Aetna Better Health® of New Jersey

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Provider Newsletter

Summer 2023

Clinical Practice Guidelines

Respected professional and public health organizations create clinical practice guidelines that document best practices and recommendations for care. We've chosen certain clinical guidelines to help our providers give members high-quality, consistent care with effective use of services and resources. These include treatment protocols for specific conditions, as well as preventive health measures.

The intention of these guidelines is to clarify standards and expectations. They should not:

- Take precedence over your responsibility to provide treatment based on the member's needs
- Substitute as orders for treatment of a member
- Guarantee coverage or payment for the type or level of care proposed or provided

Please review our Clinical Practice Guidelines for more information.

Provider Directory

Members can access the provider directory by visiting AetnaBetterHealth.com/NewJersey/find-provider or calling Member Services at **1-855-232-3596**. For a listing of NJ Smiles Dental providers (for children 0-3 years old), visit AetnaBetterHealth.com/NewJersey/members/benefits/dental.

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Benefits of Members Enrolling in Integrated Care Management

Our Care Management nurse team specializes in offering support that includes:

- Medical support
- Emotional support
- Social services support

Care Management is part of member's benefits and can help them get the health care services they need. Member's can opt in or out of Care Management at any time. For assistance, members call Member Services at **1-855-232-3596 (TTY 711)** and ask for the Care Management team. Our hours are Monday–Friday, 8 AM–5 PM.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health® of New Jersey's Member Services Department at **1-855-232-3596**.

Depression Screenings

Don't forget to screen your patients, our members for depression.

A depression screening is used to:

- Help diagnose depression
- Understand how severe depression may be
- Help figure out what type of depression you have

There are different types of depression. The most common types are:

- **Major depression**, also called major depressive disorder
  The symptoms typically make it difficult to work, sleep, study and eat. With major depression, you have symptoms most of the time for at least two weeks.
- **Persistent depressive disorder**, also called dysthymia
  The symptoms are less severe than major depression, but they last much longer, usually for at least two years.
- **Seasonal affective disorder (SAD)**
  This form of depression usually happens in winter when there's less sunlight. Most people with SAD tend to feel better in the spring and summer.
- **Postpartum depression**
  This is major depression that happens after giving birth. It's more severe and lasts longer than mild unhappiness and other mood changes that are often called the "baby blues." Major depression may also begin during pregnancy. Depression that happens during or shortly after pregnancy is called "perinatal depression." Medical experts recommend routine depression screening during pregnancy and after birth.

Source: https://MedlinePlus.gov/lab-tests/depression-screening/

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Topical Fluoride Varnish for Children

Role of Primary Care Providers (PCPs) in Dental Care

PCPs must perform basic oral screening for all members, remind them of the need for two annual preventive dental visits and perform yearly cavity assessments on all children through age twenty (20). A referral to a dentist by one year of age or soon after the of eruption the first primary tooth is recommended.

We encourage medical providers to apply fluoride varnish to children's teeth, perform dental assessments and promote routine oral heath visits for our young members. These services combine for reimbursement as an all-inclusive service and bill with a CPT code. They can be provided up to four times a year. This frequency is separate from services a dentist provides.

PCPs play a critical role in their patient's dental health by referring them to their dental home and dentist after they are seen for a medical visit. The member's dental home is listed on the front of their Aetna Better Health® of New Jersey dental ID card.

The member can also call Liberty Dental Plan at **1-855-225-1727** to find at dentist or to answer any questions they may have.

Importance of Oral Health in Children

Children begin to get their primary teeth during the first year of life. By age 6 or 7 years, they start to lose their primary teeth, which eventually are replaced by permanent teeth. Preventive dental care helps prevent tooth decay and identify other oral diseases. Tooth decay that is not treated can lead to pain, loss of teeth, and loss of self-confidence. Children who experience tooth pain may have difficulty eating or sleeping properly and may miss days of school. Early dental care will establish a lifetime of good oral habits.

Advance Directives

Please remind your patients to creative an advance directive for you to have in the medical record.

There are two types of advance directives in New Jersey:

1. Proxy directive
2. Living will (also known as an instruction directive) Your patients, our members can decide whether they want to have one of these or both.

If the member already has an advance directive, we suggest you remind them to:

- Sign and date it
- Keep a copy for yourself
- Give a copy to your health care surrogate
- Give a copy to all your providers
- Take a copy with you if you go to the hospital or emergency room
- Keep a copy in your car (if you have one).

Learn more on the State of New Jersey site.

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Developmental, Individual Difference, Relationship-Based Model (DIR) Program

Rates effective 4/1/2023 Effective April 1, 2023, DMAHS is expanding who can provide DIR services. DIR services may now be provided by individuals with a DIR certification and a minimum of a high school diploma when supervised by a master's-level practitioner with an advanced certification in DIR. New providers who possess less than a bachelor's degree must be supervised. Supervised providers must be certified to provide DIR by a certification/endorsement recognized by the Department of Human Services (DHS) and possess, at a minimum, a high school diploma, or equivalent. Reimbursement for supervision of each provider at this level shall be for a minimum of 1 hour per week, but not to exceed 2 hours per week.

Treatment assessment and treatment plan revision can only be completed by a licensed master's-level clinician whose scope of practice allows for assessment and treatment planning. These individuals are known as DIR Qualified Healthcare Providers (QHPs). Only QHPs shall review/revise the treatment plan while supervising the DIR provider. Supervision services will be billed using 96156EP26 in 15-minute units. Supervision services are billed concurrently with the services being provided by the DIR provider utilizing 96158EP through 96171EP. Supervision must be provided face-to-face.

Code with Modifier	Unit of Service/ Suggested Daily Limits	Medicaid Rate	Description	Service Provision
96156EP	Per Diem Suggested Daily Limits: 1 Units	$200.00	Health behavior assessment or re-assessment:	Development of the initial assessment and development of a treatment plan as well as reassessment and progress reporting by the QHP. Allowable activities include face-to-face time with the patient and/or caregivers to conduct assessments as well as non-face-to-face time for reviewing records, scoring and interpreting assessments, and writing the treatment plan or progress report.
96156EP26	15 Minutes Minimum of 4 units and up to 8 units per calendar week for each supervisee	$25.00	Supervision/ treatment plan modification	Supervision and/or treatment plan reassess ment and development by a QHP. Supervision may be provided by a clinician possessing a master's degree and an advanced DIR certification. Supervision must be face-to-face with the patient and the supervised employee present. Supervision is a minimum of 1-hour per week and a maximum of 2-hours per week. Treatment plan reassessment must be completed by a QHP.
96158EP 96159EP	30 Minutes Suggested Daily Limits: 1 Unit Each additional 15 Minutes Suggested Daily Limits: 30 Units	$42.50 $21.25	Health behavior intervention, initial 30 mins Health behavior intervention, each additional 15 mins	Codes 96158EP-96159EP are billed for behavior treatment by protocol, administered by, or under the direction of, a QHP, face-to-face with one patient.

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DIR Program (continued)

96164EP 96165EP	30 Minutes Suggested Daily Limits: 1 Unit Each additional 15 Minutes Suggested Daily Limits: 22 Units	$11.20 $5.60	Health behavior intervention, initial 30 mins Health behavior intervention, each additional 15 mins	Codes 96164EP-96165EP are billed for group-led sessions, by or under the direction of a QHP, for a minimum of 2 individual patients to a maximum of 8 individual patients. Billing is made for each child in the group session.
96167EP 96168EP	30 Minutes Suggested Daily Limits: 1 Unit Each Additional 15 Minutes Suggested Daily Limits: 14 Units	$50.00 $25.00	Health behavior intervention, family, initial 30 mins Health behavior intervention, family, each additional 15 mins	Codes 96167EP–96168EP are billed for guidance services provided by, or under the direction of, a QHP to a family with an autistic child with the child present. Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior. The provider may bill for each set of parents/caregivers. In the event of two autistic children with the same parents/caregivers, billing is only allowed for the parents or caregivers once.
96170EP 96171EP	30 Minutes Suggested Daily Limits: 1 Unit 15 Minutes Suggested Daily Limits: 14 Units	$50.00 $25.00	Health behavior intervention, initial 30 mins Health behavior intervention, each additional 15 mins	Codes 96170EP–96171EP are billed for guidance services provided by, or under the direction of, a QHP to a family with an autistic child without the child present. Family members/caretakers are taught to apply the same treatment protocols and interventions to reduce unwanted behaviors and reinforce appropriate behavior. The provider may bill for each set of parents/caregivers. In the event of two autistic children with the same parents/caregivers, you would only allow billing for the parents or caregivers once.

Non-QHP DIR certified providers are reimbursed based on their educational level and training. Billers should use the appropriate modifier below. Providers will be paid the listed percentage of the QHP rates in the grid above. For example, a master's-level clinician will bill 96158EPHO and will be paid $36.13.

HS Diploma/Associates Degree	HM Modifier	70%
Bachelor's Degree	HN Modifier	80%
Master's Degree	HO Modifier	85%
Doctoral Level	HP Modifier	90%

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Family Planning

This article outlines the expectations of participating health care providers related to family planning services and minors' rights to consent and confidentiality.

Please note this article relates to expectations under participating provider contracts with Aetna Better Health of New Jersey and is not legal or compliance advice.

In accordance with maintaining and implementing our Quality Assessment and Performance (QAPI) program, participating health care providers must:

- Maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards.
  - Establish a policy/procedure for *managing minor patients' right to consent and confidentiality related to family planning.*
  - Provide a copy of this policy/procedure to Aetna Better Health® of New Jersey for audit purposes and upon request.

The below summarizes the expectations of participating providers under state law:

- Health care providers, that manage health needs of minors, must comply with state laws that govern the right to consent and privacy for minors.
- Minors in the state of NJ have the right to provide consent for:
  - Contraceptives/family planning: with limitations
  - STI care
  - HIV/AIDS care
  - Pregnancy care
  - Mental health outpatient care
  - Alcohol/drug abuse treatment
  - Sexual Assault treatment/examination
- For treatments that minors have a right to provide consent, health care providers are permitted, but not required, to inform the parents/guardians of a minor. Special standards on disclosure include the following:
  - HIV/AIDS: confidential and may only be disclosed with written informed consent of the minor.
  - Mental health information: mental health professionals are limited in disclosing certain information to parents or others without a minor's consent.
  - Drug/alcohol: confidential information between health care provider and minor patient.
  - Sexual assault: parents or guardian must be notified immediately, unless the medical provider feels disclosure would not be in the minor patient's best interest.

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Help Your Patients Stay Insured

Please remind your patients, our members, to renew their NJ FamilyCare/Medicaid coverage by:

- Updating their contact information with NJ FamilyCare by calling **1-800-701-0710 (TTY 711)**
- Checking their mail: NJ FamilyCare will send them a letter about their coverage. It will let them know if they need to complete a renewal form
- Completing their renewal form.

For more information, review the Stay Covered NJ Toolkit.

Pharmacy Guidelines (Restrictions/Preferences)

Aetna Better Health® of New Jersey's pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate.

Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health® of New Jersey's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when an "A" rated generic equivalent is available Pharmacy authorization guidelines and PA forms are available on our website.

EVV Phase 2

Aetna Better Health® of New Jersey values our partnership with your practice to serve the people in the state of New Jersey by providing quality health care and accessible medically-necessary services. Our providers are one of the most critical components of our service delivery approach and we are grateful for your participation. Providers delivering services in the home must meet EVV Phase 2 (Skilled Nursing and Therapy Services) compliance requirements by July 1, 2023. If you are experiencing challenges, or have questions, please email AetnaEVVCompliance@Aetna.com. We want to keep you informed and up-to-date on all pertinent information.

For more information, review EVV newsletter 32-28, and Updated Billing Policy for Home Health Care/Personal Care Services newsletter 33-11, located on the State's NJMMIS website.

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Monitoring Metabolic Risks of Antipsychotic Meds

APM assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Antipsychotic prescribing for children and adolescents has increased rapidly over the year. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications. For more information, visit the NCQA website.

Provider Satisfaction Survey Results

Thank you for partnering with us to provide quality health care for our members.

As your partner, we want to ensure that your experience with us is positive and rewarding. You are essential to providing the highest quality health care possible for our members, and your satisfaction is important to us.

We conduct an annual provider satisfaction survey to gauge our performance and obtain provider feedback. The results of the survey helps us identify key opportunities for improving the experience of providers. The purpose of this survey is to assess overall provider satisfaction and identify specific key areas of satisfaction around finance, utilization and quality management, network coordination of care, pharmacy, health plan call center, and provider relations. Our goal is for providers to be highly satisfied and consider our plan Well Above Average.

Rights and Responsibilities

It is our policy that no provider unfairly discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please refer to the member Rights and Responsibilities Section of our Provider Manual. Ensure your staff members are aware of these requirements and the importance of treating members with respect and dignity.

In the event that we receive information that a member is not being treated in accordance to our policy, we will initiate an investigation and report the finding to the Quality Management Oversight Committee. Further action may be taken by us if deemed necessary.

You can review the Rights and responsibilities section of our website for more information.

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Pediatric ADHD HEDIS Follow Up and Tips

All children who are prescribed medications to treat attention-deficit/hyperactivity disorder (ADHD) need follow-up care to assure that the response to medication and dosage is appropriate. Please review the ADHD HEDIS measure information below and tips on how to meet the measure.

HEDIS measure: ADD–Follow Up Care for Children Prescribed ADHD Medication

Measure definition: Children 6–12 years of age, newly prescribed with ADHD medication, who had at least 3 follow-up visits within a 10-month period, one of which was within 30 days of when the ADHD medication was dispensed.

Two rates are reported:

- **Initiation Phase:** A follow up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- **Continuation Phase:** Children that remained on the ADHD medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Tips:

1. When prescribing a new ADHD medication for a patient, schedule the initial follow up appointment before the patient leaves the office.
2. Only prescribe 14-21 days worth of the medication when starting or changing prescription.
3. Schedule the initial follow up for the 2-3 week period corresponding to the prescription.
4. Explain to the parent the importance of follow up care with the provider who prescribed the medication and who will evaluate the medication.
5. Provide no refills unless the child has the initial follow up visit.
6. After the initial follow up visit, schedule at least 2 more visits over the next 9 months to check the child's progress.
7. Encourage parents/caregivers to ask questions about their child's ADHD symptoms.
8. Always coordinate care between all clinicians in your patient's treatment team.

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Accessibility Standards (Telephone)

Providers are responsible to make arrangements for after hours coverage in accordance with applicable state and federal regulations, either by being available or having on call arrangements in place with other qualified participating ABHNJ providers for the purpose of rendering medical advice, determining the need for emergency and other after hours services including authorizing care, and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and/or emergent health care issues is held to the same accessibility standards regardless of the after hours coverage managed by the PCP, current service provider, or the on call provider.

All PCPs must have a published after hours telephone number and maintain a system that will provide access to PCPs 24 hours a day, 7 days a week. In addition, we encourage our providers to offer open access scheduling, expanded hours and alternative options for communication among members, their PCPs and practice staff (e.g. scheduling appointments via the web or communication via email). We routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after hours access or if a member may need care management intervention.
- Our compliance and provider management teams evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.
- Providers must comply with phone protocols for all of the following situations:
  - Answering the member phone inquiries on a timely basis
  - Prioritizing appointments
  - Scheduling a series of appointments and follow up appointments as needed by a member
  - Identifying and rescheduling broken and no show appointments
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs)

We routinely conduct audits to validate telephone accessibility standards are being met.

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Tips to Improve Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Scores

Here are 10 tips that can help improve CAHPS scores:

1. **Friendly, helpful front desk experience**

From the first call to schedule an appointment to the last person they see before leaving the office, be sure to make that experience great for the patient. If it is possible, have bilingual staff or interrupter service available for patients.

2. **Time management**

Everyone's time is valuable. Be conscious of the patient's time and try to adhere to scheduled appointment times. On occasion, things come up, but remember to update them on any changes and apologize for any delays.

3. **Effective communication with patients**

The ability to communicate information effectively and compassionately is key to successful patient-provider relationships. Listen carefully to the patient and respect their point of view. Be empathetic and acknowledge their feelings. Provide information to the patient that is easily understood.

4. **Work as a team**

Involve the patient in the decision-making process. Review the patient's care plan and together come up with a plan for their health.

5. **Facility access**

Patients need to be able to access their doctor easily. Be sure ramps and walkways are paved and cleaned at all times. In addition, make sure your office is Americans with Disabilities Act (ADA) compliant to provide medical care to people with disabilities, such as handicap-accessible entrances/exits and bathroom access.

6. **Cleanliness**

Take pride in your office appearance. Make sure your waiting rooms, examination rooms, bathrooms, etc. are always clean and tidy.

7. **Accurate billing**

Many of the complaints received relate to patients being balance billed. Staff can help by asking patients for a copy of their member ID card to ensure that claims will process correctly. If the patient does not have their member ID card at the time of service, please check eligibility. ABHNJ patients who obtain covered services should never be balance billed except for applicable co-payments.

8. **Patient loyalty**

Patients that have a positive health care experience will most likely return. In fact, patients might refer friends or family to your practice so they can also benefit from a positive health care experience.

9. **Provider follow-up**

Provide patients with an office summary note to help patients easily follow up. After a procedure or sick visits, follow up with the patient to ensure they are doing well. This is a great time for the patient to ask additional questions or make follow up appointments, as needed.

10. **HIPAA compliance**

Be sure your office is Health Insurance Portability and Accountability Act (HIPAA) compliant at all time. Protect all patients' private information. In an area where multiple patient/staff communications routinely occur, be mindful of voice tones so personal health information isn't passed to others.

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Lead Screening in Children

Pediatric Lead Screening in Children FAQs

	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Healthcare Effectiveness Data and Information Set (HEDIS)
Definition	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.	HEDIS is a comprehensive set of standardized performance measures used in the Managed Care industry to monitor performance and opportunities for quality improvement.
Blood Lead Screening Requirements	Every child enrolled in the **NJ FamilyCare program (Medicaid)**, must be given a blood lead test at the following ages: • Complete a blood lead test at **12 months** of age (between 9-18 months) • **AND** again at **24 months** of age (between 18-26 months) • Children between 26 and 72 months of age who have **NOT** previously had a blood lead test should be tested immediately	Any blood lead test **after the age of 2** is considered late in HEDIS reporting. Providers should educate parents/ guardians regarding the importance of having their child tested for lead as well as keeping appointments. Blood lead screenings should be completed **on or before their second birthday** - it must be a capillary or venous blood lead test.
Verbal Risk Assessment	The Verbal Risk Assessment should be asked at every visit with children who are between six **(6) months of age and 72 months of age**. **To view a list of questions, visit our Provider Lead Page at:** AetnaBetterHealth.com/newjersey/ providers/ resources/lead If any answer is yes or 'I don't know', risk is considered high. All children at high risk need a blood lead test immediately, even if younger than 6 months of age. **The questions must be asked at every subsequent visit since risk can change.**	Not required to be completed under HEDIS guidelines. To better evaluate a child for a blood screening, we recommend completing a Verbal Risk Assessment.

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Lead Screening in Children (continued)

CPT	LOINC	SNOMED	Description	HEDIS	EPSDT
83655	10368-9,10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7	8655006 35833009	Lead Test	✓	
83655 52			Lead Test (52 Modifier is used when there is a reduced service)		✓
36406 59			Venipuncture for children under 3 years of age, scalp vein (59 Modifier-distinct procedural service)		✓
36410 59			Venipuncture for children under 3 years of age, other vein (59 Modifier-distinct procedural service)		✓
36415 59			Venipuncture for children 3 years and older, routine (59 Modifier-distinct procedural service)		✓
36416 59			Collection of capillary blood specimen (finger, heel, and ear stick) (59 Modifier-distinct procedural service)		✓

Please reference the above Lead Screening and EPSDT related procedure codes to assist you in performing lead screenings. 83655 refers to analysis for lead level. Modifier -59 indicates distinct procedural service separate from a visit. 52 modifier is used when there is a reduced service.

Improving Lead Screening Compliance

To help you complete testing on our members, we have contracted with Laboratory Corporation of America (LabCorp), including **MedTox Laboratories**, to provide our contracted physicians with a Filter Paper Lead Screening method that is a fast, less invasive and easy way to conduct lead testing. Supplies are provided at no charge to your office and, after the sample card(s) have been placed in the mail, results are delivered to you within 72 hours of receipt. **This is the best way to assure members are tested before leaving your office and to improve provider screening rates.**

For more information on using the MedTox technique and to set up your account, contact at **1-877-725-7241** or visit www.Medtox.com/program-services/filter-paper-lead-testing.

More questions about lead screening in children?

- Contact Provider Services at **1-855-232-3596** or by email at: AetnaBetterHealth-NJ-ProviderServices@AETNA.com
- Visit the plan's website at www.AetnaBetterHealth.com/newjersey/providers/resources/lead for up-to-date lead screening in children resources.

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Learn More About Availity

Did You Know

Availity Essentials provider portal provides access to a robust self-service and online tools to allow more independent and remote providers to easily navigate Aetna's policies, procedures, and requirements. Availity allows providers to directly communicate with Aetna's clinical and administrative staff through the Contact Us application. Providers support capabilities offered through Availity include the ability for providers to:

Claim Submissions	Appeals & Grievance Appeals	Prior Authorization Submission
Claim Status Inquiries	Appeals & Grievance Status	Prior Authorization Status
Payer Space	Panel Rosters	Eligibility and Benefits
Contact Us Messaging	Specialty Pharmacy Prior Authorization	Reports & PDM

If you're new to Availity, there are many resources to help guide providers on how to navigate the site. Availity is free for all providers and offers a single sign on for participating payers.

Bookmark these resources for easy access:

- Availity.com/Essentials — 24/7 access to training resources and recorded webinars to view at your leisure
- **Aetna Crosswalk** — Aetna Better Health tools and resources

Get to know Availity

Availity is your trusted source for payer information, so you can focus on patient care. If your organization isn't registered with Availity, get started today at Availity.com.

Live webinars for Availity portal users

Once you're registered, sign in at Apps.availity.com/availity/web/public.elegant.login. The Availity Learning Team offers regularly scheduled live webinars on a variety of topics including:

- Prior authorization submission and follow-up training
- Navigating the attachments dashboard and workflow options
- Resources and tips for new administrators on Availity
- Use Availity portal to submit professional claims
- Availity claim status

Can't make a live session?

The ALC catalog includes lots of on-demand options, too. In the ALC Catalog, look for courses with a title that ends in Recorded Webinar, for example, Navigating the Attachments Dashboard and Workflow Options – Recorded Webinar.

Tips for finding live webinars

- In the Availity Portal, select Help & Training > Get Trained to open your ALC catalog in a new browser tab.
- In the ALC catalog > Sessions tab, browse or search by webinar title and look for Live Webinar and the date. You can also scroll the months using Your Calendar in the top left of the page.

After you enroll, watch your email inbox for confirmation and reminder emails with information to join and downloadable iCal options.

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Changes to OTP Billing Codes

Effective April 1, 2023, OTP providers shall only bill utilizing the Medicaid/NJ Family Care billing codes listed in the crosswalk below. Please note that Medicaid/NJ Family Care has expanded coverage options and will include coverage of long acting injectable medications. Because of the nature of long acting medications, providers may only bill for a bundled rate that includes the medication for the week in which the medication was administered. Providers may bill G2074 for those weeks where counseling was provided but no medication was administered or distributed.

Current Code	New Code	Rate	Service Description
G2076	No change	$460.08	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment conducted by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician or qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho-social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel.
G2067	No change	$95.71	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy.
G2068	No change	$199.20	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy.
New	G2069	$1,667.97	For the provision of long acting (injectable) buprenorphine. This code shall be utilized the week in which you administer the medication along with substance use counseling, individual and/or group therapy.
New	G2073	$1253.35	For the provision of long acting (injectable) naltrexone. This code shall be utilized the week in which you administer the medication along with any substance use counseling, individual and/or group therapy.
New	G2074	$80.60	Medication assisted treatment, weekly bundle which includes substance use counseling, individual and group therapy when no drug is provided.
H0020HF	G2078	$35.28	Take-home supply of methadone; up to 7 additional day supply when no bundled services are provided. Billed as an add-on when the bundled service is provided.
H0033HF	G2079	$86.26	Take-home supply of buprenorphine (oral); up to 7 additional day supply. Billed as an add-on when a bundled service is provided.

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21st Century Cures Act

Effective January 1, 2018, the 21st Century Cures Act 114 P.L. 255, requires all Medicaid managed care network providers to enroll with the state Medicaid program or risk being removed from the Aetna Better Health of New Jersey provider network.

To safeguard your participation status in the Aetna Better Health of New Jersey provider network you must enroll in the state Medicaid program. The 21st Century Cures Act Enrollment Application should be submitted to Molina Medicaid Solutions (which manages provider enrollment).

The application is available for download at www.njmmis.com (under Communications, see Provider Enrollment Application). The mailing address to submit the application and credentials is:

Molina Medicaid Solutions Provider Enrollment
P.O. Box 4804
Trenton, NJ 08650

If you have questions about the 21st Century Cures Act Enrollment process for NJ FamilyCare, please contact the NJMMIS provider enrollment unit at **609-588-6036**.

It's Time to Raise Awareness

As this important eligibility work begins, community partners can help get the word out about what is happening next with NJ FamilyCare coverage.

Providers and community partners can assist by doing the following:

- Becoming NJ FamilyCare Ambassadors to help raise awareness. To become an NJ FamilyCare Ambassador, email CommunityCollab@dhs.nj.gov with the subject line "Ambassador."
- Checking gov/StayCoveredNJ for updated materials. Posters are available in 21 languages on the StayCoveredNJ site for on-demand printing. Posters can be posted in locations that are visible to the people we mutually serve, like reception desks and common areas. Frequently Asked Questions are also available online and updated often.