced Medical Directives, for adults
- Documentation that Member has received the Provider's office policy regarding office practices compliant to HIPAA
- Documentation regarding permission to share protected health information with specific individuals has been obtained
- The record must be legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer

A Member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting medical problems containing relevant psychological and social conditions affecting the Member's medical/behavioral health, including mental health, and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests
- Plan of treatment including:
    - Medication history, current medications prescribed, including the strength, amount, directions for use and refills
    - Therapies and other prescribed regimen
    - Follow-up plans including Consultation and referrals and directions, including time to return
- Education and instructions whether verbal, written or via telephone

Disclosure of Information

Periodically, Members may inquire as to the operational and financial nature of their health plan. Fidelis Care will provide that information to the Member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, Members may contact Member Services using the toll-free telephone number found on the Member's ID card. Providers may contact Provider Services by referring to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Cultural Competency Program and Plan

The purpose of the Cultural Competency Program is to ensure that Fidelis Care meets the unique diverse needs of all Members, that the associates of Fidelis Care value diversity within the organization, to honor the beliefs of our enrollees, and to see that Members in need of linguistic services receive adequate communication support. In addition, Fidelis Care is committed to having its Providers fully recognize and care for the culturally diverse needs of the Members they serve.

The objectives of the Cultural Competency Program are to:

- Identify Members who have potential cultural or linguistic barriers for which alternative communication methods are needed
- Use culturally sensitive and appropriate educational materials based on the Member's race, ethnicity and primary language spoken
- Make resources available to address the unique language barriers and communication barriers that exist in the population
- Help Providers care for and recognize the culturally diverse needs of the population
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served
- Decrease healthcare disparities in the minority populations Fidelis Care serves

Culturally and Linguistically Appropriate Services (CLAS) are healthcare services that are provided in a manner that is respectful of, and responsive to, cultural and linguistic needs.

The delivery of culturally competent healthcare and services requires that healthcare Providers and/or their staff possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of Fidelis Care's Cultural Competency Program include:

- Data Analysis: Fidelis Care analyzes data on the populations in each region Fidelis Care serves for the purpose of learning about that region's cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time Fidelis Care enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
    - State-supplied data for Medicaid and CHIP populations
    - Demographic data available from the U.S. Census and any special studies done locally
    - Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent
    - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
    - Data on race, ethnicity and language spoken for Members can be collected both electronically from the State and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers
- Community-Based Support: Fidelis Care's success requires linking with other groups that share the same goals.
    - Fidelis Care reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population
    - Fidelis Care develops and maintains grassroots sponsorships that enhance its effort to reach low-income communities. Fidelis Care also provides opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events
- Diversity and Language Abilities of Fidelis Care: Fidelis Care recruits diverse talented staff to work in all levels of the organization. Fidelis Care does not discriminate with regard to race, religion or ethnic background when hiring staff.
    - Fidelis Care ensures that bilingual staff Members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third of Fidelis Care's Member Services representatives are bilingual. Spanish is the most common translation required. Whenever possible, Fidelis Care will also distinguish place of origin of its Spanish-speaking staff, to ensure sensitivity to differences in cultural backgrounds, language idioms and accents. For example, in Georgia, approximately two-thirds of the Hispanic

population is of Mexican origin. In Florida and New York City, the Puerto Rican population is predominant.
    - Where Fidelis Care enrolls significant numbers of Members who speak languages other than English or Spanish, Fidelis Care seeks to recruit staff members who are bilingual in English plus one of those other languages. Fidelis Care does this even if the particular population is not of a size that triggers State agency mandates.
- Diversity of Provider Network
    - Providers are inventoried for their language abilities. This information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language
    - Providers are recruited to ensure a diverse selection of Providers to care for the population served
- Linguistic Services
    - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact Fidelis Care to arrange appropriate assistance
    - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Member Services Department
    - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hearing-impaired. These services are provided by vendors with such expertise and coordinated by Fidelis Care's Member Services Department
    - Written materials are available for Members in large-print format, and certain non-English languages prevalent in Fidelis Care's service areas
- Electronic Media
    - Telephone system adaptations: Members have access to the TTY/TDD line for hearing-impaired services. Fidelis Care's Member Services Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY/TDD number can be found on the Member identification card
- Provider Education
    - Fidelis Care's Cultural Competency Program provides a checklist to assess the cultural competency of Provider offices

Providers must adhere to the Cultural Competency Program as described above.

For more information about the Cultural Competency Program, registered Provider portal users may access the Cultural Competency training on Fidelis Care's website at **fideliscarenj.com**. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.

Cultural Competency Survey

Providers may access the Cultural Competency Survey on Fidelis Care's website at **fideliscarenj.com**.

Deficit Reduction Act

Entities covered by Section 6032 must include as part of such written policies detailed provisions regarding their own policies and procedures for detecting and preventing fraud, waste and abuse. The entity also shall include in any employee handbook a specific discussion of the laws mentioned above, the rights of employees to be protected as whistleblowers, and the policies and procedures of the entity for detecting and preventing fraud, waste and abuse. However, there is no requirement that an employee handbook be created by the entity if none already exists.

Entities covered by Section 6032 are required to disseminate these written policies and make them readily available to all of their employees, including management, and to their contractors and agents. In addition, entities must, either by contract or otherwise:

- Require that their contractors and agents comply with these policies; and
- Request that their contractors and agents disseminate these policies and make them readily available to their employees and managers.

For purposes of Section 6032, a "contractor" or "agent" includes any contractor, subcontractor, agent or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid healthcare items or services, performs billing or coding functions, or is involved in monitoring of healthcare provided by the entity. The phrase "Medicaid healthcare items or services" in the previous sentence means only those Title XIX items or services that are directly related to patient care and does not include food, fuel, landscaping and other items or services that are not directly related to patient care.

Please note that it is possible that a provider may have to comply with Section 6032 in different capacities. For example, a provider might be both an "entity" in a fee-for-service context and a "contractor" in a managed care setting.

Entities without written policies and procedures for detecting and preventing fraud, waste and abuse should develop them as soon as possible. The written policies of the entity may be in a paper or electronic format.

The Division of Medical Assistance and Health Services (DMAHS), in conjunction with other state agencies and contractors, will be monitoring compliance with Section 6032. As part of this monitoring, providers and entities subject to Section 6032 will be required to complete a form and certify that they are compliant with Section 6032 each calendar year. In addition, a sample of providers will be asked to submit documentation to support each of their answers. Onsite reviews may be conducted to further verify compliance with Section 6032. Finally, CMS may independently determine compliance with Section 6032 through audits of entities or other means.

As a Fidelis Care participating provider, it is your responsibility to ensure that you as an individual provider, any member of your provider group and your office staff are not excluded from participation in either the Federal and/or State Medicare and/or Medicaid Programs.

Additional information on excluded, unlicensed or uncertified individuals or entities can be found in the state newsletter at **njmmis.com/downloadDocuments/26-14.pdf**.

Any evidence of fraud, waste or abuse in Medicaid, NJ FamilyCare, General Assistance and other programs funded in whole or in part by the state can be reported to:

New Jersey Medicaid Fraud Division **1-888-937-2835** or
nj.gov/comptroller/divisions/Medicaid/complaint.

New Jersey Insurance Fraud Prosecutor Hotline at **1-877-55-FRAUD** (**1-877-553-7283**) or
njoag.gov/report-fraud/.

Overview of Relevant Laws

- **False Claims Act (31 U.S.C. § 3729-3733)**
  This act creates civil liability for any person who "knowingly presents or causes to be presented, to an officer or employee of the U.S. government a false or fraudulent claim for payment or approval." A party found liable for a False Claims Act violation may be required to pay a civil penalty and an additional amount equal to three times the damages sustained from the false claim. The civil penalty is subject to increase annually at a rate set forth by the US Department of Justice.

- **Whistleblower Protections**
  31 U.S.C. 3730(h) provides that any employee who is subject to retaliation or discrimination by an employer in the terms and conditions of employment because the employee lawfully sought to take action or assist in taking action under this act "shall be entitled to all relief necessary to make the employee whole." This includes reinstatement with seniority restored to what it would have been without the retaliation or discrimination, double the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the employer's actions, including litigation costs and reasonable attorney's fees.

- **Deficit Reduction Act of 2005 (DRA)**
  The Deficit Reduction Act of 2005 was signed into law in February 2006 and contains many provisions reforming Medicare and Medicaid with two provisions specifically aimed at reducing Medicaid fraud. Under Section 6032 of the DRA, every entity that receives at least $5 million in Medicaid payments annually must establish, by January 1, 2007, written policies for all employees of the entity (including management) and for all employees of any contractor or agent of the entity. The policies provide detailed information about false claims; compliance; detecting and preventing fraud, waste and abuse; and whistleblower protections.

- **Program Fraud Civil Remedies (PFCRA) (31 U.S.C. Sections 3801-3812)** The Program Fraud Civil Remedies Act of 1986 creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be enforced under the federal False Claims Act. The PFCRA imposes liability on people or entities that file a claim:

- That they know or have reason to know is false, fictitious or fraudulent;
- That includes or is supported by any written statement that contains false, fictitious or fraudulent information;
- That includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- That is payment for property or services not provided as claimed.

Currently, a violation of this section of the PFCRA is subject to civil penalty of not less than $11,665 and not more than $23,331, plus three times the amount of damages which the government sustains because of the act of that person. The civil penalty is subject to increase annually at a rate set forth by the US Department of Justice. (31 U.S.C. § 3729)

A person or entity violates the PFCRA if they submit a written statement that they know or should know states a material fact that is false, fictitious or fraudulent or omits a material fact that they had a duty to include and the omission caused the statement to be false, fictitious or fraudulent, and the statement contained a certification of accuracy. A violation of this section of the PFCRA is subject to a civil penalty of not less than $11,665 and not more than $23,331, plus three times the amount of damages which the government sustains because of the act of that person. The civil penalty is subject to increase annually at a rate set forth by the US Department of Justice. (31 U.S.C. § 3729)

- **Federal Anti-Kickback statute (42 U.S.C. § 1320a-7b)**
  The statute is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal healthcare program, including programs for children and families accessing services through the Medicaid program.

New Jersey-Specific Laws and Regulations:

- **New Jersey Conscientious Employee Protection Act (CEPA), N.J.S.A. 34:19-1 et seq**
  The New Jersey Conscientious Protection Act was enacted to protect employees from retaliation after they disclose, refuse to participate in or object to (or "blow the whistle") their employer's participation in unlawful or harmful activity. Under CEPA, an employee is protected if the employee either discloses or objects to an activity of the employer which the employee reasonably believes is in violation of law, regulation, rule or incompatible with a clear mandate of public policy. CEPA also prohibits an employer from taking retaliatory action against an employee who objects or refuses to participate in "any activity, policy or practice which the employee reasonably believes … is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment."

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified healthcare professional, reasonably believes constitutes improper quality of patient care;
- Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified healthcare professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
- Provides information involving deception of or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity;
- Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
- Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
    - Is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified healthcare professional, constitutes improper quality of patient care;
    - Is fraudulent or criminal; or
    - Is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. (N.J.S.A. 34:19-3)

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided the situation is emergent in nature.

- **New Jersey False Claims Act (NJFCA), N.J.S.A. 2A:32C-1 et seq**
  The New Jersey False Claims Act was enacted in January 2008 and became effective in March 2008. It has similar provisions to the federal False Claims Act. For example,

The Attorney General may bring an action against an individual or entity that makes a false claim. In addition, the NJFCA also allows individuals to bring a private right of action in the name of the state against wrongdoers and be able to collect a penalty from those wrongdoers. Under the NJFCA, the civil penalties we raised to match the federal penalties. As such, a party found liable for a False Claims Act violation may be required to pay a civil penalty and an additional amount equal to three times the damages sustained from the false claim. The civil penalty is subject to increase annually at a rate set forth by the US Department of Justice.

The NJFCA provides that a person will be liable for the same penalties as under the federal False Claims Act but to the State of NJ if that person:

- Knowingly presents or causes to be presented to an employee, officer or agent of the state, or to any contractor, grantee or other recipient of state funds, a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the state;
- Conspires to defraud the state by getting a false or fraudulent claim allowed or paid by the state;
- Has possession, custody or control of public property or money used or to be used by the state and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
- Is authorized to make or deliver a document certifying receipt of property used or to be used by the state and, intending to defraud the entity, makes or delivers a receipt without completely knowing that the information on the receipt is true;
- Knowingly buys or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property
- Knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state.

In addition to the above, the NJFCA has whistleblower protections similar to those outlined under the federal False Claims Act.

- **New Jersey Insurance Fraud Prevention Act, N.J.S.A 17:33A-1 et seq.**
  The purpose of this act is to confront the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud; eliminating the occurrence of such fraud through the development of fraud-prevention programs; requiring the restitution of fraudulently obtained insurance benefits; and reducing the amount of premium dollars used to pay fraudulent claims.

Other relevant laws/citations:

- **New Jersey Health Care Claims Fraud Act, N.J.S.A. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5;**
  The New Jersey Health Care Claims Fraud Act provides the following criminal penalties for healthcare claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

a. A practitioner who knowingly commits healthcare claims fraud in the course of providing professional services is guilty of a crime of the second degree and is subject to a fine of up to five times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of the practitioner's license;
b. A practitioner who recklessly commits healthcare claims fraud in the course of providing professional services is guilty of a crime of the third degree and is subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained and the suspension of the practitioner's license for up to one year;
c. A person who is not a practitioner subject to paragraph a. or b. above (for example, someone who is not licensed, registered or certified by an appropriate state agency as a healthcare professional) is guilty of a crime of the third degree if that person knowingly commits healthcare claims fraud. Such a person is guilty of a crime of the second degree if that person knowingly commits five or more acts of healthcare claims fraud and the aggregate monetary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to five times the monetary benefit obtained or sought to be obtained;
d. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits healthcare claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to five times the monetary benefit obtained or sought to be obtained.

- **New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S.A. 30:4D-17(a)through (d)**
  Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include:
  a. Fraudulent receipt of payments or benefits: fine of up to $10,000, imprisonment for up to three years, or both.
  b. False claims, statements or omissions, or conversion of benefits or payments: fine of up to $10,000, imprisonment for up to three3 years, or both.
  c. Kickbacks, rebates and bribes: fine of up to $10,000, imprisonment for up to three years, or both.
  d. False statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to $3,000, or imprisonment for up to one year, or both.

  Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor in the N.J. Division of Criminal Justice.

- **New Jersey Medical Assistance and Health Services Act – Civil Remedies, N.J.S.A. 30:4D-7.h.; N.J.S.A. 30:4D-17(e) – (i); N.J.S.A. 30:4D-17.1.a**
  In addition to the criminal sanctions discussed, violations of N.J.S. 30:4D-17(a)

through (d) can also result in the following civil sanctions:

a. Unintentional violations: recovery of overpayments and interest.

b. Intentional violation: recovery of overpayments, interest, up to triple damages and, a penalty (not less than $11,665 and not more than $23,331, plus three times the amount of damages which the government sustains because of the act of that person. (31 U.S.C. § 3729)

Under the Civil Penalties Inflation Adjustment Act, 28 CFR § 85.5., False Claims Act penalties are periodically adjusted for inflation. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all healthcare programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

Although there is no mandatory format for discussing these statutes, or the whistleblower protections that some of these statutes contain, entities may wish to use as a resource pages 4-8 of the document located at the following link:
state.nj.us/Human_Services/DMAHS/home/index

Section 9: Delegated Entities

Overview

Fidelis Care may, by written contract, delegate certain functions under Fidelis Care's contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales and marketing, utilization management, quality management, care management, disease management, claims processing, credentialing, network management, Provider appeals, and customer service. Fidelis Care may delegate all or a portion of these activities to another entity (a Delegated Entity).

Fidelis Care oversees the provision of services provided by the Delegated Entity and/or subdelegate and is accountable to the federal and State agencies for the performance of all delegated functions. It is the ultimate responsibility of Fidelis Care to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Fidelis Care policies and procedures.

Delegation Oversight Process

Fidelis Care's Delegation Oversight Committee (DOC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. Fidelis Care defines a "Delegated Entity" as a subcontractor which performs a core function under one of Fidelis Care's government contracts. The Delegation Oversight Committee is chaired by the Director, Corporate Compliance Oversight. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and Health Plans and Internal Companies . The Corporate Compliance Officer has ultimate authority as to the composition of the Corporate Delegation Oversight Committee membership. The Corporate Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

Refer to *Section 8: Compliance* for additional information on compliance requirements.

Fidelis Care monitors compliance through the delegation oversight process and the Corporate Delegation Oversight Committee by:

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function
- Providing guidance on written agreement standards with Delegated Entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory requirements and accreditation standards

- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated
- Review and initiate recommendations to Senior Management and the Corporate Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements of Fidelis Care's Medicare and Medicaid program
- Track and trend internal compliance with oversight standards, entity performance and outcomes

Section 10: Behavioral Health (BH) and Substance Use Disorder (SUD)

Overview

Fidelis Care provides all contract required Medically Necessary behavioral health aspects of care delivery for all Medicaid recipients. Fidelis Care manages all BH/SUD services identified in the Service Description chart below for Members with Managed Long Term Services and Supports (MLTSS), Division of Developmental Disabled (DDD) and Fully Integrated Dually Eligible Special Needs Program (FIDE-SNP), we well as all acute BH admissions and ASAM 3.7 and 4.0 for all Medicaid recipients. All Behavioral Health services are provided in conformance with the access standards established by DMAHS and CMS. Identification, coordination, and monitoring of behavioral and substance abuse conditions for all Members, in the above populations, are integrated into the Care Management process.

Although the State retains a separate Behavioral Health/Substance Use Disorder (MH/SUD) system for the coordination and monitoring of most mental health/substance abuse conditions for FamilyCare recipients, Care Managers will be responsible for referring or coordinating care of Members as indicated to Mental Health/Substance Use. This includes identification, coordination and monitoring of behavioral and substance abuse disorders, in addition to those diagnoses which are categorized as altering the mental status of an individual (but are of organic origin). All BH/SUD needs are fully integrated into the overall care management model.

The current Behavioral Health team consists of the following staff:

- Director, Behavioral Health Services - develops, implements and coordinates BH services and settings that can meet the BH needs of Members. This individual has oversight over the entire BH program to supervise, train, and help ensure Member needs are met.
- Supervisor, Behavioral Health (2) - responsible for the supervision, training and quality oversight of the Care Management staff.
- MLTSS Behavioral Health (21) and Medicaid Behavioral Health (3) Care Managers, - coordinate the Member's physical and behavioral health as well as long term care needs to assure Members receive effective, Medically Necessary BH services, with a strong emphasis on community based, recovery oriented and family driven services.
- and
- Care Coordinators (2) - assist BH Members with service needs and support Behavioral Health Care Managers.

All of the Behavioral Health Care Managers are field-based positions currently.

Continuity and Coordination of Care between Medical and Behavioral and Substance Use Disorder Providers

PCPs may provide any clinically appropriate BH and SUD services within the scope of their practice. Conversely, BH and SUD Providers may provide physical healthcare services if, and

when, they are licensed to do so within the scope of their practice. Behavioral Providers are required to use the ICD-10 or current version of the DSM (*Diagnostic and Statistical Manual of Mental Disorders)* when assessing the Member for BH and SUD services and document the diagnosis and assessment/outcome information in the Member's medical record.

BH and SUD Providers are encouraged to submit, with the Member's or the Member's legal guardian's consent, an initial and quarterly summary report of the Member's BH and SUD status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. Fidelis Care encourages BH and SUD Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (Fidelis Care recommends faxing the discharge instruction sheet or a letter summarizing the hospital stay to the PCP). Please send this communication, with the properly signed consent, to the Member's identified PCP noting any changes in the treatment plan on the day of discharge.

Fidelis Care strongly encourages open communication between PCPs and BH and SUD Providers to help guide and ensure the delivery of safe, appropriate, efficient and quality clinical healthcare. If a Member's medical or behavioral condition changes, Fidelis Care expects that both PCPs and BH and SUD Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Effective communication of care should be clear and timely to allow for better decision-making regarding treatment interventions, decrease the potential for fragmentation of treatment and improve Member health outcomes.

To maintain continuity of care, patient safety and Member well-being, communication between BH and SUD care Providers and medical care Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and BH and SUD and impact Member outcomes.

For Behavioral Health Prior Authorization requirements, please refer to the Prior Authorization subsection found in Section 4.

Responsibilities of Behavioral Health and Substance Use Disorder Providers

Fidelis Care monitors Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment waiting times. The provisions below are applicable only to BH and SUD Providers and do not replace the provisions set forth in *Section 2: Provider and Member Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by Fidelis Care.

Appointment Type	Access Standard
Behavioral Health Provider – Urgent	< 48 hours
Behavioral Health Provider – Post-inpatient Discharge	< 7 days

Appointment Type	Access Standard
Behavioral Health Provider – Routine	< 10 days
Behavioral Health Provider – Non-life-threatening emergency	< 6 hours

Medicaid/NJ FamilyCare	
Type of Appointment	**Access Standard**
Behavioral Health Provider – Emergent	Immediately
Behavioral Health Provider – Urgent	< 48 hours
Behavioral Health Provider – Post-inpatient discharge	< 7 days
Behavioral Health Provider – Routine	< 10 business days
Behavioral Health Provider – Non-life-threatening emergency	< 6 hours
Established Appointment – Wait time	Does not exceed 45 minutes

All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place and name of the Provider to be seen. The outpatient treatment must occur within the time frames listed above.

In the event that a Member misses an appointment, the BH and SUD Provider must contact the Member within 24 hours to reschedule.

BH and SUD Providers are expected to assist Members in accessing emergent, urgent and routine behavioral services as expeditiously as the Member's condition requires. Members also have access to a toll-free Behavioral Health Crisis Line that is staffed 24 hours a day. The behavioral crisis phone number is printed on the Member's ID card and is available on Fidelis Care's website.

For information about Fidelis Care's Care Management and Disease Management Programs, including how to refer a Member for these services, please see *Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM).*

Additional BH and SUD resources and information are available on Fidelis Cares website at **fideliscarenj.com/providers/Medicaid/behavioral-health**.

Behavioral Health and Substance Use Disorder Service Benefit Plan

Effective October 1, 2018, in order to align BH and SUD benefit coverage, all managed care plans will be providing the BH and SUD services currently covered under MLTSS to the beneficiaries enrolled in FIDE-DSNP and DDD.

These services include the following services (see MLTSS Behavioral Health Dictionary):

- Outpatient

- Partial care/Partial Hospitalization/Acute Partial Hospitalization
- Adult mental health rehabilitation
- Inpatient
- Intensive Out Patient (IOP)
- Outpatient SUD services (ASAM 1.0)
- Intensive Outpatient Services (IOP) (ASAM 2.0 and 2.1)
- SUD partial care (ASAM 2.5)
- Substance Use Disorder Long Term Residential (LTR) ASAM 3.5
- Medically Monitoring Intensive Inpatient Deox (ASAM 3.7 and 4.0)
- Ambulatory Withdrawal Management (AWM)
- Office Based Addiction Treatment (OBAT) Services (4.2.13)
- Medication Assisted Treatment (MAT)

The following services are not included in the mental health coverage benefits:
Targeted Case Management (TCM) including:

- Justice Involved Services (JIS)
- Children's System of Care (CSOC) Care Management Organizations (CMOs)
- Integrated Case Management (ICMS)
- Projects for Assistance in Transition from Homelessness (PATH)
- Behavioral Health Homes (BHH)
- Programs in Assertive Community Treatment (PACT)
- Community Support Services (CSS)
- Certified Community Behavioral Health Care Clinics (CCBHC)

All admissions to a general acute care hospital, including admissions to a psychiatric unit, shall be the responsibility of NJ Medicaid MCOs for their enrolled Members.

This includes all acute-care hospitals and psychiatric units contained within the hospital for provider types Hospitals, Special Hospitals & Rehab Centers. This does not include State or county psychiatric hospital admissions.

Office Based Addiction Treatment (OBAT) Services have been added to the Benefit Plan in effort to support Member access and utilization of non-methadone medication-assisted treatment (MAT) for patients with substance use diagnoses including opioid, alcohol, or polysubstance abuse. Fidelis Care encourages Providers with a Data 2000 Waiver to provide Members with ongoing non-methadone pharmacologic addiction treatment.
Physicians (all specialties), APNs and PAs with a DATA 2000 waiver who meet established standards can participate in OBAT. Providers with a Data 2000 Waiver may become an OBAT Provider, leading a team of individuals responsible for ongoing SUD treatment. The Team will also include a qualified Navigator, responsible for care coordination including, but not limited to, creating a comprehensive individualized SUD plan of care, facilitating access to services and resources and coordination of care with other providers. Navigators are required to be either a licensed healthcare provider (e.g. RN, LPN, or SW), or a bachelor's prepared individual with at least two years of life experience with addiction.

Additionally, the OBAT team can include a Peer. Peers are individuals who will provide non-clinical assistance and support through all stages of the recovery process through "lived" experience of substance use disorder and sustained recovery. Their services will be covered for fully integrated providers who do not need assistance connecting beneficiaries with counseling services. Peers provide their shared experience to allow others to benefit from their past experience to assist the beneficiary to maintain sobriety.

		Service Description	DDD	Liberty HMO SNP (FIDE-SNP)	MLTSS
Substance Use Disorder Services	Hospital Based Services	Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital)	Fidelis Care	Fidelis Care	Fidelis Care
	Medication Assisted Treatment OTPs	Non-Medical Detoxification/Non-Hospital based withdrawal management	Fidelis Care	Fidelis Care	Fidelis Care
	SUD - Residential	Substance Use Disorder Short Term Residential (STR) *Subject to IMD exclusion	Fidelis Care	Fidelis Care	Fidelis Care
	SUD - Residential long-term	Substance Use Disorder Long Term (greater than 30 days)	Fidelis Care	Fidelis Care	Fidelis Care
	OP - SUD	Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification	Fidelis Care	Fidelis Care	Fidelis Care
	OP - SUD	Substance Use Disorder Partial Care (PC)	Fidelis Care	Fidelis Care	Fidelis Care
	OP - SUD	Substance Use Disorder Intensive Outpatient (IOP)	Fidelis Care	Fidelis Care	Fidelis Care
	OP - SUD	Substance Use Disorder Outpatient (OP)	Fidelis Care	Fidelis Care	Fidelis Care
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Methadone Maintenance)	Fidelis Care	Fidelis Care	Fidelis Care
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Non-Methadone Maintenance)	Fidelis Care	Fidelis Care	Fidelis Care

		Service Description	DDD	Liberty HMO SNP (FIDE-SNP)	MLTSS
Mental Health Services	Psychiatric Emergency Services (PES)	Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	FFS	FFS	FFS
	Hospital Based Services	Inpatient Psychiatric Services (Acute Hospital based)	Fidelis Care	Fidelis Care	Fidelis Care
	Hospital Based Services	Inpatient Psychiatric Physician Services (Acute Hospital based)	Fidelis Care	Fidelis Care	Fidelis Care
	Hospital Based Services	Psychiatric Hospital - Inpatient (stand-alone)	Fidelis Care	Fidelis Care	Fidelis Care
	Hospital Based Services	Partial Hospital ***(Prior Authorization required for acute Partial Hospital only)***	Fidelis Care	Fidelis Care	Fidelis Care
	MH - Residential	Adult Mental Health Rehabilitation (group homes)	Fidelis Care	Fidelis Care	Fidelis Care
	OP - MH	Partial Care ***(Prior Authorization required; 25 hour per week limit)***	Fidelis Care	Fidelis Care	Fidelis Care
	OP - MH	Mental Health Outpatient (Clinic/Hospital Services) *Refer to Newsletter Vol.26 No.5	Fidelis Care	Fidelis Care	Fidelis Care
	OP - MH	Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN)	Fidelis Care	Fidelis Care	Fidelis Care
	Targeted Care Management	Targeted Care Management (Chronic Mental Illness)	FFS	FFS	FFS
Other Related	Care Management	Behavioral Health Home (Care Management)	FFS	FFS	FFS
	PACT	PACT (Program in Assertive Community Treatment)	FFS	FFS	FFS
	CSS	Community Support Services (Effective 7/1/17) *MFP not eligible	FFS	FFS	FFS

Section 11: Pharmacy

Overview

Fidelis Care's pharmaceutical management procedures are an integral part of the Pharmacy Program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of its Members. The utilization management tools that Fidelis Care uses to optimize the Pharmacy Program include:

- Preferred Drug List (PDL)
- Mandatory generic policy
- Step therapy (ST)
- Quantity limit (QL)
- Age limit (AL)
- Coverage determination review process
- Pharmacy Lock-In Program
- Network Improvement Program (NIP)
- AcariaHealth™ Pharmacy

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the Pharmacy Program. To help patients get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma Guideline, Joint National Committee (JNC) VII Hypertension Guidelines
- Prescribe drugs listed on the PDL
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
- Evaluate medication profiles for appropriateness and duplication of therapy

Consistent with Section 1903(i) of the Social Security Act, the Provider shall ensure that all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following:

- Copying of a completed or blank prescription form;
- Erasure or modification of information written on the prescription pad by the prescriber; and
- Use of counterfeit prescription forms.

This requirement does not pertain to prescriptions received by fax, telephone, or electronically.

To contact Fidelis Care's Pharmacy Department, please refer to the *Quick Reference Guide* on Fidelis Care's Provider website at **fideliscarenj.com/providers/Medicaid**.

Preferred Drug List

Fidelis Care's PDL is a published prescribing reference and clinical guide of prescription drug products selected by Fidelis Care's Pharmacy and Therapeutics Committee (P&T Committee). The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee selects drugs based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, age limitation, Prior Authorization and step therapy).

Providers may obtain a copy of the PDL on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/pharmacy**. Changes to the PDL and applicable pharmaceutical management procedures are communicated to Providers through:

- Quarterly updates in Provider newsletters
- Website updates, including P&T PDL change notices
- Pharmacy and Provider communications that detail any major changes to a particular therapy or therapeutic class

Additions to the Preferred Drug List

Providers may request consideration for the addition of a drug to Fidelis Care's PDL by writing to Fidelis Care and explaining the medical justification. For contact information, refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

For more information on requesting exceptions, refer to the *Coverage Determination Review Process* outlined below.

Generic Medications

The use of generic medications is a key pharmaceutical management tool. Generic drugs are equally effective and generally less costly than their brand name counterparts. Their use can contribute to cost-effective therapy.

Generic drugs must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand-name drug. To request an exception to the mandatory generic policy, a *Coverage Determination Request Form* should be submitted. Clinical justification as to why the generic alternative is not appropriate for the Member should be included with the *Coverage Determination Request Form*.

For more information on the Coverage Determination Review process, including how to access the *Coverage Determination Request Form*, see the *Coverage Determination Review Process* below.

Step Therapy

The P&T Committee has developed step therapy programs. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before stepping up to less cost-effective alternatives.

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on Fidelis Care's PDL have been evaluated through the use of clinical literature and are approved by its P&T Committee. Please refer to the PDL to view drugs requiring step therapy.

Quantity Limits

Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits are also used to help prevent billing errors. Please refer to the PDL to view drugs with quantity level limits.

Age Limits

Some drugs have an age limit associated with them. Fidelis Care uses age limits to help ensure proper medication utilization when necessary. Please refer to the PDL to view drugs with age limits.

Over-the-Counter Medications

Fidelis Care will only pay for over-the-counter (OTC) items listed on the PDL that are prescribed to the Member. Examples of OTC items listed on the PDL include:

- Multivitamins/multivitamins with iron
- Iron
- Non-sedation antihistamines
- Enteric coated aspirin
- Diphenhydramine
- Insulin & insulin syringes
- Topical antifungals
- Ibuprofen
- Permethrin
- Meclizine
- Urine test strips
- H-2 receptor antagonists

For a complete listing of covered OTC medications, please refer to the PDL on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/pharmacy**.

Injectable and Infusion Services

Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests require a Coverage Determination Request Review using the *Injectable Infusion Form.*

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with Fidelis Care. Please contact Fidelis Care's Pharmacy Department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require Prior Authorization when administered in a doctor's office are included in Fidelis Care's *No Authorization Required Medical Injectable List.*

Coverage Limitations

Fidelis Care covers all drug categories currently available through the Medicaid/NJ FamilyCare Fee-for-Service Program. The following is a list of non-covered (i.e., excluded from the Medicaid/NJ FamilyCare benefit) drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

Fidelis Care will not reimburse for prescriptions refilled early, duplicate therapy or excessively high dosages for the Member.

Pharmacy Lock-In Program

Members identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple Providers, or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-In (Lock-In) status for a minimum of one year. While in Lock-In, the Member will be restricted to one prescribing Provider and one pharmacy to obtain their medications. Claims submitted by other Providers or other pharmacies will not be paid for the Member. Members identified will also be referred to Care Management.

The Care Management team will work with the Member to create an individualized Care Plan. Care Managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve a Member's health. For questions or concerns regarding the Lock-In Program, Members or Providers may call **1-888-453-2534** Monday through Friday, 8 a.m. to 6 p.m. Eastern. TTY/TDD users may call **711**.

Coverage Determination Review Process (Requesting Exceptions to the PDL)

The Coverage Determination Review Program, also known as Prior Authorization, is to ensure that medication regimens that are high-risk, have high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. Prior Authorization is required for:

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit
- Most self-injectable and infusion medications (including chemotherapy)
- Drugs not listed on the PDL

- Non-formulary drugs (Medically Necessary)
- Drugs that have an age edit
- Drugs listed on the PDL but still require Prior Authorization (PA)
- Brand-name drugs when a generic exists (Medically Necessary)
- Drugs that have a step therapy edit, and the first-line therapy is inappropriate

Providers may request an exception to Fidelis Care's PDL orally or in writing. For written requests, Providers should complete a *Coverage Determination Request Form*, supplying pertinent Member medical history and information. A *Coverage Determination Request Form* may be accessed on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid/forms**.

Coverage Determination Request forms may be sent by fax to **1-888-340-9512** or by mail to:

Fidelis Care
P.O. Box 31383
Tampa, FL 33631

To submit a request orally, refer to the contact information listed on the *Quick Reference Guide* on Fidelis Care's website **fideliscarenj.com/providers/Medicaid**.

Upon receipt of the *Coverage Determination Request Form*, a decision is completed within 24 hours. If Prior Authorization for a medication claim is required, the pharmacist can call Fidelis Care to get a 72-hour emergency supply of the medication for the Member.

Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy Department by the Member or Provider. All pharmacy services are covered by Fidelis Care (except methadone and its administration when prescribed for substance use treatment, except as provided in Article 9.9.2 for MLTSS Members). This includes drugs prescribed by Fidelis Care or Mental Health/Substance Abuse (MH/SA) Providers.

Existing Plans of Care

Fidelis Care shall honor and pay for plans of care for new enrollees or when a new benefit is added as a Covered Service, including prescriptions. Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or Participating Fidelis Care Provider will always be covered by Fidelis Care regardless of the treatment plan established by Fidelis Care. The Fidelis Care formulary and Prior Authorization requirements will apply only when the initial medication treatment plan is changed.

Prescriptions written by MH/SA Providers do not require Prior Authorization. Fidelis Care shall only restrict or require a Prior Authorization for prescriptions or pharmacy services prescribed by MH/SA Providers if one of the following exceptions is demonstrated:

1. The drug prescribed is not related to the treatment of substance abuse/dependency/addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the Fidelis Care PCP or specialists in the Fidelis Care network.

2. The prescribed drug does not conform to standard rules of the Fidelis Care pharmacy plan.

3. Fidelis Care, at its option, may require a Prior Authorization (PA) process if the number of prescriptions written by MH/SA Providers for MH/SA-related conditions exceed four per month per enrollee or may be contraindicated based on the enrollee's medical conditions or other drugs already prescribed. When drugs require weekly prescriptions, these prescriptions shall be considered as four weekly prescriptions and would be covered as a one-month prescription. Fidelis Care's process for the purposes of this section shall require review and prior approval by DMAHS.

Medication Appeals

To request an appeal of a Prior Authorization decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Refer to the *Quick Reference Guide* on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**.

Once the appeal of the Prior Authorization request decision has been properly submitted and obtained by Fidelis Care, the request will follow the appeals process described in *Section 7: Appeals and Grievances.*

Pharmacy Management – Network Improvement Program

The Pharmacy Network Improvement Program (NIP) is designed to provide Providers with quarterly utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to Providers identified for the program.

AcariaHealth™ (an Envolve Pharmacy Solution)

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician's offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m., ET.

AcariaHealth Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: **1-866-458-9246** (TTY **1-855-516-5636**)

Fax: **1-866-458-9245**
Website: **acariahealth.com**

Opioid Program

Fidelis Care has created a new comprehensive Opioid Program, a national Medicaid and Medicare program for Members who overuse opioid medications and/or appear to be at risk of doing so.

The goals of the program are to:

- Promote the appropriate use of healthcare resources; and
- Reduce the risk of opioid misuse, dependence and ultimately overdose, improving our Members' health outcomes.

Interventions include:

- Care Management for Members who have been locked in to one pharmacy
- Care management for Members with low back pain and a high number of opioid prescriptions; and
- Care management for Members who have been proactively identified as being at high risk of misuse of opioids and
- Care management for Members who over utilize the emergency room for primary care services.

Fidelis Care invites our Providers to use this program to minimize inappropriate opioid prescribing and to refer to appropriate treatment as necessary. To learn more about Fidelis Care's Opioid Program, contact your Provider representative.

Section 12: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the Agreement.

Adverse Benefit Determination means any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of the Company to act within ninety (90) calendar days from the date the health plan receives a grievance, or thirty (30) calendar days from the date the health plan receives an appeal;
- For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network; and
- The denial of an enrollee's request to dispute a financial liability.

Agency means one or more of the following, when applicable: the New Jersey Department of Human Services, the New Jersey Division of Medical Assistance and Health Services.

Agreement means the Participating Provider Agreement by and between Providers and Fidelis Care.

Appeal means a request for review of some action taken by or on behalf of Fidelis Care.

Authorization means an approval of a Prior Authorization request for payment of services and is provided only after Fidelis Care agrees the treatment is necessary.

Beneficiary means any person eligible to receive Covered Services in the Medicaid/NJ FamilyCare program.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by Fidelis Care; or (b) administered by Fidelis Care pursuant to a government contract with a governmental authority. Benefit Plans and their designs are subject to change periodically**.**

Care Management means a set of Member-centered, goal-oriented and culturally relevant steps to assure that a Member receives needed healthcare services.

Care Management Program emphasizes prevention, health promotion, continuity of care and coordination of care, as necessary across Providers and settings to achieve the least restrictive and most integrated setting of care.

Care Manager is the Fidelis Care facilitator who provides communication and collaboration among the Interdisciplinary Care Team (ICT), a team which is comprised of individuals and Providers who have an impact on the health and well-being of a Member who is participating in Fidelis Care's Care Management Program. The ICT team is comprised of the Member, Care Manager, PCP, and other caregivers, specialists and home care Providers. The role of the Care Manager is to facilitate communication and collaboration among the healthcare team for optimal coordination of care and goal attainment.

Carve Out Agreement means an agreement between Fidelis Care and a third-party Participating Provider whereby the third-party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for radiology, laboratory, dental, vision or hearing services.

Centers for Medicare & Medicaid Services (CMS) means that United States federal agency which administers Medicare, Medicaid and the Children's Health Insurance Program.

Children with Special Healthcare Needs (CHSCN) those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Clean Claim means (a) the claim is for a service or supply covered by Fidelis Care under the Medicaid/NJ FamilyCare Program; (b) the claim is submitted with all the information requested by Fidelis Care on the claim form or in other instructions distributed to the Contracted Provider or Medicaid/NJ FamilyCare beneficiary; (c) the person to whom the service or supply was provided was covered by Fidelis Care on the date of service; (d) Fidelis Care does not reasonably believe that the claim has been submitted fraudulently; and (e) the claim does not require special treatment. Special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

Clinical Practice Guidelines (CPG) are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

Comprehensive Needs Assessment (CNA) is an assessment conducted by the Care Manager that identifies Member needs and barriers to care.

Comprehensive Orthodontic Treatment A coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may

be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.

Consultation is a referral between different Provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A Member cannot be denied access to the Consultation or, when needed, to Medically Necessary services provided by that specialty Provider.

Co-payment means the part of the cost-sharing requirement for which a fixed monetary amount is paid for certain services/items received from Fidelis Care's Participating Providers

Covered Determination Review means Prior Authorization.

Covered Services or Benefits Package means the healthcare services for which Fidelis Care has agreed to provide, arrange and be held fiscally responsible.

Critical Incidents includes, but is not limited to, the following incidents when they occur in Nursing Facility/Skilled Care Nursing Facilities or home- and community-based long-term care service delivery settings, including community alternative residential settings, adult day care centers, other HCBS Provider sites and a Member's home:

- Unexpected death of a Member
- Missing person and/or unable to contact
- Inaccessible for initial on-site meeting
- Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical)
- Theft with law enforcement involvement
- Law enforcement contact
- Severe injury or fall resulting in the need for medical treatment
- Medical or psychiatric emergency, including suicide attempt
- Medication error resulting in serious consequences
- Inappropriate or unprofessional conduct by a Provider/Agency involving the Member
- Sexual abuse and/or suspected sexual abuse
- Neglect/mistreatment, including self-neglect, caregiver overwhelmed, environmental
- Exploitation, including financial, theft, destruction of property
- Failure of a Member's back-up plan
- Elopement/wandering from home or facility
- Eviction/loss of home
- Facility closure, with direct impact to Member's health and welfare
- Media involvement or the potential for media involvement
- Cancellation of utilities
- Natural disaster, with direct impact to Member's health and welfare
- Other, explain

Delegated Entity is an entity that has been delegated certain functions under Fidelis Care's contracts with the Centers for Medicare & Medicaid Services (CMS) and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, care management, disease management, claims processing, claims payment, credentialing, network management, Provider claim appeals, customer service, enrollment, disenrollment, billing and sales, adjudicating Medicare organization determinations and appeals and grievances.

Delegated Services are certain healthcare plan functions under Fidelis Care's contracts with the Centers for Medicare & Medicaid Services (CMS) and/or applicable State governmental agencies that are performed by another entity other than Fidelis Care.

Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral healthcare and includes referral to dental specialists when appropriate.

Dental Records are the complete, comprehensive records of dental services, to include chief dental problem, treatment needed, and treatment planned to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on-site of enrollees' participating dentist and in the records of a facility for enrollees in a facility.

New Jersey's Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is a comprehensive preventive healthcare program designed to improve the overall health of Medicaid/NJ FamilyCare eligible infants, children and adolescents

Emergency Dental Condition an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction, uncontrolled bleeding due to tissue laceration, oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible. These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Emergency Medical Condition means 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 (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 any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists

where 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.

Emergency Services means covered inpatient and outpatient services furnished by any qualified Provider that are necessary to evaluate or stabilize an emergency medical or dental condition.

Encounter is the basic unit of service used in accumulating utilization data and/or a face-to-face contact between a Member and a Provider resulting in a service to the Member**.**

Encounter Data means Encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims, regardless of whether a Provider is reimbursed on a capitated or fee-for-service basis.

Enrollee with Special Needs--for adults, special needs include complex/chronic medical conditions requiring specialized healthcare services and persons with physical, mental/Substance Use Disorder, and/or developmental disabilities, including persons who are eligible for the MLTSS program. See also "Children with Special Healthcare Needs"

Excluded services are services that Members may obtain under the Medicaid/NJ FamilyCare plan for which Fidelis Care is not financially responsible. Excluded services may be paid for by the Agency on a fee-for-service basis or other basis.

Expedited Appeal is a request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life, health, or ability to regain maximum function, including cases in which Fidelis Care makes a less than fully favorable decision to the Member. Expedited appeal decisions are made no later than 72 hours after the Expedited appeal request.

Fidelis Care means WellCare Health Plans of New Jersey, Inc. (d.b.a. Fidelis Care)

Fidelis Care Companion Guide means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Fidelis Care or its Affiliates, as amended from time to time.

Formulary means a list of covered drugs selected by Fidelis Care in consultation with a team of healthcare Providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

Grievance means an expression of dissatisfaction about any matter or a protest by an enrollee as to the conduct by Fidelis Care or any agent of Fidelis Care, or an act or failure to act by Fidelis Care or any agent of Fidelis Care or any other matter in which a Member feels aggrieved by Fidelis Care that is submitted in writing or that is orally communicated. Grievances are to be resolved as required by the exigencies of the situation, but no later than 30 days after receipt.

Home- and Community-Based Services (HCBS) are services above State plan limits that are provided as an alternative to long-term institutional services in a nursing facility. HCBS includes personal care assistance and medical day care when they are above the limits established under New Jersey's Title XIX State Plan. HCBS are provided to Members who meet MLTSS eligibility requirements and reside in the community or in certain community alternative residential settings.

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool is comprised of 88 measures across seven domains of care, including:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Relative resource use
- Health plan descriptive information
- Measures collected using electronic clinical data systems

ICD-10-CM means *International Classification of Diseases, 10th Revision, Clinical Modification*

ICD-10-PCS means *International Classification of Diseases, 10th Revision, Procedure Coding System*

Individuals with Special Healthcare Needs (ISHCN) means Members who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

Ineligible Person means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Healthcare Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Healthcare Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

Interdisciplinary Care Team is the Care Management Program team comprised of the Member, Care Manager, PCP, and other caregivers, specialists and home care Providers.

Internal Appeal is an appeal of an adverse Utilization Management benefit determination initiated by the Member (or Provider acting on behalf of a Member, with the Member's written consent) and conducted by Fidelis Care.

Manual means the Fidelis Care Medicaid/NJ FamilyCare Provider Manual

Medical Necessity or Medically Necessary means a healthcare item or service that a healthcare Provider, exercising her or his prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the evaluating, diagnosing or treating of 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 Member's illness, injury or disease; not primarily for the convenience of the Member or the healthcare 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 Member's illness, injury or disease.

Member means an enrolled participant in the Fidelis Care's Medicaid/NJ FamilyCare plan; also means enrollee.

Member Expenses means co-payments, coinsurance, deductibles or other cost-share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

Mobile Dental Practice means a Provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These Providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentists or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare Fidelis Care Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. Fidelis Care is responsible for assisting the Member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility, and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The MCO must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.

Mobile Dental Van means a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick-and-mortar" facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). Patient records are to be maintained in the brick-and-mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements. When a mobile dental van's use is associated with health fairs or other one-time events,

services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. The MCO must maintain documentation for all locations served to include schedule of time and days.

New Encounter means an Encounter that has never been submitted to Fidelis Care.

Overlaid Encounter means an Encounter that is updated or corrected within the Fidelis Care system.

Primary Care means all healthcare services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Dentist (PCD) is a licensed dentist who is the healthcare Provider responsible for supervising, coordinating and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

Primary Care Provider (PCP) means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members, including periodic examinations, preventive healthcare and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty Providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

Prior Authorization or Coverage Determination Review means an authorization granted in advance of the rendering of a service after appropriate medical/dental review.

Provider or Participating Provider means any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of New Jersey to provide healthcare services that has contracted with Fidelis Care to provide healthcare services to Members.

Provider Portal Provider Identification Number (PIN) is the number which Providers use to access the secure Fidelis Care Provider portal.

Quality Improvement Program (QI Program) is the Fidelis Care program designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare

services, including MLTSS services. Strategies are identified and activities are implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas.

Qualified Individual with a Disability means 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 (42 U.S.C. § 12131).

Quick Reference Guide (QRG) is the *Quick Reference Guide* available on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid**. *QRGs* contain important addresses, phone and fax numbers, and authorization requirements.

Reopening means a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

Replaced Encounter means an Encounter that is updated or corrected within the Fidelis Care system.

Retrospective Review is any review of care or services that have already been provided.

Urgent Care means treatment of a condition that is potentially harmful to a patient's health and for which his or her physician determined it is Medically Necessary for the patient to receive medical treatment within twenty-four (24) hours to prevent deterioration.

Utilization means the rate patterns of service usage or types of service occurring within a specified time.

Voided Encounter means an encounter that Fidelis Care deletes from the Encounter file and is not submitted to the State.

Section 13: Fidelis Care Resources

Forms and Documents
fideliscarenj.com/providers/Medicaid/forms

Quick Reference Guides
fideliscarenj.com/providers/Medicaid

Clinical Practice Guidelines
fideliscarenj.com/providers/tools/clinical-guidelines

Clinical Coverage Guidelines
fideliscarenj.com/providers/tools/clinical-guidelines

Fidelis Care Companion Guides
fideliscarenj.com/providers/Medicaid/claims

Provider Training
fideliscarenj.com/providers/Medicaid/training

Job Aids and Resource Guides
fideliscarenj.com/providers/Medicaid

Addendum A: Managed Long Term Care (MLTSS)

Overview

This Addendum contains information specifically related to the Managed Long Term Supports and Services (MLTSS) for eligible Members. The requirements listed in this section are a supplement to the Fidelis Care Medicaid/NJ FamilyCare Managed Care plan requirements contained in *Sections 1-13* in this manual.

Please refer to *Section 1* for additional information on Fidelis Care, including, but not limited to, the *Quick Reference Guide* located on Fidelis Care's website at **fideliscarenj.com/providers/Medicaid,** Provider Services and Website Resources.

Fidelis Care's MLTSS Plan

Managed Long Term Services and Supports (MLTSS) is a program for managing long-term care services. Long-term care includes help doing everyday tasks that Members may no longer be able to do for themselves as they grow older or if they have a disability. These include bathing, dressing, getting around their home, preparing meals or doing household chores. Long-term care also includes care in a Member's own home or in the community that may keep them from having to go to a nursing home for as long as possible. These are called home- and community-based services, or HCBS. Long-term care services also include care in a nursing home.

Eligibility

Members are eligible for Fidelis Care 's MLTSS Program if they meet the following categories:

1. Categorical Eligibility
    - Age 65 years old or older, or
    - Blind ***or*** Disabled – Under 65 years of age and determined blind or disabled by the Social Security Administration or the State of New Jersey.

2. Clinical Eligibility
    - A person meets the qualifications for nursing home level of care, which means that they require limited assistance with a minimum of 3 activities of daily living (ADL) such as bathing, toileting and mobility or the consumer has cognitive deficits and ADL needs of supervision in greater than 3 ADL areas.

3. Meet Medicaid financial eligibility requirements.
    - Income for one person can be equal to or less than $2,205* per month (2017)
    - All income is based on the gross amount
    - Resources must be at or below $2,000 for an individual

In addition, the financial eligibility component includes a five-year "look back" at resources to ensure that there were no assets transferred for less than fair market value in order to meet the requirements for Institutional Medicaid. Individuals in the Alternate Benefit Plan (ABP) should avail themselves of all income sources that they may be eligible to receive.

**Subject to annual change*

[1]Note that for children applying for MLTSS and who meet the nursing home level of care, parental income and resources are not counted in determining financial eligibility.

Benefits

MLTSS Members receive a FamilyCare plan (refer to *Section 1* for FamilyCare plan benefits) plus these additional benefits below:

- Assisted living
- Personal care
- Respite care
- Care Management
- Home and vehicle modifications
- Home-delivered meals
- Substance abuse
- Partial care services
- Partial hospital program services
- Personal emergency
- Response systems
- Mental health and addiction services
- Community residential services
- Nursing home care

Short Term Nursing Stays

Short-term nursing facility stays are available for MLTSS Members receiving HCBS who require temporary placement in a nursing facility due to temporary illness, serious injury, wound care, or the absence of the primary caregiver and there is a reasonable expectation that the Member will be discharged back to the community within 180 days.

The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the Member to maintain his or her community residence for transition back to the community.

If, prior to the end of the 180-day period (post-admission date), it is determined that the Member will not be discharged from the nursing facility, the Member shall be determined as custodial. The Member is automatically converted to custodial status in the nursing facility if the Member is in the nursing facility beyond 180 days.

Members at risk for nursing home level of care will be identified for referral for a Comprehensive Needs Assessment (CNA) by a review of hospital and pharmacy utilization. Additionally, Providers can refer Members and Members can self-refer.

Provider and Member Administrative Guidelines

Provider and Administrative Guidelines

Please refer to *Section 2* for additional information on Fidelis Care's Provider and Member Administrative Guidelines including, but not limited to, Prohibited Services, Responsibilities of all Providers, Members with Special Healthcare Needs, Access Standards and Specialty Care Providers.

Training

Ongoing training is required for all Providers working with MLTSS patients and includes topics such as integrating and coordinating services for Members receiving MLTSS benefits, eligibility of Members, Covered Services and identifying abuse, neglect and exploitation.

Unable to Contact

Unable to Contact is when a MLTSS Member is absent, without notification, from any program or service offered under MLTSS where Fidelis Care, or its contracted MLTSS Providers including staff Members and care mangers, are unable to identify the location of the Member using the contact information available in the Member's record.

Fidelis Care MLTSS Providers are required to investigate and report all unable to contact events by:

1. Immediately outreach to the Member/client using the contact information on file
2. If no response, immediately outreach to the emergency contact(s) for the Member
3. If still unsuccessful, immediately notify the Member's MLTSS Care Manager

The Care Manager, after receiving notification of the unable to contact event from a MLTSS Provider, will also attempt contact with the Member including conducting a home visit on the same day of the notification to determine the safety of the Member. If attempts to contact the Member remain unsuccessful, Fidelis Care will file a Critical Incident Report through the designated State system.

If the Member cannot be contacted after 24 hours, local law enforcement may be notified.

All attempts to contact will be documented by Fidelis Care, including method of outreach, time and outcome.

Member Rights and Responsibilities

Fidelis Care Members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

Fidelis Care Members have the right to:

- Receive information about Fidelis Care's plans, services, doctors and other healthcare Providers
- Receive information about appeals, including how to initiate an appeal, in a language they understand
- The Medicaid Fair Hearing Process for Medicaid enrollees and information about the method for obtaining a State hearing (Fair Hearing and/or IURO)

- Receive information about their rights and responsibilities
- Know the names and titles of the doctors and other health Providers caring for them
- Be treated with respect and dignity
- Have their privacy protected
- Choose their PCP from Fidelis Care's Participating Providers
- Decide with their Provider on the care they receive
- Have services provided that promote a meaningful quality of life and autonomy, and support independent living in both the Member's home and other community-based settings so long as such services are medically and socially feasible, and preserve and support the Members natural support systems
- Talk openly about the care they need, no matter the cost or benefit coverage, treatment options and the risks involved (this information must be given in a way they understand)
- Have the benefits, risks and side effects of medications and other treatments explained to them
- Know about their healthcare needs after they leave a Provider's office or the hospital
- Know how Fidelis Care's Providers are paid
- A second medical opinion
- Refuse care, as long as they agree to be responsible for their decision
- Refuse to take part in any medical research
- File an appeal or grievance about their plan or the care provided; also, to know that if they do, it will not change how they are treated
- Have a choice of Providers
- Call **911** in an emergency without Prior Authorization
- A medical screening exam in the emergency room (ER))
- Be free from balance billing
- Not be responsible for Fidelis Care's debts in the event of bankruptcy and not be held liable for:
    - Covered Services provided to them for which the government does not pay Fidelis Care
    - Covered Services provided to them for which the government or Fidelis Care does not pay the Provider who furnished the services
    - Payment of Covered Services under a contract, referral or other arrangement to the extent those payments are in excess of the amount they would owe if Fidelis Care provided the services directly
- Be free from hazardous procedures or any form of restraint or seclusion as a means of force, discipline, convenience or revenge
- Ask for and get a copy of their medical records from their Provider; also, to ask that the records be changed/corrected if needed (requests must be received in writing from the Member or the person they choose to represent them; the records will be provided at no cost; they will be sent within 14 days of receipt of the request)
- Have their records kept private
- Make their healthcare wishes known through advance directives
- Have a say in Fidelis Care's Member rights and responsibilities policies and

recommend changes to other policies and services that Fidelis Care covers
- Appeal medical or administrative decisions by using Fidelis Care's appeals and grievances process
- Exercise these rights no matter their sex, age, race, ethnicity, income, education or religion
- A policy on the treatment of minors
- Have Fidelis Care staff observe their rights
- Have all of these rights apply to the person legally able to make decisions about their healthcare
- Be furnished quality services in accordance with 42 CFR 438.206 through 438.210, which include:
    - Accessibility
    - Authorization standards
    - Availability
    - Coverage
    - Coverage outside of network

Fidelis Care Members also have certain responsibilities. These include the responsibility to:
- Read their Member Handbook to understand how Fidelis Care's healthcare plan works
- Carry their Member identification card and Medicaid/NJ FamilyCare card at all times
- Give information that Fidelis Care and their Providers need to provide care to them
- Follow plans and instructions for care that they have agreed on with their Provider
- Understand their health problems
- Help set treatment goals that they and their Provider agree upon
- Show their Member identification card to each Provider when they receive services
- Schedule appointments for all non-emergency care through their Provider
- Get a referral from their PCP for specialty care
- Cooperate with the people who provide their healthcare
- Be on time for appointments
- Tell their Provider's office if they need to cancel or change an appointment
- To pay their co-pays to Providers
- Respect the rights and property of all Providers
- Respect the rights of other patients
- Not be disruptive at their Provider's office
- Know the medicines they take, what they are for and how to take them the right way
- Make sure their Provider has copies of all of their previous medical records
- Let Fidelis Care know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care
- Be responsible for cost sharing only as specified under Covered Services co-pays

Quality Improvement

Please refer to *Section 3* for additional information on Fidelis Care's Quality Improvement Program, including but not limited to, Provider Participation in the Quality Improvement Program, Member Satisfaction and Web Resources.

Overview

Fidelis Care's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and BH and SUD care and MLTSS services. It applies to all Member demographic groups, care settings and types of services afforded to Medicaid Members; including special needs, BH and SUD, Managed Long Term Services and Supports (MLTSS) and Dual Special Needs Plan (D-SNP). The QI Program addresses the quality of clinical care and non-clinical aspects of service including MLTSS and D-SNP that can be expected to have a beneficial effect on health outcomes, enrollee satisfaction, and enrollee choice in determining healthcare setting. Strategies are identified and activities are implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that includes, but is not limited to:

- Quantitative and qualitative improvement in Member outcomes
- Coordination and continuity of care with seamless transitions across healthcare settings/services
- Cultural competency
- Quality of care/service
- Patient safety
- Critical Incidents (including abuse, neglect and exploitation)
- Preventative health
- Integration of behavioral and dental health
- Service utilization
- Grievances
- Network adequacy/practitioner availability and accessibility
- Appropriate service utilization
- Disease and Case/Care Management
- Member and Provider satisfaction
- MLTSS
- Components of operational service
- Regulatory/federal/State/accreditation requirements

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS® measures and/or medical record audits. The organization's Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

Medical Records

Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to medical charts, prescription files, hospital records, Provider specialist reports, consultant and other healthcare professionals' findings, appointment records, MLTSS services and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of service provided. Medical records must be signed and dated.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted only to authorized personnel. Access to records should be granted to Fidelis Care, or its representatives without a fee to the extent permitted by State and federal law. Records remaining under the care, custody, and control of the physician or healthcare Provider shall be maintained for a minimum of 10 years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to Fidelis Care upon request at no cost to Fidelis Care. Information from the medical record review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including but not limited to, confidentiality of Member information and release of records, refer to *Section 8: Compliance* in this Manual.

Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS)

Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of healthcare delivery by all inpatient, outpatient and MLTSS Providers, Fidelis Care supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues, Critical Incident reporting and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular check-ups
- Immunizations
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, Pap smears and mammograms

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the Member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from Participating Providers and the Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools, and ongoing monitoring and measuring of outcomes. While Fidelis Care can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

Critical Incidents

Fidelis Care will require its staff Members and contracted MLTSS Providers to report, respond to, and document Critical Incidents as specified by Fidelis Care in accordance with applicable requirements.

Critical Incidents will include, but not be limited to, the following incidents when they occur in Nursing Facility/Skilled Care Nursing Facilities or home- and community-based long-term care service delivery settings, including community alternative residential settings, adult day care centers, other HCBS Provider sites and a Member's home:

- Unexpected death of a Member
- Missing person or unable to contact
- Inaccessible for initial on-site meeting
- Theft with law enforcement involvement
- Severe injury or fall resulting in the need for medical treatment
- Medical or psychiatric emergency, including suicide attempt
- Medication error resulting in serious consequences
- Inappropriate or unprofessional conduct by a Provider/agency involving the Member
- Suspected or evidenced physical or mental abuse, (including seclusion and restraints, both physical and chemical)
- Sexual abuse and/or suspected sexual abuse
- Neglect/mistreatment, including self-neglect, caregiver overwhelmed, environmental
- Exploitation, including financial, theft, destruction of property
- Failure of a Member's back-up plan
- Elopement/wandering from home or facility
- Eviction/loss of home
- Facility closure, with direct impact to Member's health and welfare
- Media involvement or the potential for media involvement
- Cancellation of utilities
- Natural disaster, with direct impact to Member's health and welfare
- Other, explain

MLTSS Providers must report a Critical Incident to Fidelis Care within 24 hours of becoming aware of the incident. When a verbal report is made, the Provider making the initial report must submit a follow-up written report within 48 hours, and fax it to **1-973-274-2121**.

Following the occurrence of a Critical Incident, MLTSS Providers must immediately (which shall not exceed 24 hours) take steps to prevent further harm to any and all Members and respond to any emergency needs of Members.

MLTSS Providers who become aware of a Critical Incident will conduct an internal Critical Incident investigation and submit a report on the investigation within the time frame specified by Fidelis Care. The time frame for submitting the report will be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, will be no more than 30 calendar days after the date of the incident.

Fidelis Care shall review the Provider's report and follow up with the Provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable time frames.

Additionally, in accordance with State requirements, MLTSS Providers shall:

- Develop and implement a Critical Incident reporting process, including the form provided by Fidelis Care, to be used to report Critical Incidents and reporting time frames
- Immediately report suspected abuse, neglect and exploitation of Members
- Cooperate, and require their staff to cooperate, with any investigation conducted by the Fidelis Care, its designee or outside agencies, including law enforcement
- Provide appropriate training for its staff and take corrective action as needed to ensure compliance with Critical Incident requirements

Fidelis Care will identify and track Critical Incidents and will review and analyze Critical Incidents to identify and address potential and actual quality of care and/or health and safety issues.

To report any actual or suspected Critical Incident, Providers may call **1-855-642-6185**

Clinical Practice Guidelines

Fidelis Care adopts validated evidence-based *Clinical Practice Guidelines* (*CPGs*) and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating Provider may supersede *CPGs*, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations, including MLTSS Members. The *CPGs* are based on peer-reviewed medical evidence and are relevant to the population served, including MLTSS Members. Approval of the *CPGs* occurs through the Quality Improvement Committee. *Clinical Practice Guidelines*, to include Preventative Health Guidelines, may be found on Fidelis Care's website at **fideliscarenj.com/providers/tools/clinical-guidelines**.

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool is comprised of 92 measures across six domains of care, including:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

HEDIS is a mandatory process that occurs annually. It is an opportunity for Fidelis Care and Providers to demonstrate the quality and consistency of care that is available to all Members, including MLTSS Members. Medical records and claims data are reviewed to ensure the required data are captured. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Members benefit from the quality and effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Utilization Management (UM), Care Management (CM), Disease Management (DM)

Utilization Management, Care Management, Disease Management

Please refer to *Section 4: UM, CM, DM* for additional information on Fidelis Care's Utilization, Care and Disease Management programs, including but not limited to Medical Necessary services, referrals, Transition of Care and Candidates for Disease Management.

Prior Authorization for MLTSS Services

Prior Authorization allows for efficient use of covered MLTSS services and ensures that Members receive the most appropriate level of care, within the most appropriate setting. Prior Authorization may be obtained by the Member's PCP, treating specialist or facility. Reasons for requiring Prior Authorization may include:

- Review for Medical Necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Care and disease management considerations

Prior Authorization is **required** for elective, non-urgent or non-emergency services as designated by Fidelis Care. Prior Authorization requirements by service type may be found on the *Quick Reference Guide* on Fidelis Care's website at
fideliscarenj.com/providers/Medicaid
or on the searchable authorization Look-up Tool at
wellcare.com/New-Jersey/Providers/Authorization-Lookup.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure
- A Prior Authorization may be given for a series of visits or services related to an episode of care. The Prior Authorization request should outline the plan of care

including the frequency and total number of visits requested and the expected duration of care

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective, non-urgent or non-emergency admission. Fidelis Care will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with Fidelis Care retroactively or in cases of emergency treatment and the payer is not known at the time of service. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member's needs at the time of service. Fidelis Care will also identify quality issues, utilization issues and the rationale behind failure to follow Fidelis Care's Prior Authorization/pre-certification guidelines.

The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member's needs at the time of service. Fidelis Care will also identify quality issues, utilization issues and the rationale behind failure to follow Fidelis Care's Prior Authorization/pre-certification guidelines.

Fidelis Care will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If Fidelis Care is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

Care Management Program

For MLTSS Members, the Care Manager will assume primary responsibility for coordination of the Member's physical health, BH and SUD and long-term care needs. To facilitate the care planning process, the Care Manager will conduct face-to-face visits, and determine the Member's interest in transitioning to the community or another alternative living setting as appropriate.

POC Development

A MLTSS Provider may be contacted by the Care Manager for Plan of Care (POC) Development.

Claims

Please refer to *Section 5* for additional information on Fidelis Care's Provider claims information and process, including, but not limited to, timely claims submission, preauthorization number, claim processing, disputed claims and reimbursement.

Universal billing format for MLTSS

For paper submissions:

- Providers need to use the "1500" form for AL facilities, HCBS service Providers, and

non-traditional Providers such as home improvement contractors, emergency response system Providers, meal delivery Providers and more.
- Providers need to use the "UB-04" form for NFs and SCNFs.

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

Patient Payment Liability

- MLTSS Members residing in an Assisted Living (AL) and/or NF setting may have a cost share as calculated by the County Welfare Agency and are responsible to pay the Provider of services the cost share. This is in addition to the Room and Board charge established by the State.

- Cost share/patient payment liability (PPL) will be deducted from the NF and/or AL Provider payments.

- The County Welfare Agency (CWA), on behalf of the State of New Jersey, will calculate the cost share for individuals determined eligible for MLTSS.

Providers will no longer calculate PPL. Any Provider who becomes aware of updated PPL information shall communicate it to the CWA for their consideration.

Prompt Payment

For MLTSS Providers, Fidelis Care will pay Clean Claims within 15 calendar days after receipt when submitted electronically, or 30 calendar days after receipt when submitted by paper. Note that a Provider's submission of a Clean Claim to Fidelis Care's billing agent or clearinghouse does not constitute receipt by Fidelis Care.

If Fidelis Care is late in paying a Clean Claim, Fidelis Care is required to pay simple interest on that Clean Claim at 12% per annum, with such interest calculated from the date that the Clean Claim should have been paid. Any such interest owed will be included with the claim payment.

Credentialing

Please refer to *Section 6* for additional information on Fidelis Care's Credentialing, including, but not limited to, Practitioner Rights, Covering Physicians, Ancillary Healthcare Delivery Organizations and Delegated Entities.

Grievances and Appeals

Please refer to *Section 7 for* additional information on Fidelis Care's grievances and appeals, including, but not limited to, actions, Provider grievances, Member grievances, Provider claim resolution and appeals.

Compliance

Please refer to *Section 8* for additional information on Fidelis Care's Compliance Program, including, but not limited to, Code of Conduct and Business Ethics, Fraud, Waste and Abuse, and confidentiality of Member information.

Delegated Entities

Please refer to *Section 9* for additional information on Fidelis Care's Delegated Entities, including, but not limited to, Compliance.

Pharmacy

Please refer to *Section 11* for additional information on Pharmacy, including, but not limited to, Preferred Drug List, Quantity and Age Limits, Coverage Limitations and Medication appeals.

Addendum B: Orthodontic Services

Orthodontic services are provided through LIBERTY Dental Plan at **libertydentalplan.com**.

Fidelis Care provides all dental services, including orthodontic services using LIBERTY Dental Plan as its dental vendor. The following standards and procedures apply to the provision of orthodontic services for children in Fidelis Care's NJ FamilyCare (NJFC) programs.

Orthodontic Consultation (D9310) – must include a visual examination and may also include a completed HLD (NJ-Mod3) Assessment Tool by the attending Provider or a Provider in the same group. This consultation does not require Prior Authorization, can be provided once a year and will be linked to the Provider and not to the patient (which allows for a second opinion with a different provider).

Pre-orthodontic Treatment Visit (D8660) – includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool. The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ-Mod3) is completed by the dentist that will be rendering the orthodontic treatment.

The new HLD (NJ-Mod3) Assessment Tool and instructions are located in Addendum C.

If the HLD (NJ-Mod3) Assessment Tool has an "X" and correctly documented clinical criteria found in sections1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool requires documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require Prior Authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the Provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor Treatment to Control Harmful Habits

Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited, interceptive or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires Prior Authorization and can be considered with documentation of incident and documentation of Medical Necessity.

For Prior Authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted

and maintained in the treatment records. Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Orthodontic Treatment Services
Limited, interceptive and comprehensive orthodontic services **must be prior authorized** and will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition for treatment of the permanent teeth.

Prior Authorization determinations shall be made and notice sent to the Provider within ten (10) days of receipt of necessary information sufficient for a dental consultant to make an informed decision.

In cases where Prior Authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment
Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition.

For Prior Authorization, the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films;
- Diagnostic study models or diagnostic digital study cast images; and,
- The referring primary care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy **must** be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the Member. Replacement of retainers or removable appliances due to loss or damage beyond repair requires Prior Authorization and can be considered with documentation of Medical Necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the Prior Authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment
For Prior Authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction and dental diagnosis;
- The interceptive or comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring primary care dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models;
- Diagnostic photographs (which may suffice in place of models;
  Diagnostic x-rays, digital x-rays or cephalometric film with tracing (when applicable); and,
- When applicable:
  - Medical diagnosis and surgical treatment plan
  - Detailed documentation of extenuating circumstances
  - Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

Interceptive Orthodontics
Interceptive treatment can be considered for localized tooth movement and may be for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary or transitional dentition. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers to the provider of placement. Replacement of retainers or removable appliances due to loss or damage beyond repair requires Prior Authorization and documentation of Medical Necessity.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately In this case, the Prior Authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase, including the expected time frame and expected initiation (month/year) of comprehensive treatment. Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

The NJFC Medicaid Fee-for-Service (FFS) program reimburses for periodic treatment visits (D8670) which are billed for the date of service. A maximum of 24 units of D8670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is requested using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) **is billed separately** on the date of service. Services reimbursed through these codes will include all appliances, **their** insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the service; however, replacement of retainers or removable appliances due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires Prior Authorization and can be considered with documentation of the incident and Medical Necessity.

Reimbursement for orthodontic services includes the placement **and removal** of all appliances and brackets; therefore, should it become necessary to remove the bands following or due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the **appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service.** In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting Prior Authorization

Prior Authorization for comprehensive orthodontic treatment will only be considered for the **late mixed and permanent dentitions**. Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning Treatment

- In addition to submission requirements already noted, the Prior Authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with a maximum number of units for treatment visits to be considered on any one Prior Authorization being twelve (12);
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- If the Prior Authorization expires before all approved units are used, a Prior Authorization may be submitted for the remaining units along with an explanation

that includes the original Prior Authorization number and why treatment did not occur within the active time of the Prior Authorization.

Continuing Treatment

- Prior Authorization for the continuation of treatment visits for the continuation of the case shall be submitted after completing the first twelve (12) units of treatment visits or at the mid-point of treatment.
- The maximum number of additional treatment visits allowed to continue the case is twelve (12).
- If the Prior Authorization expires before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original Prior Authorization number and why treatment did not occur within the active time of the Prior Authorization.
- The following shall be included with the Prior Authorization to continue treatment:
    - A copy of the treatment notes;
    - Documentation of any problems with compliance;
    - Attestation from the current primary care dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;
    - Pretreatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
    - A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC Medicaid Program

For continuation of care for transfer cases whether they were or were not started by another NJFC Medicaid provider, a Prior Authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per Prior Authorization to be considered.

The following must be submitted with the Prior Authorization:

- A copy of the initial orthodontic case approval (if applicable);
- Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes from provider that started the case (if available);
- Recent diagnostic photographs and/or panoramic radiographs and if available pretreatment images;
- The date when active treatment was started;
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed; and,
- If applicable a new treatment plan and documentation to support the treatment change if re-banding is planned.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for Prior Authorization of the orthodontic services;
- Prior Authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC Medicaid program.

Conclusion of Active Treatment

- Attestation of case completion must be submitted to document that active treatment had a favorable outcome and that the case is ready for retention.
- Procedure code D8680, orthodontic retention, shall be submitted for Prior Authorization along with recent panorex and photographs when the active phase of orthodontic treatment is completed.
- Once approved, the bands can be removed, and the case placed in retention.

Documentation for Completion of Comprehensive Cases – Final Records

The following **must** be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph;
- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen; and,
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that treatment is not progressing because the patient is exhibiting noncompliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered. A letter must be sent to the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the

discontinuation of treatment with debanding. A copy of this letter and the patient treatment records must be sent to The Bureau of Dental Services, PO Box 712, Trenton, NJ 08625.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. For Members not enrolled in a NJFC MCO, a copy of the signed form and the patient treatment records must be sent to the Bureau of Dental Services along with the request to remove the appliance for reasons other than case completion. For Members enrolled in an MCO, a copy of the signed form and the patient treatment records must be sent to the NJFC MCO of enrollment.

The reimbursement for appliance placement includes their removal. However, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

For questions regarding patients not enrolled in a NJFC MCO, please contact the Bureau of Dental Services at **1-609-588-7136**. If the patient is enrolled in a NJFC MCO, please reference this Provider Manual for guidance, or contact Liberty Dental Plan at **1-888-352-7924** 5:00 a.m. through 8:00 p.m., EST.

Addendum C: Dental Forms

Please view the forms, noted below, in the Manual's appendices, or click on the links to access the forms directly:

Appendix A: Orthodontics HLD (NJ-Mod3) Index Form

- Link to form:
  NJ Orthodontic Evaluation HLD (NJ-Mod3) Index Form & Instructions

Appendix B: PCD Caries Risk Assessment Form (Age 0-6)

- Link to form: **PCD Caries Risk Assessment Form (Age 0-6)**

Appendix C: PCD Caries Risk Assessment Form (Over Age 6)

- Link to form: **PCD Caries Risk Assessment Form (Over Age 6)**

Appendix D: AAP Oral Health Risk Assessment Form for PCP's

- Link to form: **Oral Health Risk Assessment Form**

Appendix E: Reducing Pediatric Caries Risk Fluoride Supplement Q&A

Appendix F: Bidirectional Referral Form: Medical Provider Referral to Dentist

- Link to form: **Medical Provider Referral Form**

Providers may view the NJ FamilyCare Clinical Criteria Grid and Policy statement at:

- **NJ FamilyCare Clinical Criteria Policy and Grid**

Providers may contact LIBERTY Dental Plan (dental vendor) as follows:

- Call Provider Service at **1-888-352-7924,** Monday through Friday, 5 a.m. to 8 p.m. EST
- Online at **www.libertydentalplan.com**

Appendix A: Orthodontics HLD (NJ-Mod3) Index Form

Updated Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod3) Index Form

The intent of the HLD (NJ-Mod3) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose Malocclusion. Presence of any of the conditions sections 1 through 6A and 15, or a score total equal to or greater than 26 (when scored correctly) qualifies for Medical Necessity exception. Total scores less than 26 with extenuating circumstances must include appropriate documentation.

General Information

- **Only cases with late mixed and permanent dentition will be considered (see Pre-orthodontic Treatment Visit (D8660) for exception).**
- A Boley Gauge or disposable ruler scaled in millimeters should be used;
- The patient's teeth are positioned in centric occlusion;
- All measurements are recorded and rounded off to the nearest millimeter (mm);
- For sections 1 to 6A and 15 an X is placed if the condition exists and **scoring is completed,** as needed;
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 score is entered;
- **Diagnostic models are required** with the submission of Prior Authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion; or,
- **Diagnostic Digital models may be submitted** to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views;
- **Diagnostic quality photographs** to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views). Photographs shall include views with a millimeter ruler in place to demonstrate measurement for the following condition(s) when present as found in sections 6A, 6B, 7, 8, 9 and13.

Instructions For Form Completion

1. **Cleft Palate Deformity** – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report by a qualified specialist or craniofacial panel. Score an X if present.

2. **Cranio-facial Anomaly** – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.

3. **Impacted Permanent Anterior Teeth** – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction.

Score an X if present.

4. Crossbite of Individual Anterior teeth – Score an X if present. - demonstrate that anterior tooth or teeth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive wear, significant mobility or soft tissue damage. A narrative to include the class of mobility for the involved teeth and photographs of all areas with soft tissue damage. Score X as noted. **If these conditions do not exist, it is to be considered an ectopic eruption and scored in section 10.**

5. Severe Traumatic Deviation – Damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.

6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5 – Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.

6B. Overjet equal to or less than 9mm – Overjet is recorded as in condition in section 6A. The measurement is rounded to the nearest millimeter and entered on the score form.

7. Overbite – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form.

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm – Mandibular protrusion (reverse overjet) is recorded as a condition and rounded to the nearest millimeter. Enter the score on the form and multiply the measurement by five (5).

9. Open Bite in millimeters – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply the measurement by four (4). If measurement is not possible, measurement can usually beestimated.

10. Ectopic Eruption – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition 12) also exists in the same arch, score the condition that produces the most points. **DO NOT COUNT BOTH CONDITIONS.** The exception to this rule is: (a) posterior ectopic eruptions in the same arch (b) if ectopic eruption score is transferred due to anterior crossbite without trauma, excessive wear of mobility. In these two exceptions, count ectopic eruption PLUS

the crowding.

11. Deep Impinging Overbite – This occurs when either destruction of soft tissue on palate, gingival recession and mobility and/or abrasion of teeth are present. Submit intraoral photographs of tissue damage/impingement. The presence of deep impinging overbite is indicated by a total score of three (3) on the score form.

12. Anterior Crowding – Arch length insufficiency must exceed 3.5 mm. Mild rotations are not to be scored as crowded. Score one (1) crowding per arch. Enter the total on score form and multiply the measurement by five (5). If ectopic eruption is scored in section 10 (not from crossbite in section 4), this crowding cannot be scored in addition. However if ectopic eruption is due to a transfer of score from section 4 to section 10, because crossbite did not result in damage, both ectopic and crowding can be counted.

13. Labio-Lingual Spread – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labia-lingual spread, but only the most severe individual measurement should be entered on the score form.

14. Posterior Unilateral Crossbite – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal and both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a total score of four (4) on the score form. THERE IS NO ADDITIONAL SCORE FOR Bl-LATERAL CROSSBITE.

15. Psychological factors affecting child's development – This condition requires detailed documentation by a **mental health provider** as described in the NJFC Medicaid managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

NJ Orthodontic Assessment Tool for Comprehensive Treatment
HLD (NJ-Mod3)

****Attach attestation that all needed preventive and dental treatment was completed****

Date: _____ Name: _____
DOB: _____ NJFC ID#: _____
Sex: M / F Class/Type of Case _____

The instructions for completing this form begin on Page 7. Sections 1-6A and 15 automatically qualify. Score with an X when these conditions are present. Sections 6B-14 scores must total 26 or more, or when less than 26 must include documentation of medical necessity.

	Condition	Score
1.	**Cleft palate deformity** (attach description from credentialed specialist)	
2.	**Cranio-facial Anomaly** (attach description from credentialed specialist)	
3.	**Impacted permanent anteriors** where extraction is not indicated Note the number of teeth	
4.	**Crossbite of individual anterior teeth with trauma, mobility and/or soft tissue damage must be present and documented**	
5.	**Severe traumatic deviations**	
6A.	**Overjet greater than 9 mm** with incompetent lips or **reverse overjet greater than 3.5 mm**	
6B.	**Overjet** (mm)	
7.	**Overbite** (mm)	
8.	**Mandibular protrusion** (mm) x 5	
9.	**Open bite** (mm) x 4	
10.	**Ectopic eruption or crossbite of individual anterior teeth without damage** (# of teeth x 3)	
11.	**Deep impinging overbite** (intra-oral photos showing palatal soft tissue impingement/destruction, gingival recession or attrition of teeth are required) Score 3 points if present	
12.	**Anterior crowding MX ____ MD____ Total _____ x5** (score **1** per arch)	
13.	**Labiolingual spread** (mm)	
14.	**Posterior unilateral crossbite** (involving molar): Score 4 if present	
15.	**Psychological factors affecting development ("X"** requires detailed documentation by **mental health provider** as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

☐ Documentation of extenuating circumstances attached for score total less than 26 (independent of conditions described in Nos. 1-6A and 15).

Appendix B: PCD Caries Risk Assessment Form (Age 0-6)

This form can be accessed at:
libertydentalplan.com/Resources/Documents/CariesRiskAssessmentForm/PDF.

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Appendix C: PCD Caries Risk Assessment Form (Over Age 6)

This form can be accessed at:

libertydentalplan.com/Resources/Documents/CariesRiskAssessmentForm/PDF.

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age >6)

Patient Name:				
Birth Date:			Date:	
Age:			Initials:	
		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	☐ Yes	☐ No	
General Health Conditions		Check or Circle the conditions that apply		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	**Chemo/Radiation Therapy**	☐ No		☐ Yes
III.	**Eating Disorders**	☐ No	☐ Yes	
IV.	**Medications that Reduce Salivary Flow**	☐ No	☐ Yes	
V.	**Drug/Alcohol Abuse**	☐ No	☐ Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in last 36 months ☐
II.	**Teeth Missing Due to Caries in past 36 months**	☐ No		☐ Yes
III.	**Visible Plaque**	☐ No	☐ Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐ No	☐ Yes	
V.	**Interproximal Restorations - 1 or more**	☐ No	☐ Yes	
VI.	**Exposed Root Surfaces** Present	☐ No	☐ Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins**; **Open Contacts** with Food Impaction	☐ No	☐ Yes	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	☐ No	☐ Yes	
IX.	**Severe Dry Mouth (Xerostomia)**	☐ No		☐ Yes

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age >6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Appendix D: Oral Health Risk Assessment Form: For use of PCPs and other medical personnel.

This form can be accessed at: **fideliscarenj.com/providers/medicaid/forms**

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐Yes ☐No	• Existing dental home ☐Yes ☐No	⚠ White spots or visible decalcifications in the past 12 months ☐Yes ☐No
• Mother or primary caregiver does not have a dentist ☐Yes ☐No	• Drinks fluoridated water or takes fluoride supplements ☐Yes ☐No	⚠ Obvious decay ☐Yes ☐No
• Continual bottle/sippy cup use with fluid other than water ☐Yes ☐No	• Fluoride varnish in the last 6 months ☐Yes ☐No	⚠ Restorations (fillings) present ☐Yes ☐No
• Frequent snacking ☐Yes ☐No	• Has teeth brushed twice daily ☐Yes ☐No	• Visible plaque accumulation ☐Yes ☐No
• Special health care needs ☐Yes ☐No		• Gingivitis (swollen/bleeding gums) ☐Yes ☐No
• Medicaid eligible ☐Yes ☐No		• Teeth present ☐Yes ☐No
		• Healthy teeth ☐Yes ☐No

ASSESSMENT/PLAN

Caries Risk:
☐Low ☐High

Completed:
☐Anticipatory Guidance
☐Fluoride Varnish
☐Dental Referral

Self Management Goals:

☐Regular dental visits	☐Wean off bottle	☐Healthy snacks
☐Dental treatment for parents	☐Less/No juice	☐Less/No junk food or candy
☐Brush twice daily	☐Only water in sippy cup	☐No soda
☐Use fluoride toothpaste	☐Drink tap water	☐Xylitol

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MW, Crall JJ, Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. *J Calif Dent Assoc.* 2010;38(10):746–761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics.* 2003; 122(6):1387–1394; and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. *Pediatrics.* 2003;111(5):1113–1116.

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Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment

The Bright Futures/AAP "Recommendations for Preventive Pediatric Health Care," (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

⚠ Maternal Oral Health

Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. **This child is high risk.**

Maternal Access to Dental Care

Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use

Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking

Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs

Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home

According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements

Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page http://aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months

Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, www.smilesforlifeoralhealth.org.

Tooth Brushing and Oral Hygiene

Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.

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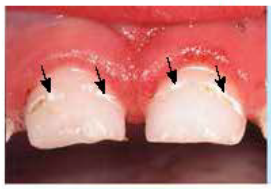
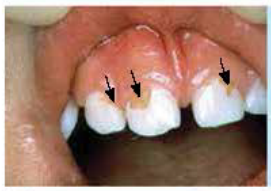
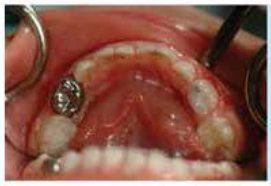
Clinical Findings



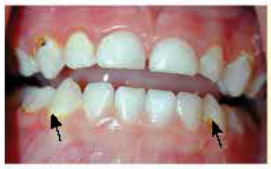
⚠ **White Spots/Decalcifications**
This child is high risk.
White spot decalcifications present—immediately place the child in the high-risk category.



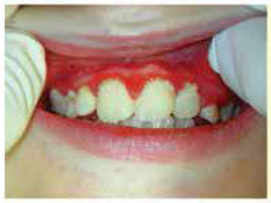
⚠ **Obvious Decay**
This child is high risk.
Obvious decay present—immediately place the child in the high-risk category.



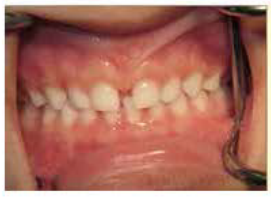
⚠ **Restorations (Fillings) Present**
This child is high risk.
Restorations (Fillings) present—immediately place the child in the high-risk category.



Visible Plaque Accumulation
Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Primary care clinicians can teach parents how to remove plaque from the child's teeth by brushing and flossing.



Gingivitis
Gingivitis is the inflamation of the gums. Primary care clinicians can teach parents good oral hygiene skills to reduce the inflammation.



Healthy Teeth
Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP's oral health activities email oralhealth@aap.org or visit www.aap.org/oralhealth.

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Bright Futures

National Interprofessional Initiative on Oral Health
engaging clinicians eradicating dental disease

Appendix E: Reducing Pediatric Caries Risk Fluoride Supplement Q&A

Reducing Pediatric Caries Risk

FLUORIDE SUPPLEMENT Q & A

Are caries risk assessments a routine part of your pediatric exams?

As a PCP/PCD, you probably evaluate a child's risk factors for dental caries. You may look at things like dietary habits, daily dental care at home and even parental knowledge of proper dental hygiene.

Could a dietary fluoride supplement help?

For your patients at higher caries risk, you may be considering dietary fluoride supplements. Clinical studies from the ADA recommend dietary fluoride supplements for certain children ages 6 months through 16 years who are at high caries risk. (See chart on back.)

How much fluoride does the patient routinely get?

In order to achieve an optimal dosing schedule, it's important to evaluate all other sources of fluoridation in the child's available water supply. This may require some discussion with the parent or guardian to determine all potential sources of drinking water. Sources could include home, school, daycare and any other environments where the child typically eats and drinks. All sources of fluoride should be considered including bottled water, tap water and even fluoride rinses. Supplements are recommended by the ADA wherever fluoride concentration in available drinking water is less than .6 ppm. (See dosing chart on back.)

Please consider making caries assessment a regular part of every pediatric exam. And refer to the ADA guidelines on the back, when dietary fluoride supplements are indicated. Simply chewing a tablet each day may help ensure a healthy mouth for children at high risk for caries.

Fluoride Supplement Dosage Schedule – 2010

Approved by The American Dental Association Council On Scientific Affairs

Dietary Fluoride Supplements: Evidence-based Clinical Recommendations[1]

Levels of evidence and strength of recommendations: Each recommendation is based on the best available evidence. Lower levels of evidence do not mean the recommendation should not be applied for patient treatment.

Correlate these colors with the text and table below.

Practitioners are encouraged to evaluate all potential fluoride sources and conduct a caries risk assessment before prescribing fluoride supplements.

For children at **low caries risk**, dietary fluoride supplements are **not recommended** and other sources of fluoride should be considered as a caries preventive intervention. **(D)**
For children at **high caries risk**, dietary fluoride supplements are **recommended** according to the schedule presented in the following table. **(D)**
When fluoride supplements are prescribed, they should be **taken daily** to maximize the caries prevention benefit. **(D)**

ADA dietary fluoride supplement schedule for children at high caries risk

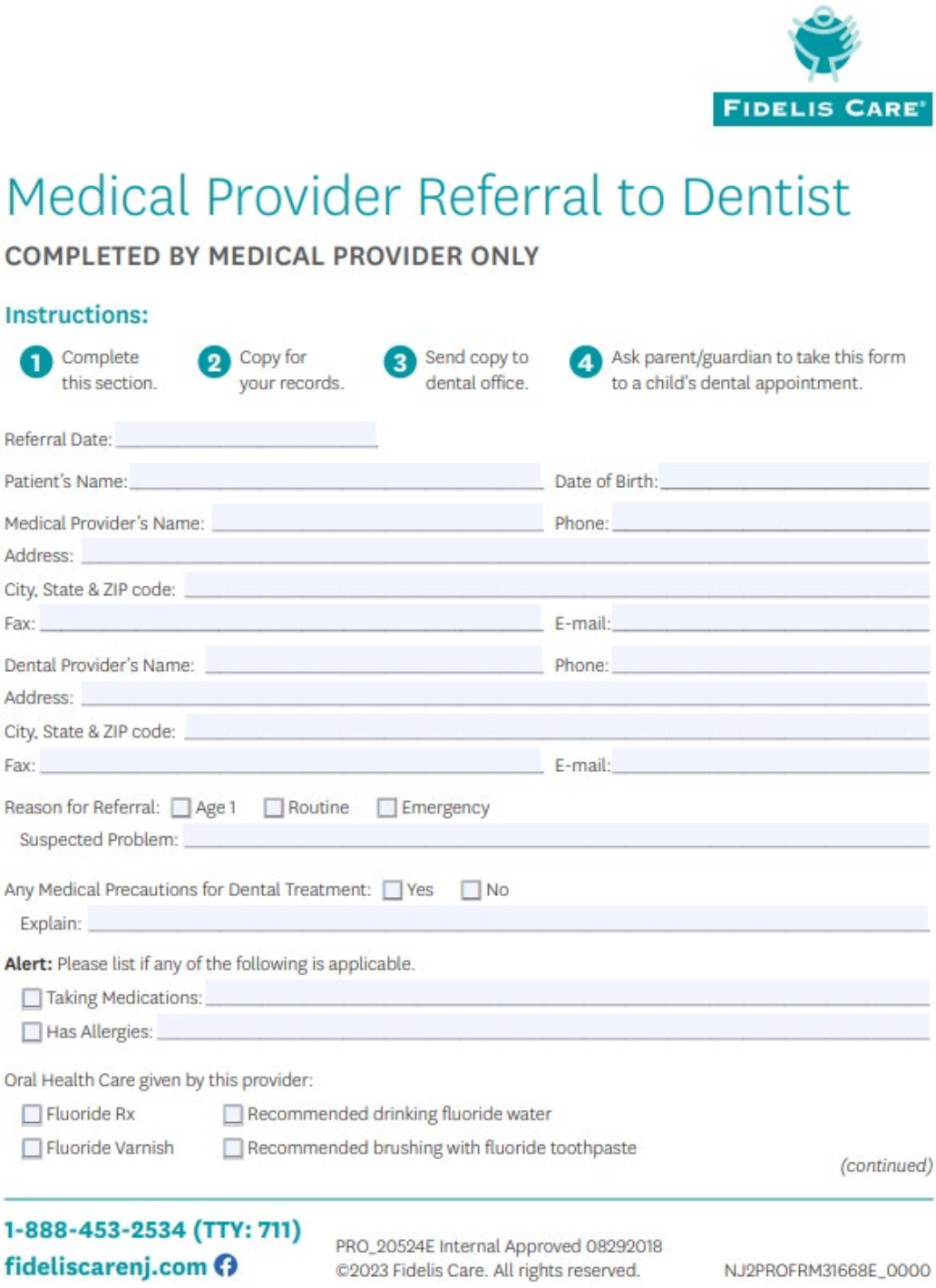
Age (Years)	Fluoride Concentration in Drinking Water (ppm)*		
	<0.3	0.3-0.6	>0.6
Birth to 6 months	None **(D)**	None **(D)**	None **(D)**
6 months to 3 years	0.25 mg/day **(B)**	None **(D)**	None **(D)**
3 to 6 years	0.50 mg/day **(B)**	0.25 mg/day **(B)**	None **(D)**
6 to 16 years	1.0 mg/day **(B)**	0.50 mg/day **(B)**	None **(D)**

*1.0 ppm = 1 mg/liter

[1]Rozier, et al. Evidence-based clinical recommendations on the prescription of dietary fluoride supplements for caries prevention: a report of the ADA Council on Scientific Affairs. Evidence-based clinical recommendations on the prescription of dietary fluoride supplements for caries prevention. JADA 2010; 141:1480-1489. Copyright © 2010 American Dental Association, All rights reserved. Adapted with permission. To see the full text of this article, please go to http://jada.ada.org/cgi/reprint/141/12/1480.

Consult the ADA chart online at:
www.ada.org/en/member-center/oral-health-topics/fluoride-supplements#dosage

Appendix F: Bidirectional Referral Form: Medical Provider Referral to Dentist



FIDELIS CARE®

Medical Provider Referral to Dentist

COMPLETED BY MEDICAL PROVIDER ONLY

Instructions:

1. Complete this section.
2. Copy for your records.
3. Send copy to dental office.
4. Ask parent/guardian to take this form to a child's dental appointment.

Referral Date: _____

Patient's Name: _____ Date of Birth: _____

Medical Provider's Name: _____ Phone: _____

Address: _____

City, State & ZIP code: _____

Fax: _____ E-mail: _____

Dental Provider's Name: _____ Phone: _____

Address: _____

City, State & ZIP code: _____

Fax: _____ E-mail: _____

Reason for Referral: ☐ Age 1 ☐ Routine ☐ Emergency

Suspected Problem: _____

Any Medical Precautions for Dental Treatment: ☐ Yes ☐ No

Explain: _____

Alert: Please list if any of the following is applicable.

☐ Taking Medications: _____

☐ Has Allergies: _____

Oral Health Care given by this provider:

☐ Fluoride Rx ☐ Recommended drinking fluoride water

☐ Fluoride Varnish ☐ Recommended brushing with fluoride toothpaste

(continued)

1-888-453-2534 (TTY: 711)

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PRO_20524E Internal Approved 08292018

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Dental Report to Medical Provider

COMPLETED BY DENTIST ONLY

Dental Provider: _____ Date: _____

Instructions:

1. Complete this section.
2. Copy for your records.
3. Mail, fax or e-mail form to medical provider.

☐ Oral hygiene ☐ Cleaning ☐ Restorative tx ☐ Exam/X-rays
☐ Sealants ☐ Fluoride Rx ☐ Fluoride Varnish/Topical Fluoride

Comments: _____

☐ tx completed ☐ Additional tx needed Approx. # of units needed: _____

Addendum D: Fully Integrated Dual-Eligible Special Needs Plans

Important Information about Fidelis Care Liberty (HMO SNP) in New Jersey

Fidelis Care Liberty (HMO SNP) is a Dual-Eligible Special Needs Plan, which means only beneficiaries eligible for both Medicare and Medicaid may enroll in the plan. In addition, Fidelis Care Liberty (HMO SNP) further qualifies as a Fully Integrated Dual Eligible (FIDE) SNP, which means that Members receive their Medicare benefits from the plan and their full Medicaid benefits – including, when eligible, Long Term Services and Supports.

As a FIDE-SNP, Fidelis Care Liberty (HMO SNP) is a zero cost-share plan. This means Members, so long as they are active with the plan, owe nothing for Covered Services and may not be balance-billed for Covered Services. Claims for Fidelis Care Liberty Members will be adjudicated first through their Medicare benefits and then through their Medicaid benefits. Services not covered by Medicare may in turn be covered by the Members' Medicaid benefits. This includes cost shares (i.e., deductibles, co-payments and coinsurance) for Medicare-Covered Services.

Liberty Members Are Not Responsible for Medicare Cost Shares.

Therefore, although Member deductibles, co-payments or coinsurance may appear on your Explanations of Payment (EOPs) or Remittance Advices (RAs), those amounts may not be billed to plan Members. Fidelis Care Liberty (HMO SNP) Members are cost-share protected by the State, which means they must not be billed. Instead, the Medicare cost shares will be adjudicated through the Members' Medicaid benefits to determine what, if anything, is still owed by the plan. Fidelis Care payment for Covered Services for which the Members' Medicare benefit is primary must be considered payment in full and will be the lesser of the Medicare or Medicaid Allowable Amounts.

New Identification Card

Fidelis Care Liberty Members will receive a plan ID card. This single card gives the Member access to all of the Fidelis Care Liberty plan's benefits, including Medicare Parts A and B, Part D prescription drugs and all Medicaid managed care benefits.

If you have any questions about the Fidelis Care Liberty plan, please contact our Provider Relations Department at **1-888-453-2534**. We will be happy to assist you.

Balance Billing Guidelines

Participating Providers are required to accept payment directly from Fidelis Care as payment in full. Any bill generated to a Member to collect for cost sharing is prohibited. Balance billing of "zero cost-share" dual-eligible Members is prohibited, including co-payments, etc.

Please consider the following scenarios that may unintentionally create a balance billing problem:

- You have a billing/practice management system that automatically generates a bill to a Member if they have not received a Remittance Advice from the plan within a certain time frame or if the expected amount received (in some cases zero, for denials) is less than the remitted amount.
- You have sent a lab test or other services out of network without proper authorization, creating a situation where our Member may be inappropriately billed
- You have not confirmed eligibility with Fidelis Care, resulting in the incorrect classification of a Member as self-pay, which in turn generates a bill to the Fidelis Care Member for services rendered. You can avoid this scenario by requiring all patients to present their ID cards at the time of their visit.

The generation of a balance bill to a dual-eligible (Medicare Advantage and Medicaid Managed Care Member) is not only against Fidelis Care's policy but is also strictly prohibited by CMS guidelines.

If you have any questions or concerns regarding claims, please call the Provider Services phone number at **1-888-453-2534** or contact your Provider Relations representative.

Note: A Provider may charge a Member for services not covered by Fidelis Care only when both parties have agreed prior to the service being rendered that the Member is being seen as "private pay". The Provider must obtain the Member's written consent that he or she will be financially responsible for the non-covered service, and that consent must be signed and dated on or before the date of service.

Explanation of Payment (EOP)

The NJ Liberty plan is a "two-way" contract plan. This simply means that we have separate contracts with Medicare and Medicaid individually. Because we have separate contracts with each entity, we have to generate a claim for each of them. The Medicare claim is generated first and calculates the Medicare allowable for the service. The co-pay/coinsurance that the Member would have paid under Medicare is deducted from the allowable amount and is shown on the EOP. The Medicaid claim is then produced with the amount already paid by Medicare, and Medicaid pays the remainder. If the Medicaid allowable amount is less than what was already paid by Medicare, then Medicaid pays $0. This has confused some Providers, and we have added the following statement to the EOP (highlighted in yellow below).

Payee: [redacted]	Check Date:	2/16/2016	Tax ID: [redacted]	LOB:	JMR
Check Number: 1000161699	Check Amount:	$69.20	Vendor: [redacted]		

Explanation of Payment Codes and Comments

2PMCR	MEDICARE 2% REDUCTION
CP011	COPAY - SPECIALIST SERVICES
PCFSC	PRICED PER FEE SCHEDULE RATE

CODE PR209 PLEASE READ: If code appears on this statement, this DSNP member is cost share protected per federal and state guidelines and via your provider contract with WellCare. If an amount is listed in the Total PR section along with code PR209 you cannot bill member for this cost share. You will automatically receive another EOP for what will be paid by Medicaid from WellCare. If your provider agreement includes a capitated payment for any services associated with this code you will receive no additional payment to cover the PR amount.

Fidelis Care Remittance Advice

PLEASE REVIEW LAST PAGE OF THIS DOCUMENT FOR FURTHER DESCRIPTION OF EXPLANATION CODES

Remittance Advice

Payee: FLORIDA HOSPITAL MEDICAL CENTER	Check Date:	7/1/2016	Tax ID:	590724459	NPI#:	1306938071	
Check: [redacted]	Check Amount:	$622,723.55	Vendor: [redacted]		LOB:	[redacted]	

Dates of Service	Procedure/Modifier	Billed Units	Paid Units	Denied Units	Billed	Allowed	Co-Pay Amount	Co-Ins Amount	Deductible Amount	Other Carrier	2% CMS Mandate	Paid	Explanation Code
Provider: FLORIDA HOSPITAL ORLANDO NPI#: 1457500191 Provider ID#: 20468 Patient ID#: 13709465 DRG Code: Total PR: 0.00													
[redacted] Interest: [redacted] Add-on: 0.00 [redacted] Pt Acct: 0085782668 Clm Lvl PR: 0.00													
[redacted]	LABOR ROOM DELIVE	2 [redacted]		2	778.00	0.00	0.00	0.00	0.00	0.[redacted]		0.00	DNM10 HSSAL PR209
					2,286.00	153.36	0.00	0.00	0.00	0.00	3.07	150.29	

Member Services

The Member Services team has a dedicated FIDE-SNP team to handle calls. The team receives special training on the D-SNP program. NJ has a specific training program that is required for each team member.