Aetna Better Health ®
of New Jersey

Provider Training

aetna®

June 30.2022

Agenda

About us

The Aetna Medicaid Difference

Nationally recognized – locally focused

30 years of Medicaid and MLTSS experience

Expertise in serving complex, high-risk populations

Integrated, member-centric care model

Local, community-based plan

Focus on quality outcome improvement

Value-based provider payment alignment

Commitment to health care transformation and technology

“At Aetna Better Health of New Jersey, we believe in improving every life we touch as good stewards to those we serve.”

Key Dates in Aetna Medicaid History

SCHALLER ANDERSON INCORPORATED

1986

2007

SCHALLER ANDERSON INCORPORATED

COVENTRYCARES® is now AETNA BETTER HEALTH®

2013

2015

aetna®

Aetna Better Health of New Jersey

2017

Aetna Medicaid

30 yrs

Experience managing the care of complex, high-risk members

3 million

members

15

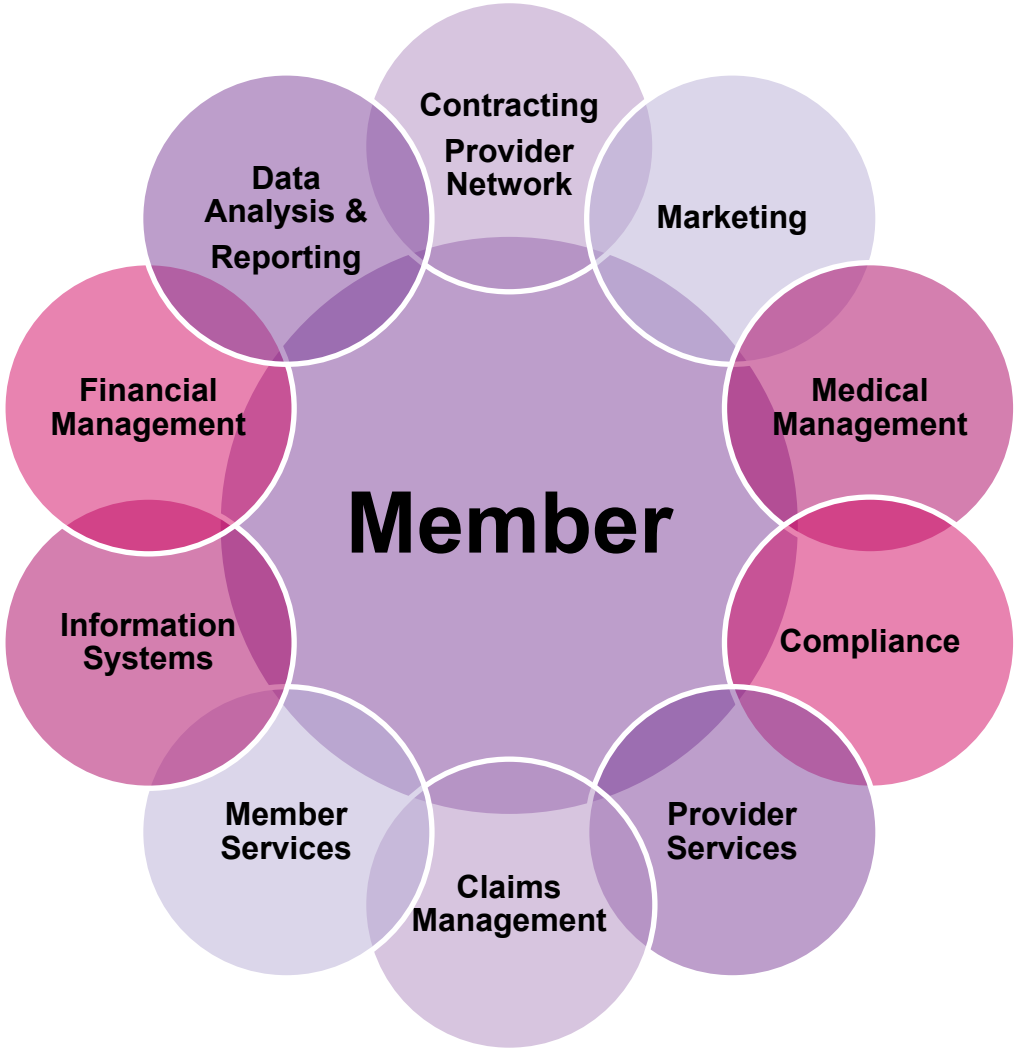
states

Who we serve

We serve New Jerseyans, of all ages, who quality for NJ FamilyCare.

We provided serviced statewide in all 21 Counties.

Overview



"We put the member at the center of everything we do"

aetna®

Eligibility

To be eligible for New Jersey Medicaid, a person must:

- Be a resident of New Jersey and be a U.S. Citizen or qualified alien (most immigrants who arrive after August 22, 1996, are barred from Medicaid for five years, but could be eligible for NJ FamilyCare and certain programs for pregnant women)
- Meet specific standards for financial income and resources

In addition, a person must fall into one of the following categories:

- NJ Family Care Program
- Families w/Dependent Children
- People who are 65 years of age or older, blind or permanently disabled
- Pregnant Women

NJ FamilyCare Plans

The following plans are covered by Aetna:

- Medicaid
- NJ Family Care A
- NJ Family Care B
- NJ Family Care C (copay)
- NJ Family Care D (copay)
- NJ Family Care ABP
- DDD Clients
- MLTSS

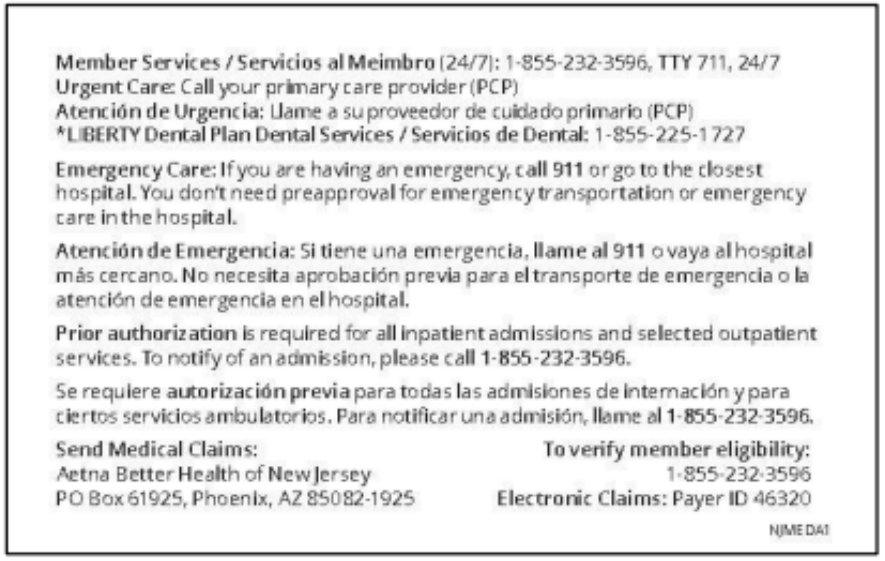
Covered Services

The benefits grid in the Provider Manual shows what services Aetna Better Health of New Jersey and Medicaid Fee-for-Service (FFS) covers

- Members under NJ FamilyCare C or D may have to pay a copayment during their visit
- All services must be medically necessary and the provider may have to ask for a prior approval before some services can be provided

Sample ID Cards

FRONT



BACK

Utilization Management

Utilization Management

- Discharge planning begins on first day of hospitalization to ensure a timely and appropriate discharge plan
- Utilization Management and Case Management staff partner with hospital discharge planners and work together to resolve difficult placement issues
- Acute hospitals are assigned a designated ABHNJ nurse to collaborate with and facilitate post discharge care

Medical Prior Authorization

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:

- Fax 1-844-797-7601
- Phone 1-855-232-3596 Option 6 then Option 5

Please submit the following with each authorization request:

- Member Information (correct and legible spelling of name, ID number, date of birth, etc.)
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s) if known
- All supporting relevant clinical documentation to support the medical necessity in legible format
- Include an office/department contact name, telephone and fax number

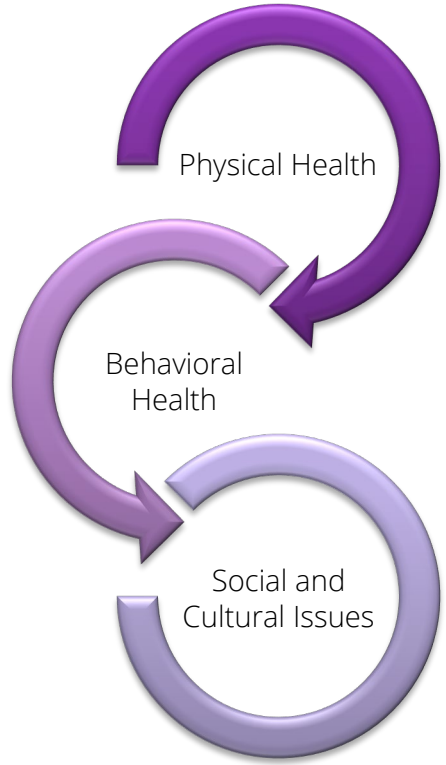
Prior Authorization Decision Timeframes

Decision	Decision/ notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner/Provider	Telephone and in writing
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner/Provider	Telephone and in writing
Continued / extended services approval (non-ED/acute inpatient)	1 business day of receipt of necessary information	Practitioner/Provider	Telephone and in writing
Post-service approval of a service for which no pre-service request was received	30 calendar days from receipt of the necessary information	Practitioner/Provider	Telephone and in writing

Clinical Care Management

Care Management Programs

Our Integrated Care Management Program manages members holistically and combines both Case and Disease Management. This assures one stop shopping and a single point of contact for members and providers.



Features of our bio-psycho-social integrated care model:

- Empowering members to self-manage their condition to facilitate optimum level of functioning and improve quality of life
- Promoting partnership and enhancing communication between provider and member
- Involving provider and member in care planning

Care Management Components

Condition Management

- Congestive Heart Failure, Diabetes, COPD, Low and High Risk Pregnancy, HIV/AIDS, Hypertension, Depression

Care Management

- Recurrent admissions, inappropriate ER utilization, Intensive Case Management of complex illness or situations

Managed Long Term Services and Supports (MLTSS)

- All members in MLTSS are care managed
- Inclusion of both traditional and non-traditional benefits

Care & Case Management Components

Care Management:

- Is member-centered, goal-oriented, culturally relevant
- Addresses prevention, safety, continuity & coordination of care
- Helps in early identification of special needs
- Assesses member risk factors
- Develops a plan of care
- Refers and helps w/ timely access to providers
- Coordinates care actively linking the member to providers, medical services, residential, social and other support services where needed
- Monitors, follows-up and documents interactions and interventions
- Seeks quality-based outcomes: Improved functional/clinical status, quality of life, satisfaction, safety, savings…

Care & Case Management Components
Continued

Case Management:

- Includes a set of care management activities tailored to meet a Member's situational health-related needs:
  - Situational health needs can be defined as time-limited episodes of instability
- Facilitates access to clinical and non-clinical services by connecting the Member to resources that play an active role in the self-direction of their health care needs
- Works toward an expectation for quality based outcomes

If you have a member who could benefit from Case or Care management, call **1-855-232-3596** and ask to speak to a Care Manager

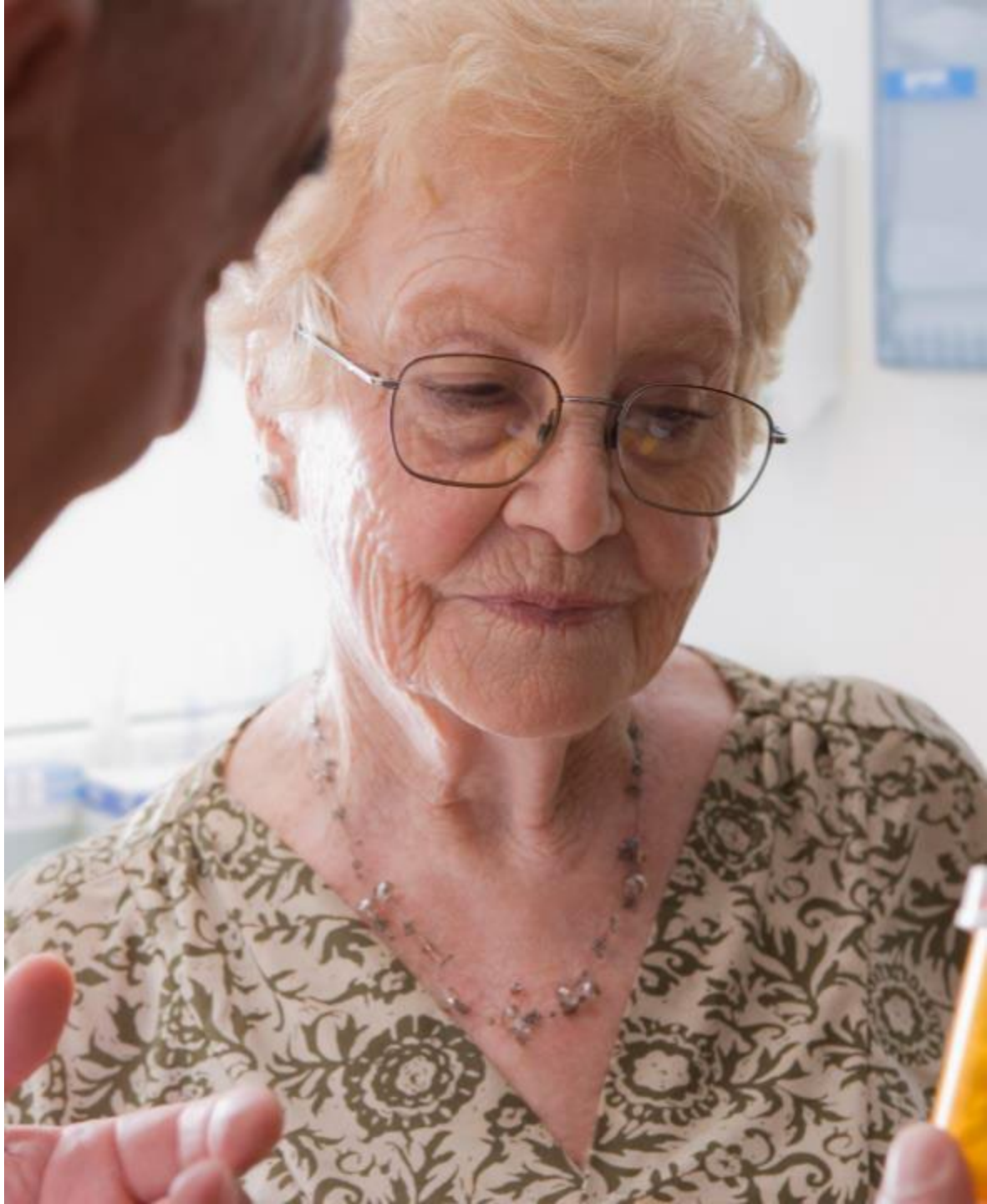
Additional Care Management Programs

- Nursing Facility transitions to Community
- Self-Directed Care Options
- Nursing Facility Collaborations:
  - NF Contact Information Sheet

Pharmacy Coverage

CVS Caremark administers the prescription drug benefit for our members:

- Please review the Provider Manual for copay information
- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications
- The following document are available online:
  - Preferred Drug List (PDL)
  - Over-the-Counter Drug List
  - Prior Authorization Form
  - Mail Order Form



Mental Health/Substance Abuse (MH/SA)

To meet the behavioral health needs of our members, we provide a continuum of services to members at risk of or suffering from mental, addictive or other behavioral disorders. We expect mental health issues to be identified expeditiously so that timely intervention, including treatment and patient education, can occur. To that end, providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and/or substance abuse disorders within the primary care providers' scope of practice
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to an in-network behavioral health care provider without a referral from the member's PCP
- Whenever a PCP is concerned about that a member may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen members with possible MH/SA concerns.

Member Rights & Responsibilities

It is our policy that no provider will 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 review the list of member rights and responsibilities in the Provider Manual. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that we are made aware of an issue with a member not being treated according to the above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee; further action may be undertaken by us if necessary.

For a complete list of member's right and responsibilities, review the Provider Manual.

Provider Services

Availity Provider Portal

Effective 1/19/2021, Aetna Better Health Of New Jersey utilizes the Availity Provider Portal.

Provider Portal Benefits include:

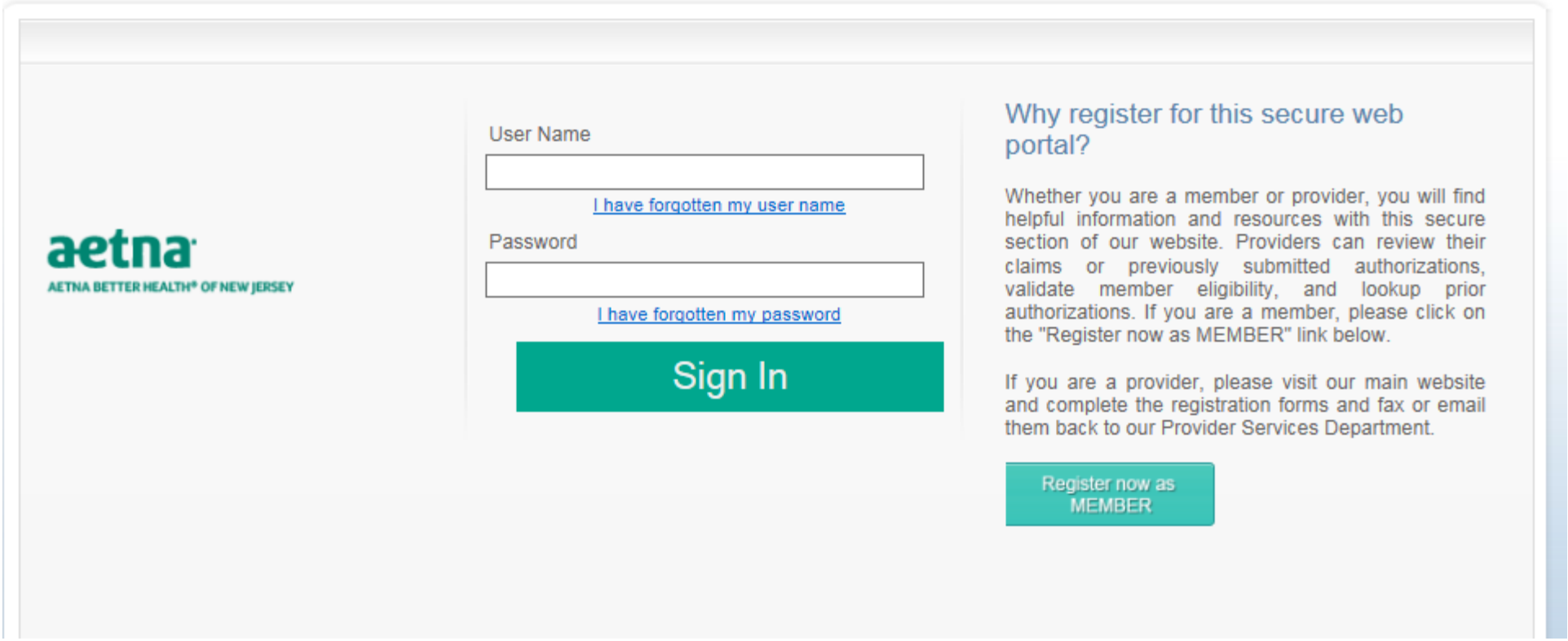
- Claim Status Inquiry
- Grievance Submission
- Appeals Submission
- Grievance and Appeals Status

The link for provider registration:

https://www.availity.com/provider-portal-registration

Availity Client Services is available via 1-800-282-4548 between the hours of 8:00 am and 8:00 pm Eastern Monday-Friday to assist you with any questions.

Provider Secure Web Portal



aetnabetterhealth.com/newjersey/providers/portal

Provider Services Department

Provider Services Manager

- Responsible for oversight of Provider Services Representatives
- Responsible for training Provider Services Reps in all areas (i.e., provider questions, provider complaints, provider responsibilities prior authorization requirements and member eligibility)

1-855-232-3596

AetnaBetterHealth-NJ-ProviderServices@aetna.com

Provider Services Representative

- Educate network providers on our policy and procedures & claim submission
- Inform providers of changes through face-to-face visits, provider forums, webinars
- Provide written or electronic communication including the Provider Manual, Periodic Provider Newsletters and fax/email blasts

*If you're interested in participating in our EFT program and/or would like electronic 835 remits, email us for additional information.

Clearinghouse & Clean Claims

We accept paper and electronic claims

- Change Healthcare is our preferred clearinghouse for electronic claims:
  - EDI claims received directly from Change Healthcare
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate member enrollment
    - Facilitate daily upload to Aetna Better Health system

CHANGE HEALTHCARE

Insight. Innovation. Transformation.

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

- We process clean claims according to the following timeframes:
  - 90% of all claims (the totality of claims received whether contested or uncontested) submitted electronically by medical providers within 30 days of receipt
  - 90% of all claims filed manually within 40 days of receipt
  - 99% of all claims, whether submitted electronically or manually, within 60 days of receipt; and
  - 99.5% of all claims within 90 days of receipt

Billing and Claims

- Timely filing is 180 days from the date of service
- Coordination of Benefits (COB) claims must be submitted within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the date of services, whichever is later
- National Provider Identifier (NPI):
  - ✓ Be certain that your claim form has a NPI number to match each corresponding provider name

Claim Submission

Aetna Better Health encourages participating providers to electronically submit claims through Emdeon.

You may submit claims by visiting Change Healthcare via www.changehealthcare.com. Payer ID# 46320

Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare. Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health of New Jersey:

Paper Claims:
Aetna Better Health of New Jersey
P.O. Box 61925
Phoenix, AZ 85082

Claim Submission

Please note that we follow New Jersey's billing practices, (i.e., required diagnosis codes, CPT, HCPCs and associated modifiers), and New Jersey's fee schedule methodologies. We also follow New Jersey's timely filing requirements along with the claim dispute processes and timeframes.

Common Barriers:

- 5010 Requirements (Rendering NPI and pay-to NPI; Both are required)
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

Resubmissions:

- Electronic and paper resubmitted claims are accepted; however, we prefer electronic claims. Resubmitted claims must be labeled appropriately
- Our Provider Services staff, Manager or the Director of Operations are available for any escalated issue and/or concerns

Claim Submission

ICD -10 HELPFUL GUIDES

Road to 10 The Centers for Medicare and Medicaid Services (CMS) has created a website that's a great resource for small physician practices and specialty practices.

- Crosswalks for the Top 50 Codes by Specialty at the AAPC website
- 100 Tips for ICD-10-PCS Coding at icd10monitor.com
- Free code conversion tool from icd10monitor.com

Claim Submission

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

- How to fill out a CMS 1500 Form
  - cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
- Sample CMS 1500 Form
  - cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf
- How to fill out a CMS UB-04/1450 Form
  - cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Claims Resubmissions

- Providers have 365 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute a reconsideration or claim dispute
- Electronic Resubmission:
  - Include the appropriate resubmission code “7” or “8”
  - Any claims with a frequency code of “5” will not be paid
- Include the following information when filing a resubmission:
  - Resubmission Form located on our website
  - An updated copy of the claim; all lines must be rebilled; a copy of the original claim (reprint or copy is acceptable) must be included
  - A copy of the remittance advice on which the claim was denied or incorrectly paid
  - Any additional documentation required
  - A brief note describing requested correction
  - Clear label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address

Claims Resubmissions

All Claims Disputes – Resubmitted Claim with Corrections or Missing information for reconsideration must be submitted to:

Aetna Better Health of New Jersey

P.O. Box 61925

Phoenix, AZ 85082-1925

For resubmissions, please stamp or write one of the following on the paper claim:

- Resubmission, Rebill, Corrected Claim, Corrected or Rebilling

EFT/ERA

- Electronic Funds Transfer:
  - EFT is a safe, convenient way to receive payments
  - EFT is quick and easy to sign up
  - EFT is accompanied by Electronic Remittance Advice (ERA)

- EFT and ERA forms on the website

Demographic Changes

All Demographic changes can be submitted by:

- Mail
- Fax
- Provider Relations email: AetnaBetterHealth-NJ-ProviderServices@aetna.com
- Please remember to submit in writing any Demographic changes prior to the change effective date
- Changes include address and telephone numbers

Credentialing and Recredentialing

Aetna Better Health of New Jersey is responsible for ensuring credentialing/recredentialing processes are completed for:

- Practitioners (Professionals)
- Ancillary Facilities
- Hospitals

Provider Contracting: Provider Network manages the contracting process

Questions about Contracting and Credentialing?

1-855-232-3596
AetnaBetterHealth-NJ-ProviderServices@aetna.com

Provider Participation in Committees

Grievance & Appeals

- Member complaints and appeals
- Provider complaints and appeals

Dental Advisory

- Input to Quality activities from the local dental provider community
- Opportunities to improve dental care and services

Credentialing

- Review of candidates to join and maintain plan participation
- Review of delegated credentialing

Utilization Management

- Guideline adoption
- Utilization processes and best practices

Provider Participation in Committees (continued)

Provider Advisory & Pharmacy Forum

- Input to Quality activities from the local provider community
- Review of Clinical Practice Guidelines, preventive health guidelines
- Opportunities to improve clinical care and services
- Discussion of changes to Pharmacy programs from National Pharmacy and Therapeutics Committee

Quality Assurance Committee

- Review the Quality Program and Work Plan
- HEDIS, Accreditation, Surveys of members and providers, Provider medical record audits
- Service performance measures
- Program components regarding availability of care, accessibility of care, barriers to care, cultural competency and other plan initiatives to meet state goals
- Make recommendations regarding plan Quality activities within the Program
- Review potential quality of care concerns
- Review fraud and abuse issues
- Review outcomes of chronic condition programs
- Has Peer Review Subcommittee reporting to it

Provider Communications

Provider Newsletters

We publish periodic provider newsletters available to all participating network providers. The purpose of periodic newsletters is to provide a consistent and reliable method of communication with participating network providers. The newsletter is posted on our webpage at **aetnabetterhealth.com/newjersey/providers/newsletters.**

Special Provider Communications

Special provider communications are used to distribute information updates to our provider practices, when the distribution and implementation timeline for the information (e.g., new evidence-based practice guidelines) precedes the next regularly scheduled provider communication.

Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

Provider Responsibilities in Providing EPSDT Services

Participating providers are contractually required to do the following in providing EPSDT services:

- Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with New Jersey's periodicity schedule, including federal and State laws, standards and national guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care: brightfutures.aap.org/clinical_practice.html) and as federally mandated
- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling's visit)
- Participate in the Department of Health and Senior Services (DHSS) Vaccine for Children (VFC aka NJVFC) Program, the federally funded, state-operated vaccine supply program that provides pediatric vaccines at no cost to doctors who serve children who might not otherwise be vaccinated because of inability to pay
- Participate in the statewide immunization registry database, the New Jersey Immunization Information System (NJIIS)
- Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and ensure that the record is completed and readable
- Comply with Aetna Better Health of New Jersey's Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law

Provider Appointment Standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventive & Routine Care	Wait Time in Office Standard
Primary Care Provider (PCP)	Same day	Within 24 hours	Within 72 hours	Within 28 days (1)	No more than 45 minutes
Specialty Referral	Within 24 hours	Within 24 hours of referral	Within 72 hours	Within 4 weeks	No more than 45 minutes
Dental Care	Within 48 hours (2)	24		Within 30 days of referral	No more than 45 minutes
Mental Health/ Substance Abuse (MH/SA)	Same day	Within 24 hours		Within 10 days	No more than 45 minutes
Lab and Radiology Services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Provider Appointment Standards
Continued

Physicals:	
Baseline Physicals for New Adult Members	Within 180 calendar days of initial enrollment.
Baseline Physicals for New Children Members and Adult Clients of DDD	Within 90 days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
Routine Physicals	Within 4 weeks for routine physicals needed for school, camp, work, or similar.

Provider Appointment Standards
Continued

Prenatal Care: Members shall be seen within the following timeframes:
Three weeks of a positive pregnancy test (home or laboratory)
Three days of identification of high-risk
Seven days of request in first and second trimester
Three days of first request in third trimester

Provider Appointment Standards
Continued

Initial:	
Initial Pediatric Appointments	Within 3 months of enrollment
Supplemental Security Income (SSI) and New Jersey Care (ABD & Disabled Members)	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.

Maximum number of Intermediate/Limited Patient Encounters. Four per hour for adults and four per hour for children.

Cultural Competency

CULTURAL COMPTENCY

To improve patient health and build health communities, providers need to recognize and address the unique culture, language and health literacy of diverse patients and communities.

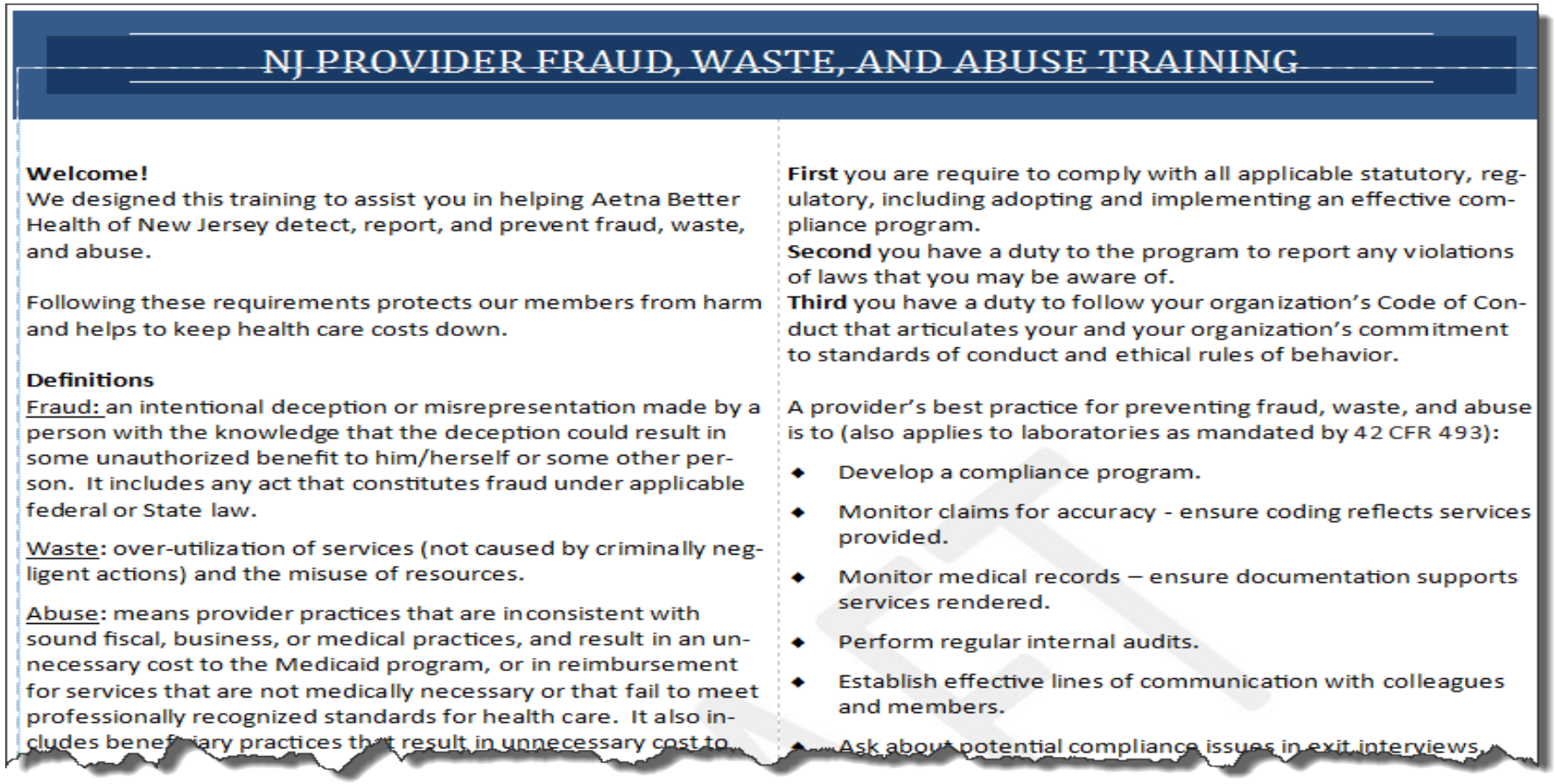
Aetna Better Health® of New Jersey promotes cultural competency and offers sensitivity education and training in an effort to help eliminate health care inequalities. We offer free online cultural competency courses that providers and their staff can take advantage of to help with daily interactions with patients.

To access Aetna Better Health's online cultural competency courses, please visit: http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Our Qual[illegible]tions® course series is designe[illegible]o

need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern. To train providers to care for diverse populations, the U.S. Department of Health and Human Services (HHS) Office of

Fraud, Waste, & Abuse



NJ PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

Welcome!
We designed this training to assist you in helping Aetna Better Health of New Jersey detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions
Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to...

First you are require to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.
Second you have a duty to the program to report any violations of laws that you may be aware of.
Third you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

A provider's best practice for preventing fraud, waste, and abuse is to (also applies to laboratories as mandated by 42 CFR 493):

- Develop a compliance program.
- Monitor claims for accuracy - ensure coding reflects services provided.
- Monitor medical records – ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and members.
- Ask about potential compliance issues in exit interviews.

Americans with Disabilities Act (ADA)

The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. Our providers are obligated to provide:

- Reasonable accommodations to those with hearing, vision, cognitive or psychiatric disabilities (e.g., accessible and appropriate physical locations, waiting areas, examination space, furniture, bathroom facilities and diagnostic equipment)
- Waiting room and exam room furniture that meet the needs of all members, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or adequate parking
- Clear signage and directions (e.g., color and symbol signage) throughout doctors' offices/facilities

Resources: ada.gov/reg3a.html

Additional Information & Important Requirements

Providers must:

- Not refuse treatment to qualified individuals with disabilities, including but not limited to, individuals with the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)

- Accommodate members with special needs, which includes but is not limited to: offering extended office hours to include night and weekend appointments, promoting practices offering extended hours and offering flexible appointment scheduling systems

- Ensure that hours of operation are convenient to and do not discriminate against members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals; all services must be available 24-hours-a-day, 7-days-a-week when medically necessary

Medical Records - Standards

Laws, rules and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a members or to their contract with Aetna Better Health of New Jersey to permit inspection, evaluation and audit for the longer of:

- A period of 5 from the date of service; or 3 years after final payment is made under the provider contract/subcontract and all pending matters are closed

Additional Information:

- Providers must maintain member records in either a paper or electronic format
- Providers must also comply with HIPAA security and confidentiality of records standards

Our standards for medical records have been adopted from our state contract, NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Provider disputes

- Providers may file a payment dispute verbally or in writing to resolve billing, payment and other administrative disputes for any reason including but not limited to:
  - lost or incomplete claim forms or electronic submissions;
  - requests for additional explanation as to services or treatment rendered by a health care provider; or
  - any other reason for billing disputes
- Provider Payment Disputes are distinct from disputes related to medical necessity

Provider Complaints, Grievances, Appeals

Provider Complaints

- Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of New Jersey that can be resolved outside of the formal appeal and grievance process
- Provider complaints include but are not limited to dissatisfaction with:
  - Policies and procedures
  - A decision made by the Aetna Better Health of New Jersey
  - A disagreement as to whether a service, supply or procedure is a covered benefit, is medically necessary or is performed in the appropriate setting
- Providers can file a complaint with Aetna Better Health of New Jersey by calling the Provider Services Department at 1-855-232-3596
- Provider complaints about Aetna Better Health of New Jersey staff, contracted vendors or other issues, not requesting review of an action, that require a written decision will automatically be transferred to the provider grievance process in cases where the complaint was transferred to the formal appeal or grievance process
- Provider complaints requesting review of an action; that cannot be resolved through the informal complaint process; or that require a written decision will automatically be transferred to the provider appeal process

Provider Complaints, Grievances, Appeals

Provider Grievances

- The preferred method for submitting a grievance is electronically through the Availity provider portal via https://apps.availity.com/availity/web/public.elegant.login

- Providers may file a formal grievance in writing directly with Aetna Better Health of New Jersey in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action
- Providers may also file a verbal grievance with Aetna Better Health of New Jersey when it is related to Aetna Better Health of New Jersey staff or contracted vendor behavior by calling **1-855-232-3596**

- To file a grievance in writing, providers should write to:

  Aetna Better Health of New Jersey
  PO Box 81040
  Cleveland, OH 44181

  An acknowledgement letter will be sent within 3 business days

- Aetna Better Health of New Jersey will resolve all provider grievances within 45 calendar days of receipt of the grievance and will notify the provider of the resolution within 10 calendar days of the decision
- Provider grievances are reported quarterly to the State

Provider Complaints, Grievances, Appeals

Provider Appeals

- A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with Aetna Better Health of New Jersey
- Appeals must be submitted within 90 calendar days from the Aetna Better Health of New Jersey Notice of Action. The expiration date to file an appeal is included in the Notice of Action
- All written appeals should be sent to the following:

  Aetna Better Health of New Jersey
  Grievance System Manager
  PO Box 81040
  Cleveland, OH 44181
- An acknowledgement letter will be sent within 3 business days

- The appeal with all research will be presented to the Appeal Committee for decision

- The Appeal Committee will include a provider with same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision

Thank you!

aetna®