

## IME Provider Questions Friday July 8 and 11, 2016

We received several questions that had been covered repeatedly in the trainings and the training materials. Please visit the NJSAMS Home Page and our website, FFS Transition page to find those answers at this link:

<http://www.state.nj.us/humanservices/dmhas/initiatives/managed/>. Or resubmit your question to the email address: [MBHOinput@dhs.state.nj.us](mailto:MBHOinput@dhs.state.nj.us). We also received specific provider questions regarding NJSAMS. Please submit a ticket for these.

- 1. Could you please clarify if Medicaid will pay for SUD Outpatient and if they are, what are the billing procedures, the clinical requirements and if the services will be capped.**

This is an area where we have changed the directive since the all day trainings. You can find this on page 6 of the Medicaid Newsletter, Volume 26 #6. But in short, Medicaid Standard OP does not require an initial PA. It will require a PA through the IME once a client hits the cap of \$6,000. That cap is per client, per provider, per year and the year is calculated by client service date. It is a rolling year that can cross fiscal year, or calendar year based on clients services.

### **If Medicaid does not need an initial PA for standard OP, why am I getting a message that the client status is pending submission to IME?**

As mentioned above, we have changed the requirement. Prior to July 1, 2016 the requirement was for a PA for OP. That did not change in NJSAMS until July 1. So individuals admitted to Medicaid standard OP between May 24 and June 30 the system required a PA. On July 1 the system no longer required an initial PA. If you have a client that was admitted to standard OP during that time frame is now pending IME review, you can change the payer source from Medicaid to Medicaid (same actual payer!). Because the new rules are in effect in NJSAMS now, the new status will be admitted.

- 2. How do I request OTP and IOP for Medicaid?**

If an OTP requests an IOP Level of Service and a Methadone Level of Service, choose Opioid Maintenance-Intensive Outpatient in NJSAMS, complete the LOCI, submit to the IME, IME will review and if approved, will put two authorization numbers in the Medicaid PA Screen. The LOS for Methadone bundle will be 12 months, the LOS for the IOP will be 30 or 60 days. To continue in either level of care, an ERL is required and will be available in NJSAMS 10 days prior to end date of current authorization.

- 3. How do I get an authorization for a client in the admitted status?**

To request an auth for a client in the admitted status, one option is to change the payer source. This is especially relevant for those clients who had been served in contracted slots but provider now wants to move to the NJSI or the SAPT. Instructions to change

payer source in NJSAMS were distributed via email on July 6, 2016. Those instructions are now on our DMHAS website on the FFS Transition Page. It is named, “How to submit clients to the IME for review and authorization” at the link below:

[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Change\\_Payer\\_Source.pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Change_Payer_Source.pdf)

However, when changed the payer source, NSAMS does not require the DSM and LOCI, these may be items that the IME requires. To complete them for these clients, go to the LOCI Module, hit the reevaluation button on the top of the page, and complete. Go to the DSM Module in NJSAMS, hit the reevaluation button on the Bottom of the page and complete. There is no submit button, the IME will be able to see these versions. You may want to let them know that these are updated through NJSAMS notes.

**4. I am getting Medicaid authorizations for the wrong provider number or I get an error message that says, “Provider number is invalid”. What should I do?**

If you have received one of these errors in a letter from Molina, please contact the IME at 844-276-2444. The IME will cancel the authorizations and supply a new authorization. The IME can backdate the authorizations to the relevant start date.

**5. What is the amount of time we will be able to backdate an authorization for IOP treatment?**

For all Levels of Care:

State- authorizations can be backdated for 15 days during the month of July. However, the start date must be in July and cannot precede the admission date in NJSAMS. It reverts back to the 5 day backdating rule on August 1.

Medicaid- Authorizations can be backdated up to one year but not prior to admission date. Start dates are at the IME discretion.

**6. If a client just recently applied for Medicaid, do we have to wait to start treatment or will authorization be backdated to the date of application.**

If client becomes enrolled for Medicaid benefits the authorization for treatment can be backdated to the Medicaid application date. See question # 3 of the FAQ’s posted on the DMHAS website. They can be accessed at this link:

[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/IME\\_IIFAQs.pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/IME_IIFAQs.pdf)

**7. Why is the Halfway House level of care being denied (NJSI) for clients with Medicaid, when it is not a covered service?**

When the state administrative authorizations were issued to slot contracted providers on June 30, 2016 those clients with Medicaid were not issued state PA numbers.

Unfortunately, 67 of these included individuals in non-Medicaid covered services. PAs

for those Medicaid clients who were eligible for services not covered by Medicaid were then issued on July 5, 2016. The PA numbers will be in NJSAMS treatment authorization list. The authorization numbers can also be found in the slot to FFS conversion list. Please remember that state admin auths issued on June 30 and July 5 tracked the slot contract limit.

**8. I currently work within the Mental Health Department of the Ocean County Jail. I am working with inmates who have been sentenced to 180 days for their 3rd DUI offense. Inmates who are sentenced to the 180 days are at times eligible to complete 90 days in jail and the remaining 90 in an inpatient facility. What will happen?**

Need for treatment/level of care determinations are based purely on medical necessity. Legal requirements do not necessarily qualify as medical necessity.

**9. Why have the codes for enhanced services changed? Ex: FY17... How will this effect billing?**

Some packages have been changed as of July 1, 2016. Billing will track the new packages. Please refer to the NJSAMS 3.4.1 Release Content Letter on NJSAMS home page or your FFS contract documents for full details of the package changes.

**10. How are the criteria for treatment or clinical observation being weighed in terms of getting approved for treatment? What specific factors are being considered for approval?**

Please refer to the Power Point "Tips to Get Your Clinical Authorization Approved by the IME" at the link below:

[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Tips%20%2026%20edit%20clinical%20Authppt%20\(1\).pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Tips%20%2026%20edit%20clinical%20Authppt%20(1).pdf)

**11. Why have some patients currently under SJI or DUI funding but also have Medicaid been given PA #'s but not all?**

Clients currently enrolled in Medicaid will be given a Medicaid prior authorization for Medicaid-eligible services. Services not covered under Medicaid, such as HWH, LTR, STR can be billed under FFS initiatives.

**12. Why are some PA's authorized for a year and others for only 5 or 6 months until the end of 2016 or beginning of 2017?**

Each level of care has its own length of stay limits and therefore varies. Also, Administrative authorizations were issued with staggered end dates so that all agency clients did not come due for an extension on the same day!

**13. Why does a full discharge have to be done when changing patients LOC? This effects their actual admission date to treatment.**

This has been the design of NJSAMS since its inception. It allows the state to report to our federal funders' specific data on lengths of stay per level of care and also track individuals across continuums of care. This provides information for our outcome measurements which are required for the state to receive continued funding from the federal government.

**14. Slot Conversion Clients**

**Prior to June 30th we made sure to request authorization for all “slot” contract clients currently enrolled in the program through the “slot conversion clients” module in NJSAMS to transfer them over to NJSI. However, once the system changed over on July 1st we checked the status of those clients and only about half the clients were approved. Why weren’t these clients approved?**

There a variety of reasons that some authorizations did not get approved. The auths had to be at a site and level of care that corresponded with agency license and contract. Medicaid clients were not issued state authorizations. Agencies were issued authorizations that corresponded with their cap, and no additional. Some agencies attempted to make changes after the deadline and may have not received those administrative authorizations.

**15. If our agency does not participate with FFS, can we simply bill Medicaid as usual for mental health and substance abuse disorders?**

If your Medicaid provider ID is for Mental Health treatment services are not prior authorized by the IME. All SUD Medicaid authorizations will require an IME approved PA.

**16. I can’t get an authorization for a client under 18, what do I do?**

State initiatives do not serve clients under 18. Medicaid authorizations for individuals under 18 can be obtained by Medicaid. Please notify the IME that you will be requesting an authorization for a Medicaid client under age 18 and they will forward that request directly to the Medicaid office.

**17. I was advised to contact you via email to obtain more information and the application to apply for NJSI, SAPT contacts. Please send us the information.**

NJSAI AND SAPT are not open for provider enrollment at this time.

**18. I would like to have the service descriptions for the Medicaid codes similar to what DMHAS provides for the FFS. Molina does not provide such information.**

Service descriptions are available in the recently released Medicaid newsletter.

Newsletter can be found at [www.njmms.com](http://www.njmms.com) in the Newsletters and Alerts tab on the left side.

**19. Since we are in the Medicaid “True-up” as of 7/1/16, does that mean all type of Medicaid will now pay for suboxone?**

ABP and Plan A are the same benefit package. Suboxone rates will be paid to an OTP. A provider other than an OTP, can prescribe the medication and it will be paid through the client’s pharmacy benefit.

**20. Please supply crossover week billing clarification for 7/1 & 7/2 dates of service. Can providers bill for bundled if qualified and NOT billing FFS for week of 6/26-6/30?**

The bundled rate cannot be billed prior to 7/1/16. Bills must be submitted after services have been delivered.

**21. Please supply clarification regarding IOP/PC, psych eval and intake billing in addition to the OTP bundled rate.**

For Medicaid Only

- Can bill IOP and methadone bundle
- Can bill Psych eval and methadone bundle
- But can't bill IOP and psych eval on same day
- Can bill Urine Analysis and the methadone bundle
- A Medicaid Newsletter will be forthcoming.

**22. Does the claim need to have PA beginning and end date? Some PA's start as early as 6/18/16. Will the PA number suffice?**

Yes. All you need on the claim is the PA number.

**23. We have not been able to secure authorizations for MATI MMU or MATI FFS clients despite the Clinical Authorizations being approved. When will the PA be made available and how do we bill for the services in the meantime?**

MATI MMU is not FFS we don't issue a PA. however, you can receive enhanced services for those served in an MMU contracted slot.

MATI FFS follows all FFS rules regarding client limits.

Additional MATI guidance is expected the week of July 11, 2016.

**24. If client has health insurance will the IME approve of the person for a level of care that insurance does not cover?**

Please refer to the Payer of Last Resort hierarchy at this link:

[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Payor\\_of\\_Last\\_Resort.pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/Payor_of_Last_Resort.pdf)

State will pay for services not covered by insurance. But rejection should be documented.

**25. Can we bill group and one individual in one day with Medicaid?**

One group and one individual are allowable in one day. Two groups or two individuals in one day are not allowable. No more than two counseling services in one day.

**26. Our understanding was that uninsured clients with income levels between 0 to 133% of the federal poverty level should move to Chapter 51 County funding and that individuals between 134 and 300% of the poverty level were eligible for NJSI. Can you please clarify?**

We cannot provide direction for Chapter 51 funds since we do not manage those funds. State eligibility is up to 350% of poverty.

**27. With regards to the Medicaid "true up" plan.: Will we be treating current Medicaid Plan A a/k/a straight Medicaid or non ABP plans the same as ABP plans, as far as approved treatments/authorizations/billing?**

Yes

- 28. Are PA decisions going to be made within an hour? If not what is the projected wait time.**  
Initial requests are responded to within an hour. 98% are being answered in one hour.
- 29. Do PA's expire when patient is discharged from NJSAMS?**  
Yes, for state authorizations but not for Medicaid authorizations.
- 30. How quickly can a patient be readmitted once discharged from the program and NJSAMS?**  
There is nothing in NJSAMS that will stop a re-admission once a client is discharged from treatment.
- 31. Is there a process in place for readmission/readmitting?**  
If a NJSAMS client has been discharged they must be readmitted as a new client.
- 32. Transitioning patient from IOP to OP for administrative detox, how to we request a new PA.**  
Any change in payer source, level of care or provider requires a new admission in NJSAMS.
- 33. Once we reach a limit of \$6000 for adult outpatient Medicaid clients, how will we be informed about this so that we know when to start requesting PA's?**  
You won't be notified. Providers are expected to track their own utilization.
- We list Medicaid as the payor source for clients who have Medicaid, and we bill under Hospital Revenue codes.**  
We do not manage Rev Codes.
- 34. When we receive PA's, we are not being informed as to how many sessions are covered, only time periods. Can the amount of sessions approved be included in the PA's?**  
Number of units is communicated through the note section in NJSAMS.
- 35. Code #90791 HF is listed under SUD but says Psychiatric Dx- is that the general SUD (non-medical) assessment?**  
Yes
- 36. Code #90792 HF-Is that code used for both MAT and Psychiatric intakes?**  
Yes it is a comprehensive evaluation code that is used for any medical evaluation.
- 37. Which code is to be used for medication monitoring, either by the psychiatrist or by the OTP physician treating a client in a non-bundled service (such as MIOP)?**

The medication monitoring for MAT is included in the bundle and cannot be billed separately. Medication Monitoring can be billed individually for a psychiatric visit. All codes are in the July Medicaid Newsletters.

**38. With regard to NJSAMS, we have a few other concerns:**

**Under the slot conversion to FFS list, we can neither delete nor add new clients.**

The slot conversion to FFS has been completed the conversion list is no longer active. Any new client a provider wishes to admit should go through the IME.

**39. There is no CWRP button for those DCF-funded clients**

DCF involvement should be endorsed in the DASIE and the CWRP will become available in the drop down.

**40. We have admitted three patients to SAPT who are in Opioid Maintenance Treatment. The Assessment Authorizations are being directed to the IME, and the Treatment Authorization tab is not available. OMT does not require IME approval. When will this be corrected?**

All managed state assessments require an IME review regardless of level of care or initiative.

**41. We are not receiving any responses to questions being sent to the IME in the message queue. We just received a response yesterday to a message sent on 6/22/16. We have several messages that were sent on 6/30/16 with no response.**

This is being addressed with the IME.

**42. Will there be a way to override the 5 day limit for obtaining authorizations when there are issues with admitting a patient in NJSAMS? We have a patient that we are unable to admit and a trouble ticket was opened on 6/27/16. We have another patient who we are unable to change the funding source and the ticket was opened on 5/25/16 and the status is still "in progress."**

No. You can request an offline payment and it will be reviewed based on offline billing rules.

**43. We were able to add the enhancement packages. However, the co-occurring adult services tab only gives the code for an assessment. There are no codes for individual, group, etc.**

State COD enhancement packages have changed. Ambulatory rates are COD capable and only an assessment is allowed as an enhancement. Residential rates are not COD capable and those services have access to the COD package. However, there have been changes to the full package. These were included in your FFS contract documents.

## Questions Submitted on July 11, 2106

**1. The IME Implementation Team –The Funding Source NJIS is not listed in the NJSAMS.**

Because there are no specific criteria other than the poverty level and age, The NJSI and SAPT are not available for selection during completion of the DASIE, however, when the DASIE Summary indicates which initiatives can be selected for that client, the NJSI or SAPT will become available to select.

**2. Why are some IOP authorizations approved for 60 days and others for 30, even though the cases are very similar and DSM-5 and LOCI are properly filled out?**

We can't be sure if you are referring to state or Medicaid Authorizations. State Authorizations have two mechanisms. The Clinical review is for the set lengths of stay published during the April and May 2016 trainings, however, the state system still requires an administrative authorization every thirty days to keep the authorization active for billing. This may be the reason why for state authorizations that appears to be 30 instead of 60 days.

Without knowing the exact details of the cases you reference in your question, we cannot answer specifically. However, the IME is reviewing each case and making case by case determinations.

**3. It will not allow you to enter the comments if you do not out in the name of Professional that diagnosed them.**

It appears that you are asking about the Co-Occurring section of the DSM module. If the clinician entering the diagnosis is properly licensed and enters their name and credentials, than they are able to open comments in the COD dx section. If the person completing the DSM 5 Module does not have the credentials required to complete the COD section, the comments on the COD dx element will not be available, but comments can be added to the SUD diagnosis section.

**4. Regarding question #2 response, please explain the clinical requirements for a client authorized for IOP and OTP.**

Clinical requirements are based on ASAM criteria. Please refer to ASAM.

**5. We have 55 QMBs on our slots because Medicaid did not pay for their services and they qualified as per the DMHAS sliding scale to be on the slots.**

QMB is a Qualified Medicare Benefit client who is eligible for assistance paying for Medicare part B coverage. This message does not affect SUD providers since they are not Medicare providers.



**6. What is the expected time for the groups and for the individual sessions for Medicaid?**

90 minutes for group, and depending on the code, either 20-30 minutes or 45-50 minutes. Please refer to the Medicaid Newsletter Volume 26N. It can be accessed at [www.njmmis.com](http://www.njmmis.com).

**7. Are we able to bill to the FFS Initiatives psychiatric services rendered by tele psychiatry?**

Currently telepsychiatry is not available in the state FFS network.