



Laboratory Provider Managed Care Claims Training

NJ FamilyCare Substance Use Disorder
Laboratory Service Integration

Housekeeping



All attendees will enter the meeting on **mute**



This **meeting will be recorded** to act as an ongoing resource



You can **enable closed captions** at the bottom of the screen



Submit your **questions using the "Q&A" function** – direct them to State or specific MCO
(Note: we will aim to respond to all questions directly during or after the meeting. Responses to broadly-applicable questions may be shared publicly)



Materials and recording will be published and available on DMAHS website

Agenda

Welcome and SUD Lab Integration update Shanique McGowan, BH Program Manager, DMAHS	5 min
Coordination of Benefits Geraldyn Molinari, Director, Managed Provider Relations, DMAHS	5 min
Overview of Claims Processes Geraldyn Molinari, Director, Managed Provider Relations, DMAHS Jana Lang, BH Program Manager, DMAHS Steven Tunney, Director of Behavioral Health, DMAHS	25 min
MCO Round Robin Aetna, Fidelis, Horizon, UHC, Wellpoint	50 min
Next Steps Shanique McGowan, BH Program Manager, DMAHS	5 min
Q&A – Breakouts Steven Tunney, Director of Behavioral Health, DMAHS Shanique McGowan, BH Program Manager, DMAHS Aetna, Fidelis, Horizon, UHC, Wellpoint	30 min

On July 1, 2026, the NJ Division of Medical Assistance and Health Services (DMAHS) will integrate substance use disorder (SUD) laboratory services, also known as drug testing, under the management of the Medicaid Managed Care Organizations (MCOs)

Planned services for integration:

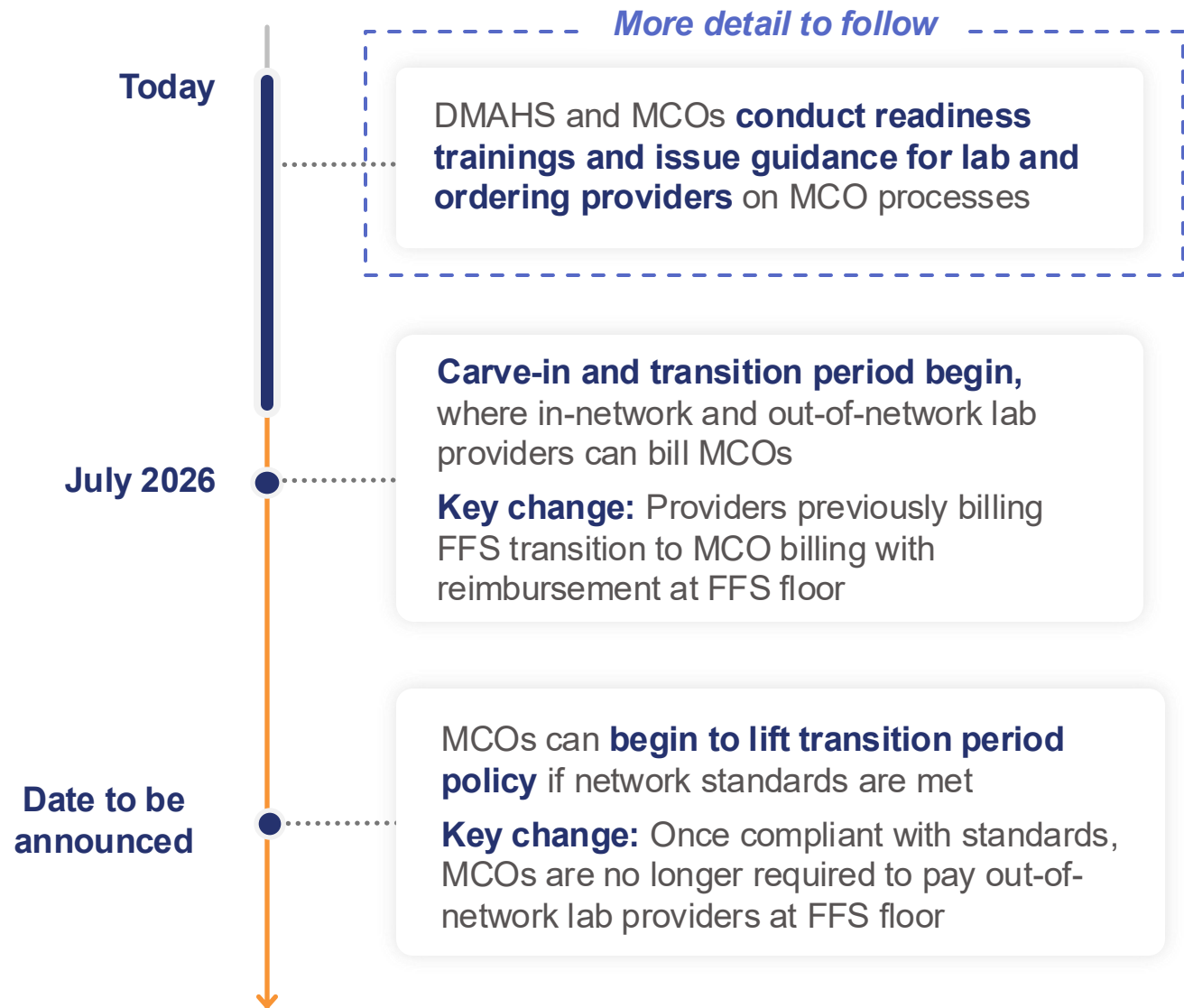
- **80305** – Presumptive drug test through direct optical observation
- **80306** – Presumptive drug test through instrument-assisted observation
- **80307** – Presumptive drug test through chemistry analyzer
- **G0480** – Definitive drug test for 1-7 drug classes
- **G0481** – Definitive drug test for 8-14 drug classes

Transition period:

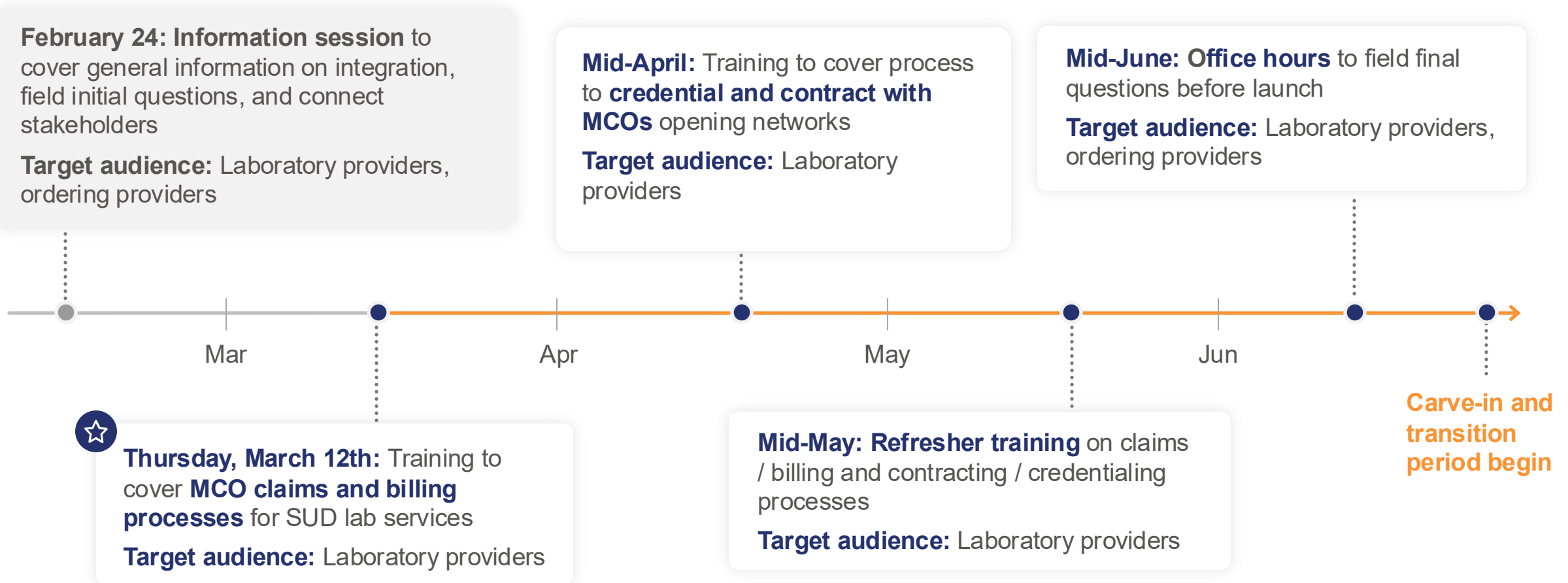
To mitigate disruption, DMAHS is implementing a transition period at the onset of integration requiring MCOs to reimburse out-of-network labs until their networks comply with DMAHS-defined standards (*under development; to be shared before implementation*)

Recall | DMAHS is integrating all SUD lab services under managed care, to take effect July 1, 2026

Timeline | SUD lab service integration will go live July 1, 2026, with a transition period to mitigate disruption

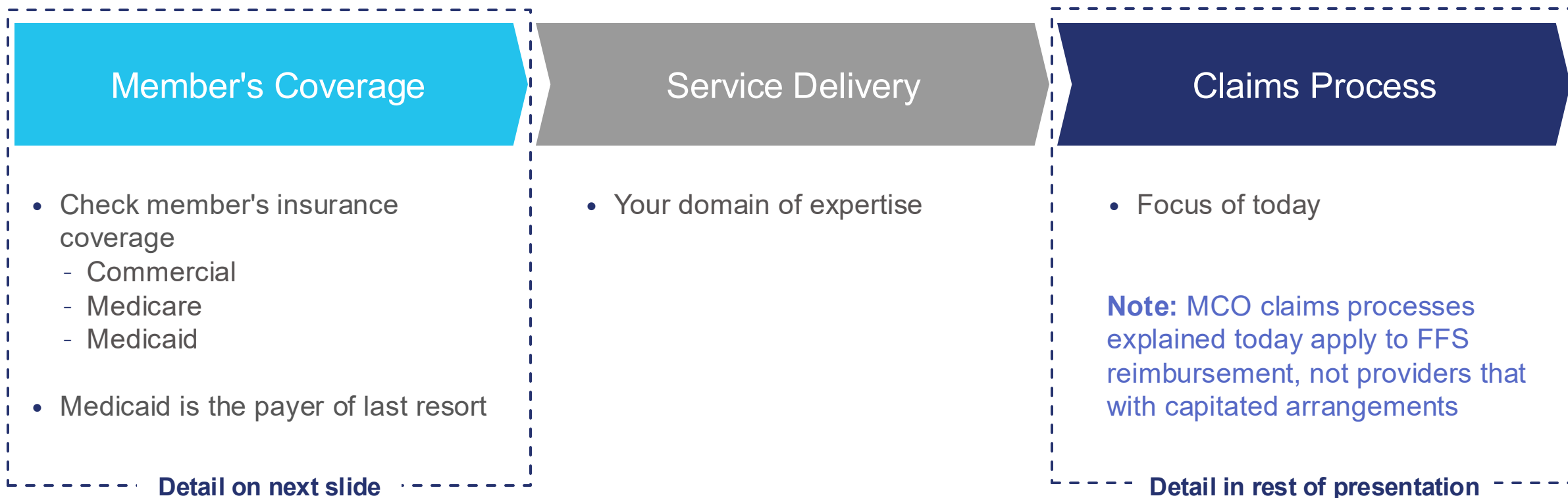


Provider readiness | DMAHS will host trainings for lab and ordering providers to ensure readiness for the integration



Lab and ordering providers can **sign up for DMAHS Behavioral Health mailing list** or **visit the BH Integration Stakeholder Information website** to receive notifications and information about these forums

We will focus today on managed care claims, but first a reminder to check member's coverage



Providers are responsible for coordination of benefits (COB) when members are covered by more than one health plan

Medicaid is always the payer of last resort

Coordination of benefits required

Scenario 1: Member covered by Commercial insurance

- Commercial is primary payer until benefits are exhausted

Scenario 2: Member covered by Medicare and Medicaid

- Medicare is the primary payer
- Medicaid is the secondary payer

Scenario 3: Member covered by Medicaid only

- Medicaid is the sole payer

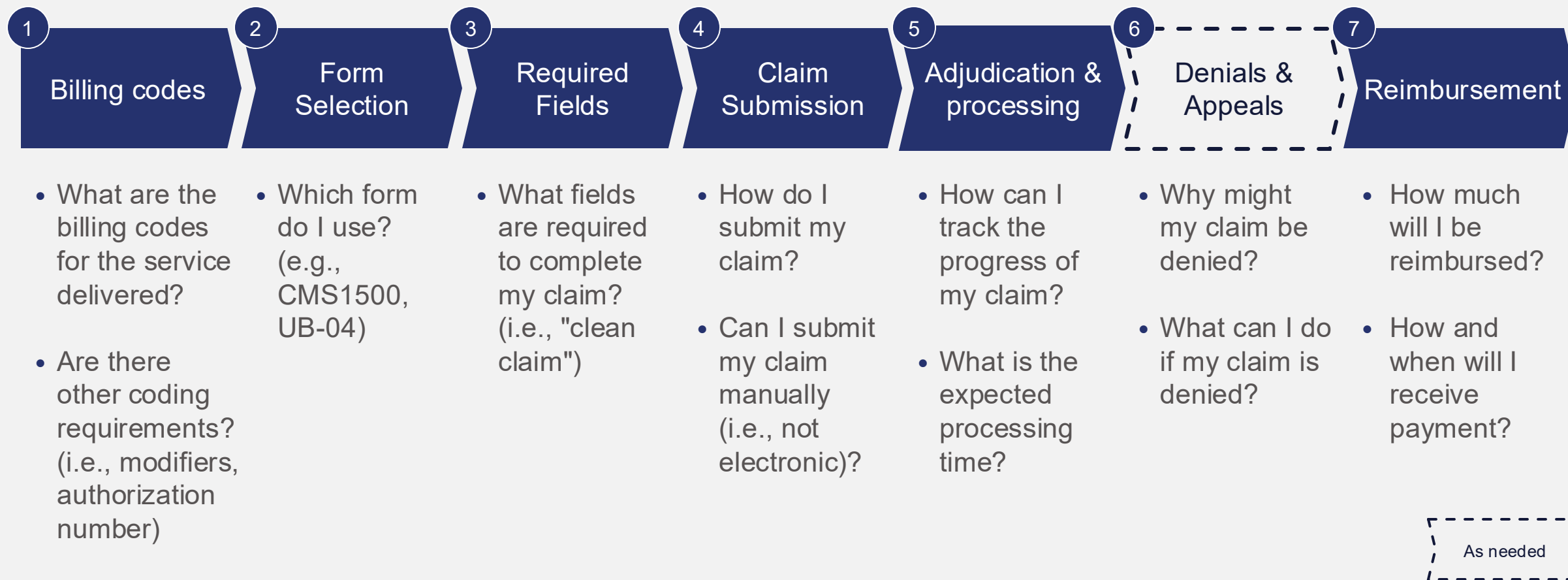


Commercial / Medicare also cover lab testing services; important to check member coverage

- Medicare is primary payer, and Medicaid is **secondary payer**
- If member is dually eligible, MCO will **not pay the full amount**, only the balance
- Providers can enroll in Medicare online using [PECOS](#)¹
- Contact your Medicare Administrative Contractor (MAC) to help you navigate enrollment

1. PECOS = Provider Enrollment, Chain, and Ownership System; A National Provider Number (NPI) is required to enroll in Medicare. If you do not have one, you can apply on the [National Plan & Provider Enumeration System \(NPPES\) website](#)
Note: Refer to DMAHS Coordination of Benefits Guidance for additional detail

Medicaid claims process: Seven steps for providers



Medicaid coding requirements for accurate billing

Diagnosis codes

Why is service is needed?

[ICD-10-CM](#) codes for primary diagnosis

Procedure codes

What services were performed?

[CPT or HCPCS](#) codes for procedures and services
ICD-10-PCS for inpatient hospital procedures

Revenue codes

Where were the services provided?

Rev codes for hospitals and facilities to indicate location or department where service performed



Other codes

Is service authorized or billable?

Coordination of Benefits (COB) codes to indicate how claim should be processed

Medicaid follows National Correct Coding Initiative (NCCI) edits to prevent improper coding and overbilling.
Providers must also follow MCO-specific coding requirements (detail to come in MCO round robin)

MCOs use same CMS 1500 or CMS 1450 forms as Medicaid FFS

CMS 1500 / 837P

 A sample of the CMS 1500 Health Insurance Claim Form (Form 837P). The form is a complex grid with various fields for patient information, provider details, and claim data. A large, semi-transparent "SAMPLE" watermark is overlaid across the center of the form.

[Link to form](#)

Provider types

- Independent clinical laboratories
- Individual providers
- Agency or clinic
- Medical group practice
- Physician office

CMS 1450 ("UB-04") / 837I

 A sample of the CMS 1450 (UB-04) Health Insurance Claim Form (Form 837I). This form is designed for institutional providers and includes a large table for detailing charges and services. A large, semi-transparent "SAMPLE" watermark is overlaid across the center of the form.

[Link to form](#)

Provider types¹

- Hospitals
- Other facilities

1. Select independent laboratories to use the CMS 1450 for United; providers should confirm appropriate with United.
Source: MCO input

What is a clean claim? – Division of Banking & Insurance (DOBI) definition

"Clean claim" means:

- A Claim is for a **service or supply covered** by the health benefits plan
- B Claim is submitted with **all the information requested** on the claim form or in other instructions - *focus*
- C **Person** to whom service was provided **was covered** on the date of service;
- D The carrier does **not** reasonably believe the claim has been **submitted fraudulently**; and
- E The claim **does not require special treatment**¹

Providers need to know **exactly which fields are required** for each service by MCO

1. 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

Overview of claims adjudication and processing

Two-types of adjudication

Auto adjudication: goes into pay or deny status automatically.

- Moves to post-adjudication immediately
- Paper / electronic remits are created
- Checks / EFTs are sent to the provider

Manual claims review: Route to a claim's processor for manual review and processing.

Expected decision timelines

State processing timelines for clean claims must be within:

- 15 days for 90% of electronically submitted clean claims
- 30 days for 90% of manually submitted clean claims
- 45 days for 99.5% of all claims

For additional detail on MCO specific processing timelines (which may be shorter), please refer to each MCO

How to check the status of your claim

MCO portal: Some MCOs have a portal to track the status of claims, adjusted claims and appeals

Other MCOs require providers to reach out directly

More details to come from specific MCOs

If your claim is denied, you have the right to appeal

Right to appeal

- Providers have **right to appeal** denied or underpaid claims if they believe the decision was incorrect
- Appeals must be submitted **within a specified time** after receiving denial, **typically 60-90 days**, depending on MCO
- Each MCO provides specific contact information and forms for submitting appeals
 - Most MCOs use a version of the [NJ Healthcare provider appeal form](#)

Steps to appeal

- 1 **First level appeal**
 - Submit appeal to MCO for reconsideration
 - Include supporting documentation, such as medical records and billing codes that show why the services are necessary
- 2 **Second level appeal**
 - If first appeal is denied, some MCOs allow a second appeal within the required time
- 3 **External Review: PICPA**
 - If appeal is still denied, providers can request an external review through the Program for Independent Claims Payment Arbitration (PICPA)
 - Claims must have completed internal review and be \$1,000 or more to be eligible¹
 - Submit via Maximus (vendor) [here](#)

Tips for submitting appeals

- Reference denial reason
- Submit documentation to show medical necessity
- Use correct coding (CPT/HCPCS, authorization and rev codes)

1. To be eligible, claims must have completed internal review with MCO and be for a total dispute amount of \$1,000 or higher

The State requires MCOs to provide transparency on required fields in provider manual and trainings

Category	Fields
Patient information	Demographics: Address, DOB, phone number, sex, member ID, marital status)
	Insured's information: Name, relationship to member, phone number, address, date of birth, member ID, sex)
	Employer or school name
Provider information	Referring provider name and NPI
	Billing provider name, NPI, and federal tax ID
	Rendering provider Medicaid ID and NPI
	Facility information
Service information	Illness: Diagnosis code including procedure, services, or supplies CPT/HCPCS with modifier), dates unable to work
	Service: Dates, place, units of service
	Billing information: PA, charges

Aetna

Fidelis Care

Horizon

United

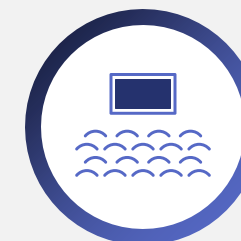
Wellpoint

Required fields can vary depending on the **type of service** provided and **specific MCO** guidelines

As of January 1, 2025, each MCO is required to outline the required fields (in CMS 1500 and CMS 1450) for a claim to be considered "clean":



Provider manual



Provider trainings

Initial claims can be submitted in two ways but electronic is preferred

	Electronic <i>Submit via provider portals or electronic data interchange</i>	Paper <i>Submit by mail only to specified address for each MCO</i>
Aetna	<i>Note: for in-network providers only</i> Availity Payer ID is 46320	Aetna Better Health of New Jersey P.O. Box 982967 El Paso, TX 79998
Fidelis Care	Fidelis Care Provider Portal or Availity Payer ID is 14163	Fidelis Care, Claims Department P.O. Box 31224 Tampa, FL 33631-3224
Horizon	Availity or Horizon NJ Health EDI Payer ID is 22326	Horizon NJ Health Claims Processing Dept.. P.O. Box 24078 Newark, NJ 07101
United	Provider Express or EDI Payer ID is 86047	UnitedHealthcare Community Plan P.O. Box 5250 Kingston, NY 12402-5250
Wellpoint	Availity Payer ID is WLPNT	New Jersey Claims, Wellpoint P.O. Box 61010 Virginia Beach, VA 23466

Managed care claims must be submitted within 180 days from date of service (DOS)¹

1. If coordination of benefits is involved, where MCO is a secondary payee, most MCOs require COB of claims to be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from dates of services (DOS), whichever is later
Note: Electronic Data Interchange (EDI) facilitates streamlined data exchange between MCOs and providers

Benefits of electronic submissions

- Faster processing and payment of claims
- Eliminates cost of sending paper claims
- Allows tracking of each claim sent
- Minimizes data entry errors

During the SUD Lab Integration transition period, MCOs must pay rates at or above the FFS floor to all lab providers without a capitated agreement

Today, lab providers can negotiate rates with MCOs

MCO reimbursement rates are negotiated between the lab provider and individual MCO

For lab services, some MCOs set up capitated arrangements with lab providers to reimburse them at a fixed rate for a certain volume of tests

During the transition period, the State is requiring all MCOs to pay at or above FFS rates for non-capitated agreements

During the transition period, all MCOs must pay lab providers, both in-network and out-of-network, at or above FFS rates for SUD lab services

- This FFS rate requirement does not apply to any capitated agreements established between MCOs and lab providers

If FFS rates change during the transition period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS.

Medicaid FFS rates (as of March 12th) are found [here](#):

Presumptive test codes	FFS Rate	Definitive test codes	FFS Rate
80305	\$10.08	G0480	\$91.54
80306	\$13.71	G0481	\$125.27
80307	\$49.71		

During the transition period, if you believe you have been paid rates below the FFS floor, please contact OMHC with specific details regarding your claims, including but not limited to the MCO, service provided, units, and rate paid.

Lab providers can receive reimbursement electronically or by check



Electronic: Most MCOs offer faster payments via electronic remittance, such as ACH transfers



Check: Paper checks are an option for those without electronic payment capabilities

Electronic payments are preferred because they avoid potential delays and potential errors

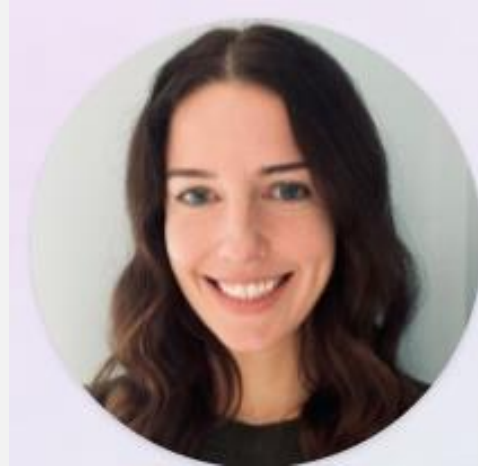
MCO Round Robin



10 mins x 5 MCOs

- Introduce claims team
- Overview of MCO specific processes
- Explain claims platform / portal

Aetna | Meet our claims & billing team

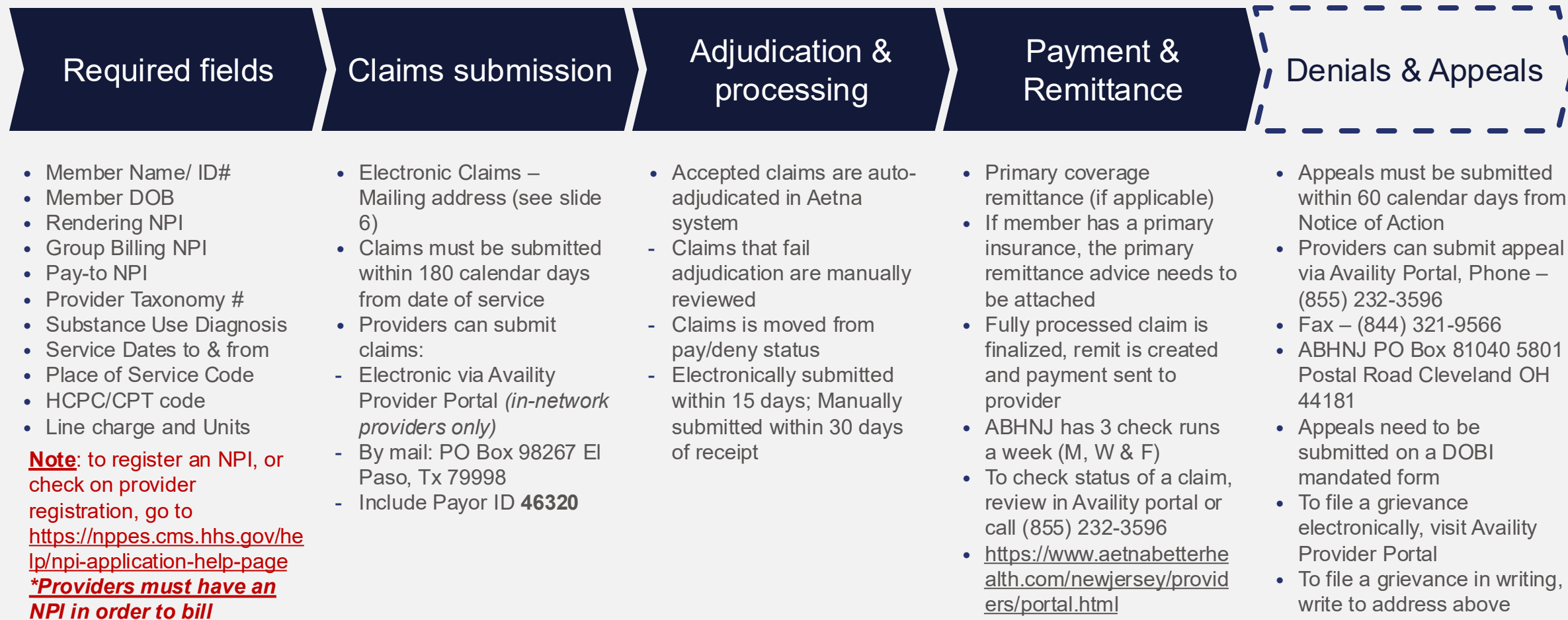


Kate Mignone

Senior Manager, Network Management

- Claims and Network Point of Contact

Aetna | Our claims process



Aetna | Make sure NPI numbers match guidance from MCO – CMS 1500

Four sections on CMS 1500 form for NPI numbers

The image shows a portion of the CMS 1500 form. Four specific areas are highlighted with blue boxes and labeled with callouts:

- 17b**: Located in section 17, 'NAME OF REFERRING PROVIDER OR OTHER SOURCE', specifically in the '17b NPI' field.
- 24J**: Located in section 24, 'PHYSICIAN OR SUPPLIER INFORMATION', in the 'NPI' column of the table.
- 32a**: Located in section 32, 'SERVICE FACILITY LOCATION INFORMATION', in the 'NPI' field.
- 33a**: Located in section 33, 'BILLING PROVIDER INFO & PH#', in the 'NPI' field.

- **17b** – Ordering or referring provider
- **24J** – Rendering provider
- **32a** – NPI of facility
- **33a** – NPI of billing provider

NPIs must match MCO billing requirements

If billing as an independent laboratory:

- 24J - Providers should enter their Type 2 NPI
- 32a – Providers should enter their Type 2 NPI
- 33a - Providers should enter their Type 2 NPI

If billing as a licensed agency or clinic:

- 24J – Type 2 NPI of clinic/agency, but Type 1 NPI required if OBAT prescriber/supervisor
- 32a – Type 2 NPI
- 33a – Type 2 NPI

If billing as a group practice:

- 24J – Type 1 NPI of practitioner
- 32a – Type 2 NPI
- 33a – Type 2 NPI

If billing individually:

- 24J – Type 1 NPI
- 32a – Type 1 NPI
- 33a – Type 1 NPI

How to specify ordering / referring providers in field 17b:

- Type 1 NPI

Aetna | Make sure NPI numbers match guidance from MCO – CMS 1450 / "UB-04"

Sections on CMS 1450 form for NPI numbers

PAGE		OF		CREATION DATE		TOTALS	
50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME		59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		
66 DX	67	A	B	C	D	E	F
68	G	H	I	J	K	L	M
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	75	76 ATTENDING NPI	QUAL
c.	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	d.	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	77 OPERATING NPI	QUAL
80 REMARKS		81CC a	b	c	d	78 OTHER NPI	QUAL
						79 OTHER NPI	QUAL

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

- 56 – Billing provider
- 76 – Attending provider
- 77 – Operating provider
- 78 & 79 – Other provider(s)

Both attending provider and operating provider may be classed as the "rendering provider" depending on service being billed

NPIs must match MCO billing requirements

If billing as an independent laboratory:

- Field 56: Type 2 NPI
- Field 76: Type 2 NPI
- Field 77: Type 2 NPI

If billing as a facility:

- Field 56: Facility Type 2
- Field 76: Facility Type 2, but Type 1 NPI required if OBAT prescriber
- Field 77: Not required

How to specify ordering / referring providers:

- Specify Type 1 NPI in field 78, use qualifier code DN for referring provider

Aetna | Additional billing requirements for CMS 1500 and CMS 1450



CMS 1500

Notes

- Name / signature in box 31 must be registered to NPI in box 24J
- **Aetna requires laboratories to specify their taxonomy codes**
 - Use billing 2000A-PR Box 33b on CMS-1500/
Rendering Box 24J shaded



CMS 1450 ("UB-04")

Notes

- **Aetna requires laboratories to specify their taxonomy codes**
 - Include taxonomy code on box 81a of UB-04 form

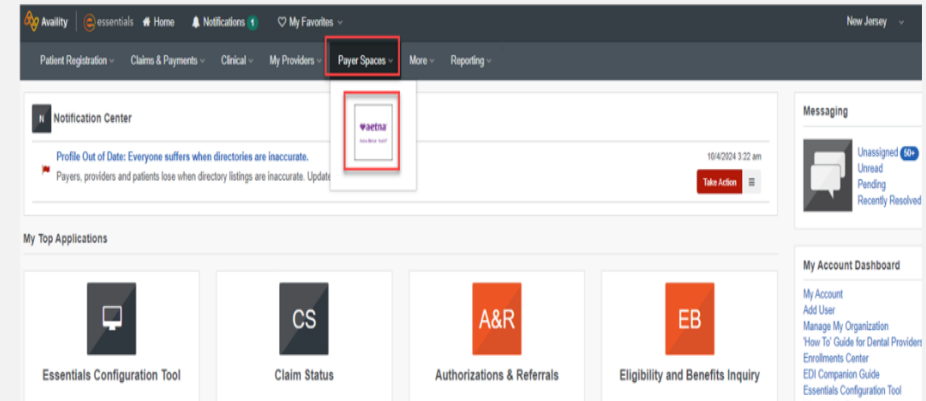
Aetna | Claims portal demo

1

Submit claims using Aetna Better Health of NJ Portal: [Access Availability Here](#)

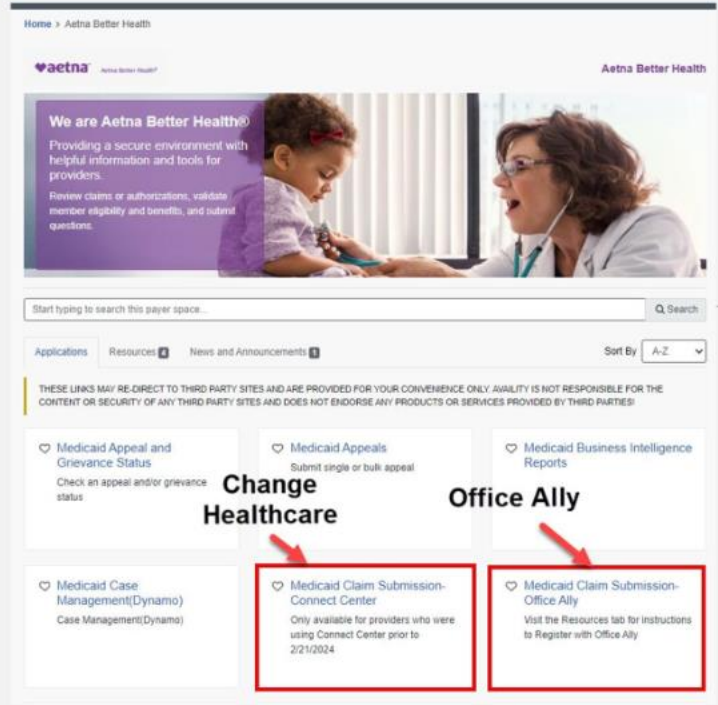
2

Once provider is logged into Availity they can go to NJ and then the payer spaces and select "Aetna Better H



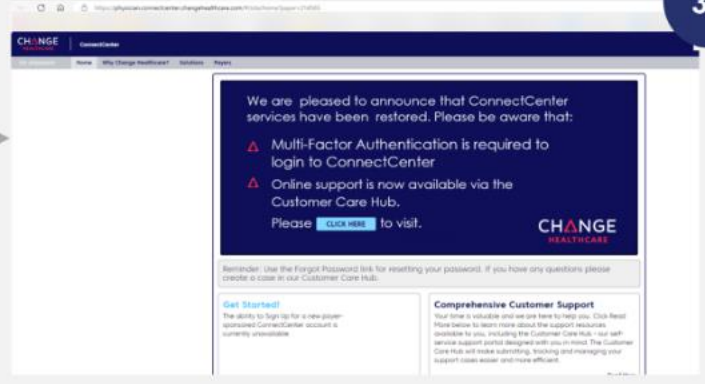
Submit claims using ABH NJ Portal
(<https://www.aetnabetterhealth.com/newjersey/providers/portal.html>)

3 Once the provider is in the payer space, select either Change Healthcare OR Office Ally.



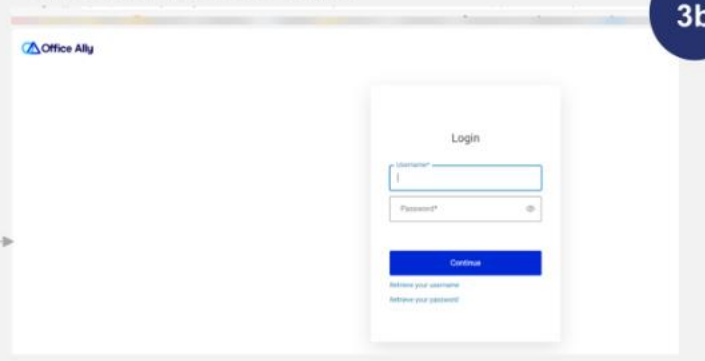
Change Healthcare website log in

3a



Office Ally website log in

3b



Fidelis Care of NJ | Meet our claims & billing team

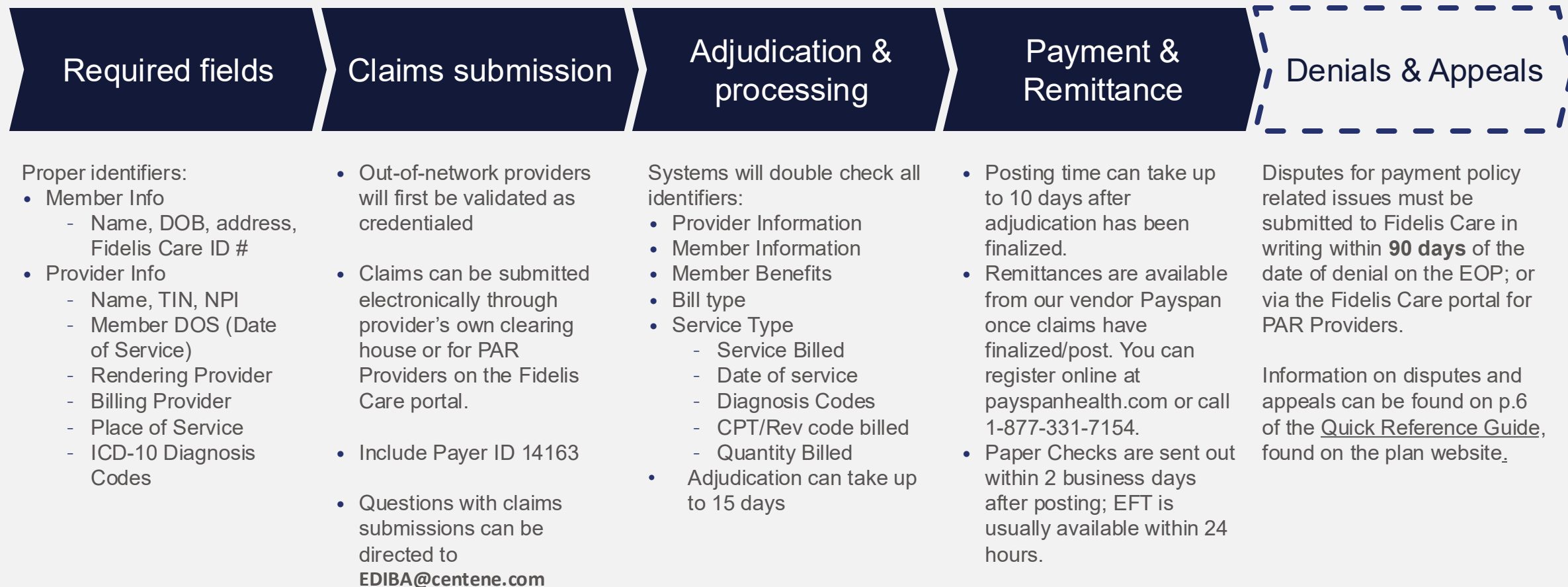


Misti Little

Manager, Claims & Contract Support

- Claims and Business Operations Oversight

Fidelis Care | Our claims process



Fidelis Care | Make sure NPI numbers match guidance from MCO – CMS 1500

Four sections on CMS 1500 form for NPI numbers

The image shows a CMS 1500 form with four specific fields highlighted in blue:

- 17b**: Located in field 17, 'NAME OF REFERRING PROVIDER OR OTHER SOURCE', specifically the NPI sub-field.
- 24J**: Located in the 'PHYSICIAN OR SUPPLIER INFORMATION' section, specifically the NPI field for the rendering provider.
- 32a**: Located in field 32, 'SERVICE FACILITY LOCATION INFORMATION', specifically the NPI sub-field.
- 33a**: Located in field 33, 'BILLING PROVIDER INFO & PH#', specifically the NPI sub-field.

NPIs must match MCO billing requirements

If billing as an independent laboratory:

- Field 24J: Individual Type 1 NPI of performing provider, if applicable; otherwise, laboratory rendering
- Field 32a: Laboratory facility Type 2 NPI
- Field 33a: Laboratory facility Type 2 NPI

If billing as a licensed agency or clinic:

- Field 24J: Rendering clinician's Type 1 NPI
- Field 32a: Clinic or agency Type 2 NPI
- Field 33a: Clinic or agency Type 2 NPI

If billing as a group practice:

- Field 24J: Rendering clinician's Type 1 NPI
- Field 32a: Group practice location Type 2 NPI
- Field 33a: Group practice billing Type 2 NPI

If billing individually:

- Field 24J: Individual Type 1 NPI
- Field 32a: Individual Type 1 NPI
- Field 33a: Individual Type 1 NPI

How to specify ordering / referring providers in field 17b:

- Field 17b: Type 1 NPI of the ordering / referring practitioner
- Applies to: Lab orders, Diagnostic services, any service requiring an ordering/referring provider

- **17b** – Ordering or referring provider
- **24J** – Rendering provider
- **32a** – NPI of facility
- **33a** – NPI of billing provider

Fidelis Care NJ Claims portal demo



Sign In

User ID

Password



Sign In

[Forgot your user ID?](#)

[Forgot your password?](#)

Submit claims using Availity

<https://www.availity.com/>

Providers will go to **Claims & Payments**, and select **Claims & Encounters**

The screenshot shows a navigation menu with the following items: **Claims & Payments** (highlighted with a red box and an orange arrow), **My Providers**, **Reporting**, and **Payer St**. Below the menu, there are two columns of options:

- Claim Status & Payments**
 - Claim Status (CS) - highlighted with a red box
 - Remittance Viewer (RV)
- Claims**
 - Claims & Encounters (CE) - highlighted with a red box
 - Quick Claims (QC)
 - Medical Attachments (MA)

Organization: Centene

Claim Type: [Type to search...]
 Professional Claim
 Facility Claim

Payer: [Type to search...]

Responsibility Sequence: Primary

Complete the required fields (*) based on type of claim

PATIENT INFORMATION

Select a Patient [?]
 Type to search...

* Last Name
 Type to search...

* Date of Birth
 mm/dd/yyyy

* Address [?]
 Type to search...

* City
 Type to search...

Patient is deceased

+ Add Auxiliary Claim/Treatment Information

BILLING PROVIDER INFORMATION

Select a Provider [?]
 Type to search...

* Organization / Last Name [?]
 Type to search...

* NPI [?]
 Type to search...

Specialty Code [?]
 Type to search...

Country [?]
 United States

Pay-to address is the same as the billing address

+ Add Contact Information

+ Add Rendering Provider

SUBSCRIBER INFORMATION [?]

* Subscriber / Insured ID [?]
 Type to search...

+ Add Secondary Insurance Plan

CLAIM INFORMATION

* Patient Control Number / Claim Number [?]
 Type to search...

* Provider Accepts Assignment [?]
 Type to search...

* Claim Filing Indicator
 CI - Commercial Insurance Co.

DIAGNOSIS CODES

* Principal Diagnosis Code [?]
 Type to search...

+ Add

+ Add Additional Claim Information

LINES

1	* Service From Date [?] mm/dd/yyyy	Service To Date mm/dd/yyyy	Place of Service [?] Type to search...	* Procedure Code [?] Type to search...	Procedure Description	Modifier
						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> Emergency indicator			* Diagnosis Code Pointer [?] Type to search...	* Charge Amount	* Quantity [?] UN-Unit

+ Add a Line

Total: \$0.00

Clear Form Continue

Claims & Encounters

INSURANCE COMPANY / HEALTH PLAN INFORMATION

Claim Type Professional Claim	Payer EXAMPLE PAYER	Responsibility Sequence P
---	-------------------------------	-------------------------------------

PATIENT INFORMATION

Patient Name PATIENT, POLLY	Date of Birth (MM/DD/YYYY) 01/01/1980	Gender Female
Relationship Self	Address 123 MAIN ST SOMEWHERE, ST 123456789 United States	

BILLING PROVIDER INFORMATION

Organization Name or Provider's Last Name PROVIDER	NPI 1234567893	Address 456 MAIN ST SOMEWHERE, ST 123456789 United States
--	--------------------------	---

Pay-To address is the same as the billing address

DIAGNOSIS CODES

Principal Diagnosis Code

A001

SERVICE LINE SUMMARY

Line 1

Service Dates (mm/dd/yyyy)	Place of Service	Procedure Code	Description	Modifier Codes				Diagnosis Code Pointer				Charges	Quantity
				1	2	3	4	1	2	3	4		
05/03/2022 - 12/08/2022	11	A4719						A001				\$100.00	1

TOTAL: \$100.00

[VIEW ALL SERVICE LINE DETAILS](#)

Back

Print

Submit



Claim Submitted

Your claim has been accepted by the payer.

Transaction ID

123456789

Patient Account Number

123456

Submission Type

Professional Claim

Submission Date

4/20/2023

Date(s) of Service

4/19/2023 - 4/19/2023

Patient Name

PATIENT, POLLY

Subscriber ID

ABC123456789

Billing Provider Name

PROVIDER

Billing Provider NPI

1234567893

Billing Provider Tax ID

111111111

Total Charges

100.00



Print

New Claim

Horizon NJ Health | Meet our claims & billing team



Michael Healey
Director, GP
Operations

- Responsible for the ownership of projects and daily operations



Jennifer McGinley
Manager, GP
Operations

- Responsible for the management of projects and daily operations



Michelle Ray
Business Analyst III,
GP Operations

- Responsible for analysis and resolution of system-related contract/pricing discrepancies



Toni Gorski
Claims Business Tech
Analyst, GP
Operations

- Responsible for gathering data for analytic reporting purposes

Horizon NJ Health | Our claims process



Required fields

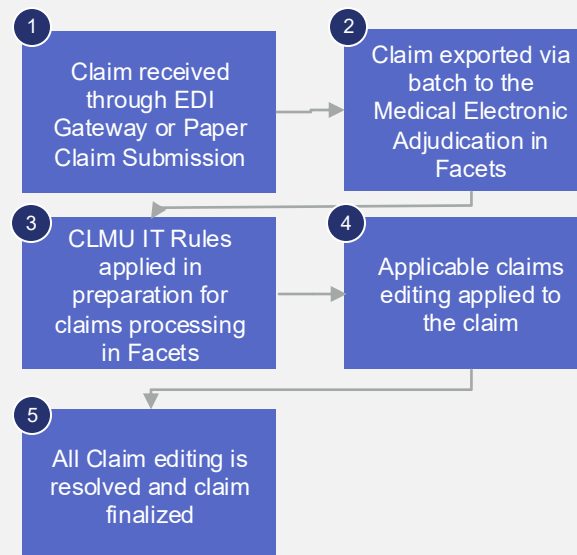
- Key required fields include:
 - Horizon NJ Health Member ID (YHZ#), Name, DOB
 - Provider Name, TIN, Rendering NPI
 - DOS, Service, Diagnosis, Units

Claims submission

- Submit claims **within 180 days** from Date of Service or Date of Discharge
- **Electronic¹:**
 - Horizon NJ Health EDI Gateway through direct submission through clearinghouse / vendor using payor ID **22326**
 - Availity Essentials
- **Paper:**
 - Horizon NJ Health, Claims Processing Department, PO BOX 24078, Newark, NJ 07101-0406

Adjudication & processing

- Horizon NJ Health pays claims 5x weekly, Mon – Frid and will pay clean claims as follows:
 - 90% within **15 days** - for electronic
 - 90% within **30 days** - for paper



Denials & Appeals

- To submit a claim dispute/inquiry:
 - Please contact Provider Services at **1-800-682-9091** or;
 - Submit a Claim Investigation inquiry via **Availity Essentials**
- To submit a claim appeal to dispute the amount you have been reimbursed, send a [HCAPPA form](#) **within 90 days of denial** and any supporting documentation to us using one of:
 - Horizon NJ Health, Claims Appeals, PO Box 63000, Newark, NJ 07101-8064 or;
 - Fax: 1-973-522-4678

1. Hospitals, physicians and health care professionals should send EDI claims

Horizon NJ Health | Make sure NPI numbers match guidance from MCO – CMS 1500

Four sections on CMS 1500 form for NPI numbers

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a			17b NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A L B C D E F G H I J K L ICD Ind. DIAGNOSIS POINTER						22. RESUBMISSION CODE ORIGINAL REF. NO												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EMPLOYER ID. #		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1													NPI					
2													NPI		24J			
3													NPI					
4													NPI					
5													NPI					
6													NPI					
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (or opt class, see 1231) YES NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION 32a				33. BILLING PROVIDER INFO & PH# () 33a										
SIGNED				DATE														

- 17b – Ordering or referring provider
- 24J – Rendering provider
- 32a – NPI of facility
- 33a – NPI of billing provider

NPIs must match MCO billing requirements

If billing as an **independent laboratory**:

- 24J - Providers should enter their Type 2 NPI
- 32a – Providers should enter their Type 2 NPI
- 33a - Providers should enter their Type 2 NPI

If billing as a **licensed agency or clinic**:

- 24J - Providers should enter their Type 2 NPI
- 32a – Providers should enter their Type 2 NPI
- 33a - Providers should enter their Type 2 NPI

If billing as a **group practice**:

- 24J - Providers should enter their Type 1 NPI
- 32a – Providers should enter their Type 2 NPI
- 33a - Providers should enter their Type 2 NPI

If billing **individually**:

- Type 1 NPI of practitioner in 32a, 33a, and 24J

How to specify ordering / referring providers in field 17b:

- Type 1 NPI

Horizon NJ Health | Make sure NPI numbers match guidance from MCO – CMS 1450 / "UB-04"

Sections on CMS 1450 form for NPI numbers

The image shows a portion of the CMS 1450 UB-04 form. Key sections include:

- Header:** PAGE OF, CREATION DATE, TOTALS
- 50 PAYER NAME:** 51 HEALTH PLAN ID, 52 REL INFO, 53 ASG BEN, 54 PRIOR PAYMENTS, 55 EST. AMOUNT DUE, 56 NPI, 57 OTHER PRV ID
- 58 INSURED'S NAME:** 59 P.REL, 60 INSURED'S UNIQUE ID, 61 GROUP NAME, 62 INSURANCE GROUP NO.
- 63 TREATMENT AUTHORIZATION CODES:** 64 DOCUMENT CONTROL NUMBER, 65 EMPLOYER NAME
- 66 DX:** 67 (A-H), 68
- 69 ADMIT DX:** 70 PATIENT REASON DX, 71 OPS CODE, 72 ECI, 73
- 74 PRINCIPAL PROCEDURE CODE:** a. OTHER PROCEDURE CODE, b. OTHER PROCEDURE CODE, c. OTHER PROCEDURE CODE, d. OTHER PROCEDURE CODE, e. OTHER PROCEDURE CODE
- 75:** 76 ATTENDING NPI, 77 OPERATING NPI, 78 OTHER NPI, 79 OTHER NPI
- 80 REMARKS:** 81CC a, b, c, d

At the bottom of the form, it reads: "UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF."

- 56 – Billing provider
- 76 – Attending provider
- 77 – Operating provider
- 78 & 79 – Other provider(s)

Both attending provider and operating provider may be classed as the "rendering provider" depending on service being billed

NPIs must match MCO billing requirements

If billing as a **facility**:

- Field 56: Type 2 NPI
- Field 76: Type 1 NPI
- Field 77: Type 2 NPI

How to specify ordering / referring providers:

- Type 1 NPI in field 78 (other providers)

Horizon NJ Health Claims portal demo

CE Claims & Encounters

Need Help? [Watch a demo](#) for submitting Professional Encounters.

Give Feedback



INSURANCE COMPANY/BENEFIT PLAN INFORMATION

Organization	Claim Type	Payer	Responsibility Sequence
Horizon BCBSNJ	Professional Encounter	HORIZON NJ HEALTH	Primary

PATIENT INFORMATION

Select a Patient [+](#)

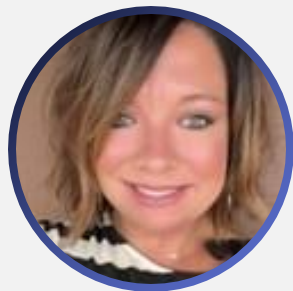
Type to search ..

* Last Name	* First Name	Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Date of Birth	* Gender	* Relationship	
mm/dd/yyyy <input type="text"/>	Type to search .. <input type="text"/>	Self <input type="text"/>	
* Address	Address 2	Country	
<input type="text"/>	<input type="text"/>	United States <input type="text"/>	

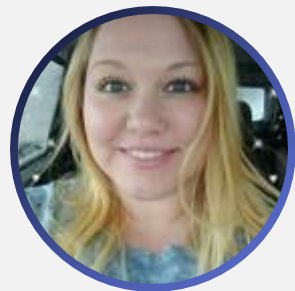
Submit claims using HNJV Portal
<https://www.availity.com/>

[Watch a demo](#)

United Healthcare Community & State - NJ | Meet our claims & billing team



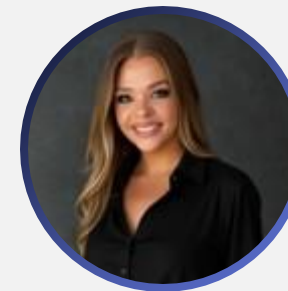
Brooke Link
Manager Bus Claims
Process



Regina Garner
ISG Subject Matter Expert

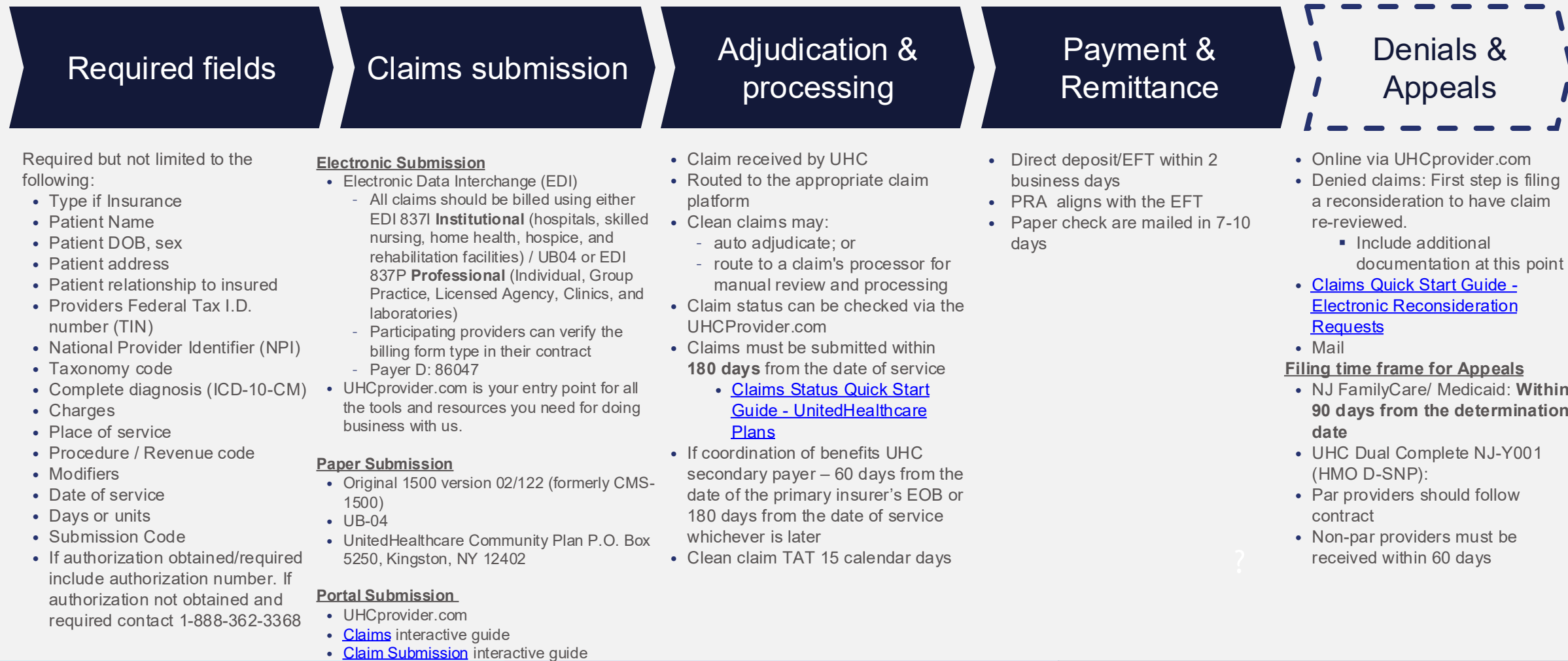


Thomas Ouradnik
ISG Subject Matter Expert



Lauren Crane
JOC Contact

United Healthcare Community & State – NJ | Our claims process



Out of Network (OON) Provider Registration

- If you need to submit an out-of-network medical claim, or you have received a letter requesting information to verify provider billing, you can start the process of registering your tax ID (TIN) now [Out-of-network registration | UHCprovider.com](https://UHCprovider.com).
- Be sure to have a PDF version of your W-9 tax form and documentation to prove your primary practice location address.
- Providers are recommended to bill a HCFA 1500 unless required otherwise.

United Healthcare Community & State - NJ | Make sure NPI numbers match guidance from MCO – CMS 1500

Sections on CMS 1450 form for NPI numbers

The image shows a portion of the CMS 1450 form. Key fields are highlighted in blue and labeled with callouts:

- 17b**: Field 17b, NPI, highlighted in blue.
- 24J**: Field 24J, NPI, highlighted in blue.
- 32a**: Field 32a, highlighted in blue.
- 33a**: Field 33a, highlighted in blue.

A vertical label on the right side of the form reads "PHYSICIAN OR SUPPLIER INFORMATION".

- **17b** – Ordering or referring provider
- **24J** – Rendering provider
- **32a** – NPI of facility
- **33a** – NPI of billing provider

NPIs must match MCO billing requirements

If billing as an independent laboratory:

- Field 24J: Type 2 NPI of laboratory
- Field 32a: Type 2 NPI (can either match the billing in Box 33a or be a separate NPI tied to the physical service location)
- Field 33a: Type 2 NPI of laboratory

If billing as a Licensed agency or clinic:

- Field 24J: Individual rendering provider Type 1 NPI
- Field 32a: Type 2 NPI (can either match the billing in Box 33a or be a separate NPI tied to the physical service location)
- Field 33a: Type 2 NPI of agency or clinic

If billing as a group practice:

- Field 24J: Individual rendering provider Type 1 NPI
- Field 32a: Type 2 NPI (can either match the billing in Box 33a or be a separate NPI tied to the physical service location)
- Field 33a: Type 2 NPI of group practice

If billing individually:

- Field 24J: Individual rendering provider Type 1 NPI
- Field 32a: Type 1 NPI (can either match the billing in Box 33a or be a separate NPI tied to the physical service location)
- Field 33a: Individual rendering provider Type 1 NPI

Field 17b:

- Referring provider Type 1 NPI required for lab claims. This is the provider who referred the member for the lab services.
- If billing individually, field 24J and 17b will be the same NPI.

**Providers are recommended to bill HCFA 1500, unless required otherwise.

United Healthcare Community & State - NJ | Make sure NPI numbers match guidance from MCO – CMS 1450 / "UB-04"

Sections on CMS 1500 form for NPI numbers

PAGE		OF		CREATION DATE		TOTALS	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	
						55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER PRV ID	
58 INSURED'S NAME		59 REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX	67	A	B	C	D	E	F
		T	K	L	M	N	O
69 ADMIT DX	70 PATIENT REASON DX	a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE CODE	DATE	DATE		DATE			73
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		
80 REMARKS		81CC					
		a					
		b					
		c					
		d					
					76 ATTENDING NPI	QUAL	
					LAST	FIRST	
					77 OPERATING NPI	QUAL	
					LAST	FIRST	
					78 OTHER NPI	QUAL	
					LAST	FIRST	
					79 OTHER NPI	QUAL	
					LAST	FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

- 56 – Billing provider
- 76 – Attending provider
- 77 – Operating provider
- 78 & 79 – Other provider(s)

Both attending provider and operating provider may be classed as the "rendering provider" depending on service being billed

NPIs must match MCO billing requirements

If billing as an independent laboratory or facility:

- *Field 56* should include the Type 2 NPI of the lab or facility performing the service

How to specify ordering / referring providers:

- Outpatient Services: In Field 76, enter the ordering/referring providers name and type 1 NPI
- Inpatient Services: In Field 76, enter the attending or ordering providers name and type 1 NPI.

****Field 77-79, (operating and other providers) are generally not required for standard outpatient lab claims.**

UHC Community Plan Claims portal demo

The screenshot shows the UHC Community Plan Claims portal interface. At the top, the United Healthcare logo is on the left, and navigation links for Training & Support, Practice Management, Trackit, and Denise are on the right. A search bar and dropdown menus for Payer (87726 - UnitedHealthcare) and Provider (Medical Center) are also present. A dark blue navigation bar contains links for Eligibility, Claims & Payments (highlighted with an orange box), Referrals, Prior Authorizations, Clinical & Pharmacy, Documents & Reporting, and Additional Tools.

The main content area features a 'Action Required' section with a sub-header 'Take action on any items that require attention.' Below this are several status cards: Trackit Claims (6 Require Action), Trackit Smart Edits (0 Expiring Soon), Trackit Prior Authorizations (0 Require Action), Document Library Teams View (0 Assigned to You), and My Practice Profile Days to Attest (71 Days).

An 'Access Requests' section follows, showing Pending user requests (30), Expiring user requests (0), Pending 3rd party requests (1), and Expiring 3rd party requests (0).

A 'Welcome, Denise!' message is displayed, followed by a note: 'Before you get started, make sure your [payer information](#) and [provider information](#) in the top right corner of the page are correct.' A 'Customize Tabs' button is located to the right.

The main task area is titled 'Select a Task' and includes buttons for 'Create Request', 'View Existing', and 'Check if Required'. Below this, there are instructions for creating new submissions for standard services and for medical services (Radiology, Cardiology, Oncology and Radiation Oncology). A sidebar on the right contains 'PAAN Resources' (Tool resources, Interactive training guide, Peer to peer requests) and 'Quick Links & Tools'.

Submit claims using UHC Portal
UHCprovider.com > Sign In (upper right corner)

Additional Claim Resources

The following online resources provide additional claims information and trainings

Claim Overview: [Claims, billing and payments | UHCprovider.com](#)

Claim Submission: [Claim Submission](#)

Claim Reconsideration: [Claims Quick Start Guide - Electronic Reconsideration Requests](#)

Claim Status: [Claims Status Quick Start Guide - UnitedHealthcare Plans\](#)

Electronic Payment Options: [Claims Status Quick Start Guide - UnitedHealthcare Plans](#)

Wellpoint | Meet our claims & billing team



Heidi Coluni
Director, Provider Solutions

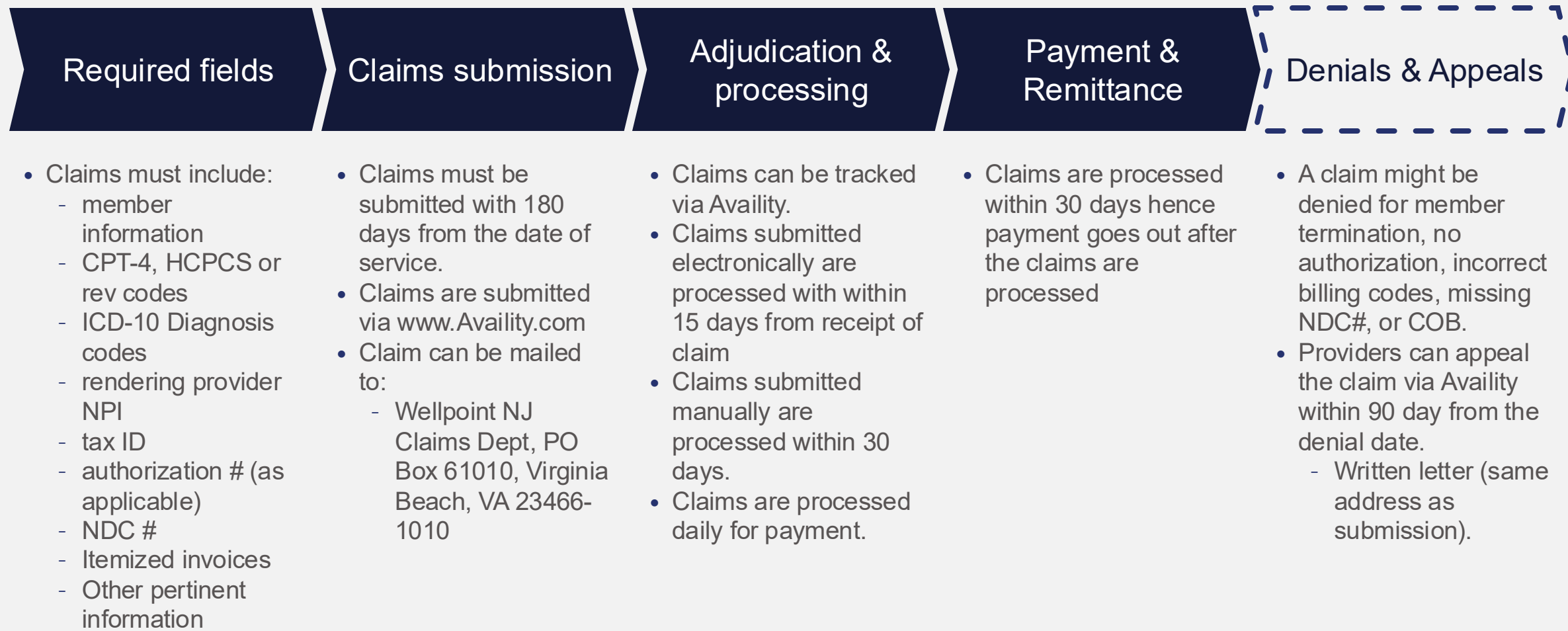


Eyreny Mekhaiel
GBD State Operations
Director



Michael Giaimo
Business Change
Manager, Sr.

Wellpoint | Our claims process



Wellpoint | Make sure NPI numbers match guidance from MCO – CMS 1500

Four sections on CMS 1500 form for NPI numbers

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a			17b NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A L B C D E F G H I J K L ICD Ind. DIAGNOSIS POINTER						22. RESUBMISSION CODE ORIGINAL REF. NO.				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EMPLOYER ID #	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI
2										NPI
3										NPI
4										NPI
5										NPI
6										NPI
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (or give class. no. 1231) YES NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd. for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION 32a			33. BILLING PROVIDER INFO & PH# () 33a				
SIGNED		DATE		3		4		5		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

- **17b** – Ordering or referring provider
- **24J** – Rendering provider
- **32a** – NPI of facility
- **33a** – NPI of billing provider

NPIs must match MCO billing requirements

If billing as an independent laboratory :

- 24J – Not required for laboratories
- 31 – Not required for laboratories
- 32a – Type 2 NPI of facility, only populated if different from 33a
- 33a – Type 2 NPI of billing provider

If billing under a group practice OR licensed agency/clinic:

- 24J – Enter Type 1 NPI of the provider who rendered services.
- 31 – Rendering physician signature; may be a stamp, print or computer-generated signature; otherwise, the practitioner or practitioner's authorized representative MUST sign
 - **Note:** Field 31 does not exist in electronic 837P, meaning this field is not required when claim is submitted electronically.
- 32a – Type 2 NPI of facility, only populated if different from 33a
- 33a – Type 2 NPI of billing provider

If billing individually:

- Type 1 NPI of practitioner in 32a, 33a, and 24J

Wellpoint | Additional billing requirements for CMS 1500 and CMS 1450



CMS 1500

Notes

Independent labs must bill on Claim Form 1500

- Laboratory **CLIA number MUST be included in Box 23** on claim to avoid denial
- **Referring physician MUST be included in Box 17b** on claim to avoid denial



CMS 1450 ("UB-04")

Notes

Typically, hospitals will not bill SUD labs as standalone service

- SUD labs would be in combination with other services being provided (such as ER visit, observation, inpatient etc.).

Three sections to enter NPI:

- 56 – Billing provider
- 76 – Attending provider
- 77 – Operating provider

Billing as a facility:

- Field 56 – *Type 2 NPI*
- Field 76 – *Attending provider name and Type 1 NPI; also classified as ordering provider in inpatient settings*
- Field 77 – *Operating provider name and Type 1 NPI*

Wellpoint Claims portal demo



Submit claims using Availity

Need help? Visit the state's BH Integration Stakeholder website or contact the member's MCO; if you cannot reach a resolution, outreach DMAHS

BH Integration Stakeholder Information website¹

The [Provider Resources webpage²](#) of the BH stakeholder website has information for providers including:

- Notices of upcoming office hours or updates
- NJSAMS Training materials
- NJSAMS, IME, and MCO contact information
- [Provider guidance packet](#)

Member's Managed Care Organization

For specific member inquiries and MCO-related questions, please contact the member's MCO:



Aetna Fidelis Care Horizon NJ Health



UnitedHealthcare Wellpoint

Find more MCO-specific PA resources in the [appendix](#)

DMAHS – Office of Managed Health Care


If your issue is related to **contracting & credentialing, claims & reimbursement, appeals, or prior authorizations**, then contact **OMHC**:


 mahs.provider-inquiries@dhs.nj.gov

- Include specific details regarding your claims
- If multiple claims are impacted, the information should be summarized using an Excel file
- All Protected Health Information (PHI) must be sent securely

DMAHS Behavioral Health Unit

If your issue is related to **policies & guidelines, access to services, or general questions**, then contact DMAHS BH Unit:

 dmahs.behavioralhealth@dhs.nj.gov

 1-609-281-8028

1. <https://www.nj.gov/humanservices/dmhas/resources/providers/stakeholder/> 2. <https://www.nj.gov/humanservices/dmhas/resources/providers/stakeholder/provider-resources.shtml>



State Q&A

DMAHS claims questions





MCO Q&A

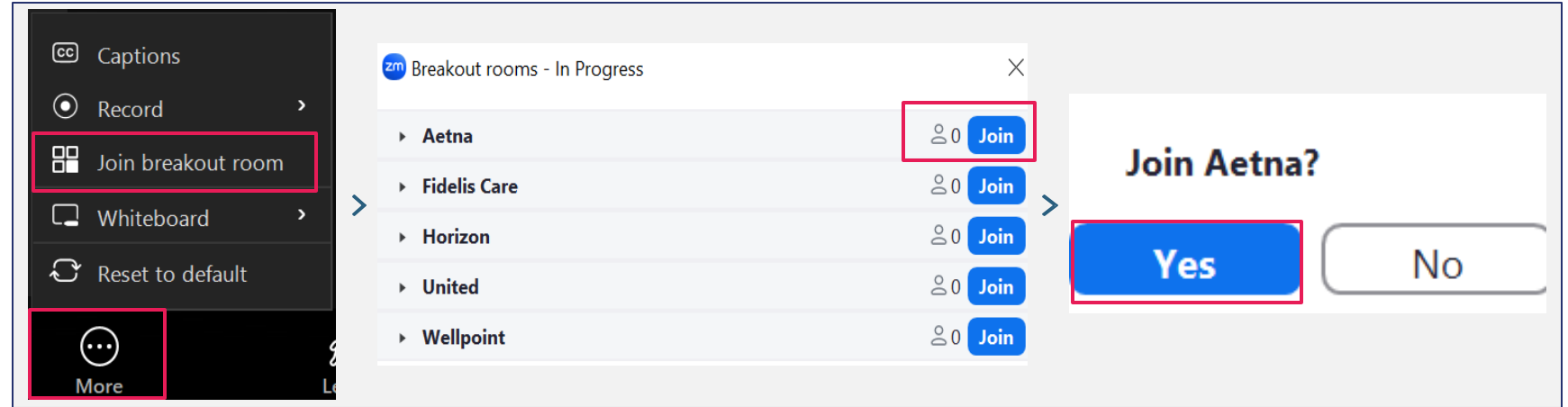
MCO-specific claims questions



Choose your breakout room

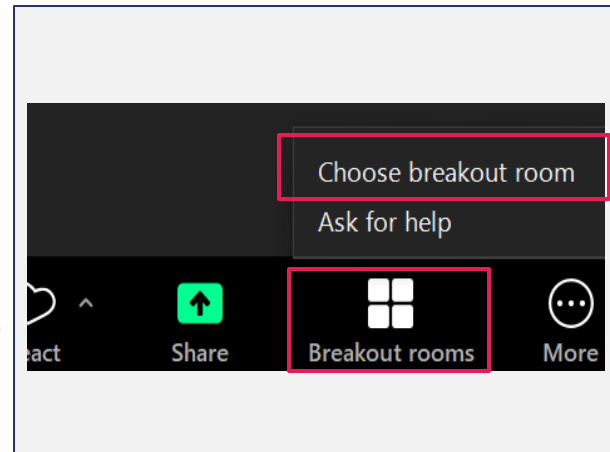
To join a breakout room:

1. Click "**Join breakout room**" on toolbar at the bottom of the Zoom. If the button is not visible, click "More" and then "Join breakout room".
2. Click "**Join**" for the MCO room you wish to be in
3. Click "**Yes**" to be moved into the room



To switch to another MCO room:

1. Click the "**Breakout room**" button on the toolbar at the bottom of the zoom
2. Then, click "**Choose breakout room**"
3. Like above, click "**Join**" for the MCO room you wish to be in



To go back to the Main Room:

1. Click the "**Leave room**" button on the bottom right of the screen
2. Click "**Leave Breakout Room**"

