



Claims & Billing

NJ FamilyCare Behavioral Health Integration

OCTOBER 2, 2026

Housekeeping



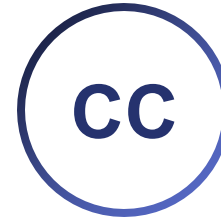
All attendees will enter the meeting on **mute**



Submit your **questions using the "Q&A" function** and we will compile them



Use the **"raise hand"** function if you wish to speak



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



This meeting will be recorded to act as an ongoing resource



Materials and recording will be published and available on DMAHS website

Agenda

1:00pm – 1:15pm

- Overview of standards and transitional rate policy of FFS rate floor

1:15pm – 2:30pm

- MCO Claims Submission Process
- Billing Codes and Claims Requirements
- Submitting Clean Claims
- Claims Payment, Denials, and Remittance Advice
- Claims Reconsiderations and Appeals
- Q&A

NJ FamilyCare/NJ Medicaid has two delivery models

NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes core Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion populations. Medicaid services are provided through **two delivery models**:

Fee For Service (FFS)

- **Providers bill state** Medicaid directly for services
- Currently, **many behavioral health (BH) services** are billed under FFS for the **general population**, but are shifting to managed care
- In addition to certain services, used for **members not enrolled in a managed care organization (MCO)** and members with **presumptive eligibility**



~5% of NJFamilyCare members covered under FFS only

Managed care

- Services managed by one of **5 MCOs**: Aetna, Fidelis, Horizon, United, Wellpoint
- **Providers bill MCOs** for services; MCOs receive funding from state to **coordinate member care** and **offer special services** in addition to regular NJ FamilyCare benefits
- **MCOs responsible** for provider network management, care coordination and care management, utilization management, quality assurance, etc.



~95% of NJFamilyCare members enrolled in an MCO

Overview of NJ Behavioral Health Integration

Context

While physical health is managed by MCOs, many behavioral health (BH) services are still managed through FFS

BH includes mental health (MH) services and substance use disorder (SUD) services

NJ's BH Integration began shifting BH services from FFS to managed care as of Jan 2025

Goals of BH Integration

- ☆ **Increase access** to services with a focus on member-centered care
- ☆ Integrate behavioral and physical health for **whole person care**, with potential to improve healthcare outcomes
- ☆ Provide appropriate services for members in the **right setting, at the right time**

Phase 2 of BH Integration will go-live January 2027

Jan 1, 2025

Phase 1

Outpatient BH Services
(for adults and children)

- MH outpatient counseling/psychotherapy
- MH partial hospitalization
- MH partial care in outpatient clinic
- MH outpatient hospital or clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinic (includes ambulatory withdrawal management)
- SUD partial care

July 1, 2026

SUD Laboratory Services

- Presumptive drug tests (with SUD diagnosis)
- Definitive drug tests (with SUD diagnosis)

Jan 1, 2027

Phase 2

Residential & Opioid Treatment Programs

- SUD – medically monitored inpatient withdrawal management
- SUD short-term residential
- SUD long-term residential
- Opioid treatment programs (OTPs)

Phase 2 of BH Integration go-live planned for Jan 1, 2027

TBD¹

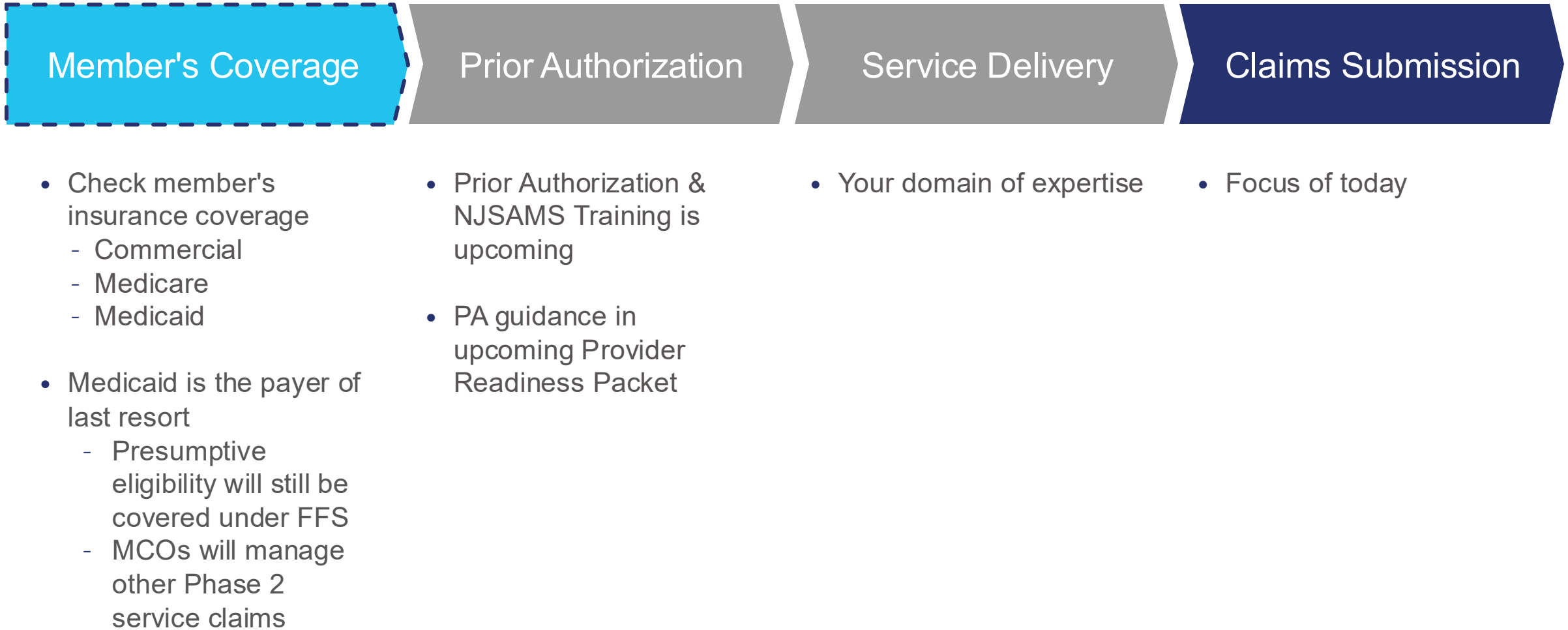
Phase 3

Additional BH services
TBD

- Adult mental health rehabilitation / MH supervised residential
- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM)

1. Scope and timing of Phase 3 to be determined after Phase 2 go-live

Focus today will be submitting managed care claims but first a reminder to check member's coverage



Checking members' healthcare coverage and benefits: Three key scenarios

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

Medicaid-exclusive claim

Scenario 3: Member covered by Medicaid only

- Medicaid is the sole payer



In all scenarios, Medicaid is the payer of last resort

Scenarios 1 & 2: Providers responsible for coordination of benefits (COB)

Members may be covered by one or more health plans

Commercial

Medicare

Medicaid

Not exhaustive



Commercial / Medicare also cover BH services¹

Not exhaustive

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Professional Counselors (LPC) & Licensed Clinical Social Worker (LCSW)
- Intensive Outpatient Program provided by the following:
 - Hospital outpatient
 - Federally qualified health centers (FQHCs),
 - Opioid treatment programs (OTPs)

Important to enroll as Medicare provider, if applicable

- Medicare is primary payer, and Medicaid is **secondary payer**
- If member dually eligible, MCO will **not pay the full amount**, only the balance
- Providers can enroll in Medicare online using [PECOS](#)²
- Contact your Medicare Administrative Contractor (MAC) to help you navigate enrollment

1. Dually Eligible Beneficiaries Receiving Medicare Part B Marriage and Family Therapist Services, Mental Health Counselor Services, and Intensive Outpatient Services Effective January 1, 2024; 2. 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](#)

Value of being a Medicare enrolled provider: An example

Member covered by Medicare and MCO Medicaid Plan

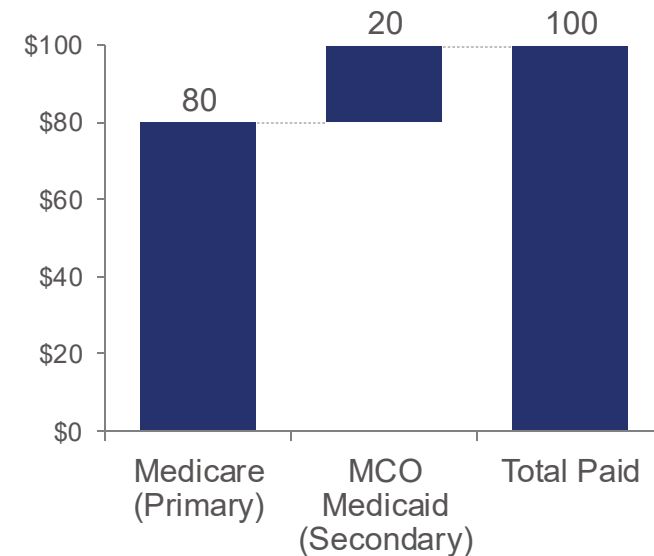
Medicare approved amount for service = \$100

Medicare reimbursement = 80%

MCO Medicaid contract rate for service = \$100

A Provider enrolled in Medicare and Medicaid – billed Medicare first

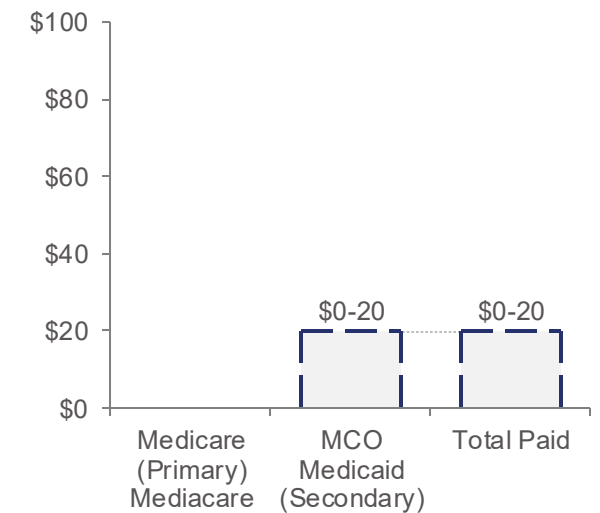
Provider A reimbursement



- Medicare first pays its portion, \$80
- MCO pays provider remaining balance up to agreed contract rate
- Provider is reimbursed \$100 in total

B Provider not-enrolled in Medicare – billed Medicaid only

Provider B reimbursement



- MCO won't pay full amount because Medicare was not billed
- Since provider not enrolled, MCO will typically deny claim

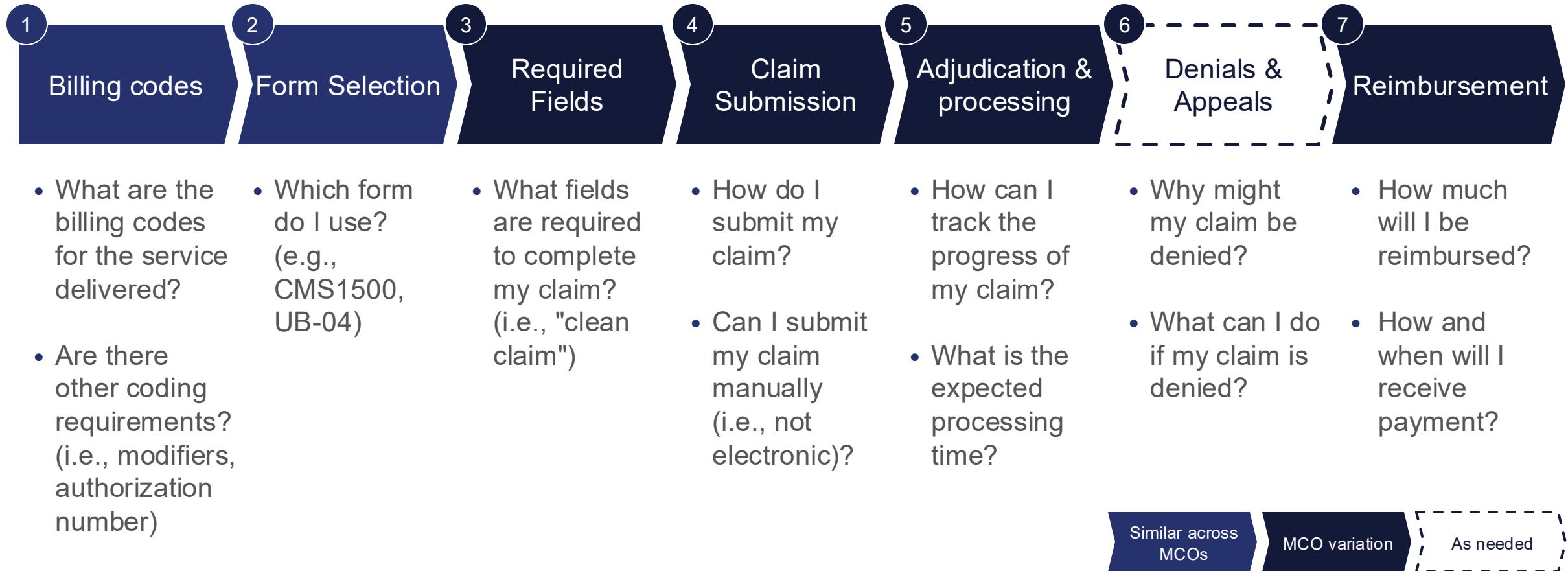
Claims

A documented request for payment to a Managed Care Organization after providing covered services

Goals

- ☆ **Timely and accurate reimbursement:** Ensure prompt and correct payment to healthcare providers while validating the necessity and compliance of services
- ☆ **Program integrity:** Detect fraud and monitor expenses to maintain the program's financial sustainability
- ☆ **Transparency:** Maintain clear records for accountability and gather data to improve program efficiency and policy decisions

Medicaid claims process: Seven steps for providers



Medicaid and MCO specific coding requirements for accurate billing

	Diagnosis codes	Procedure codes	Revenue codes	Other codes
General coding requirements (i.e., same as FFS)	<i>Why is service is needed?</i> ICD-10-CM codes for primary diagnosis	<i>What services were performed?</i> CPT or HCPCS codes for procedures and services ICD-10-PCS for inpatient hospital procedures	<i>Where the services were provided?</i> Rev codes for hospitals and facilities to indicate location or department where service performed	<i>Is service authorized or billable?</i> Coordination of Benefits (COB) codes to indicate how claim should be processed
MCO Medicaid specific requirements	ICD-10 diagnosis codes must meet MCO Medicaid medical necessity criteria	HCPCS Level II codes required for services not in CPT codes (e.g., ambulance services) Some MCOs more stringent on modifiers in specific situations	Modifiers required in specific situations May impose payment caps based on rev code	MCO specific COB process Authorization number: Covered in State Prior Authorization training

Medicaid follows National Correct Coding Initiative (NCCI) edits to prevent improper coding and overbilling.
These edits identify improper coding combinations and ensure billing adheres to specific rules

Same CMS 1500 or CMS 1450 ("UB-04") forms used for Medicaid FFS

CMS 1500 / 837P¹

For independent medical professionals
(outpatient claims)

 A sample of the CMS 1500 Health Insurance Claim Form. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes a QR code in the top left corner. It is divided into several sections for patient information, provider information, insurance information, and a detailed list of services rendered. A large "SAMPLE" watermark is overlaid diagonally across the center of the form.

[Link to form](#)

CMS 1450 ("UB-04") / 837I²

For hospitals and facilities
(inpatient claims)

 A sample of the CMS 1450 ("UB-04") Health Insurance Claim Form. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes a QR code in the top left corner. It is divided into several sections for patient information, provider information, insurance information, and a detailed list of services rendered. A large "SAMPLE" watermark is overlaid diagonally across the center of the form.

[Link to form](#)

1. 837P is the standard format electronic equivalent of CMS 1500; 2. 837I is the standard format electronic equivalent of CMS1450

Make sure NPI numbers match guidance from MCO – CMS 1500

Three sections on CMS 1500 form for NPI numbers

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

NPIs must match MCO billing requirements

Three sections to enter NPI:

- 24J – Rendering provider
- 32a – NPI of facility
- 33a – NPI of billing provider

In general, if billing under a group:

- Type 2 NPI of group in 32a and 33a
- Type 1 NPI of rendering provider in 24J

If billing individually:

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

MCO specific requirements may differ
Details to come

Make sure NPI numbers match guidance from MCO - CMS 1450

Three sections on CMS 1450 ("UB-04") 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 PREL	60 INSURED'S UNIQUE ID
61 GROUP NAME		62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66	
67		68		69	
70		71		72	
73		74		75	
76		77		78	
79		80		81	
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NPIs must match MCO billing requirements

Three sections to enter NPI:

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

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

Billing as a facility:

- Type 2 NPI of Facility in 56
- Type 1 NPI of attending provider in 76
- Type 1 NPI of operating provider in 77

MCO specific requirements may differ
Details to come

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

State requiring 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

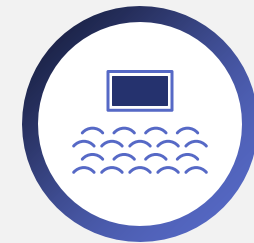
Wellpoint

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

Starting 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	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 P.O. Box 898 Amherst, NY 14226
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 87726	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402
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

Rate and claims policies to improve provider experience for BH Integration



Introduced FFS rate floor

- All MCOs must pay providers **at or above** FFS rates for BH services
- If FFS rates change during existing contract period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS



Shortened BH claims processing times

- Processing timelines must be aligned with MLTSS standards
 - 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



Reduced minimum weekly payment cadence from 2 weeks to 1 week

- Payments for clean claims must be paid weekly, reduced from bi-weekly



Require 'clean claim' definition in MCO provider manual

- Require MCOs to specify fields that must be completed in UB-04 or CMS 1500 to satisfy the definition of a "clean claim" – [more details to follow](#)



Mandated claims be covered in MCO BH provider trainings

- Claims must be covered by MCOs in provider trainings

Rates individually negotiated, but must be at or above FFS floor

Each MCO negotiates own rates with providers

MCO reimbursement rates are negotiated between provider and individual MCO

Some MCOs may be willing to provide a fee schedule upon request

- For more information, please reach out to each MCO separately

State requires payment to be at or above Medicaid FFS rates

- All MCOs must pay providers at or above FFS rates
- If FFS rates change during existing contract period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS
- Medicaid FFS fee schedule can be found [here](#)

Receive payments 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

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.

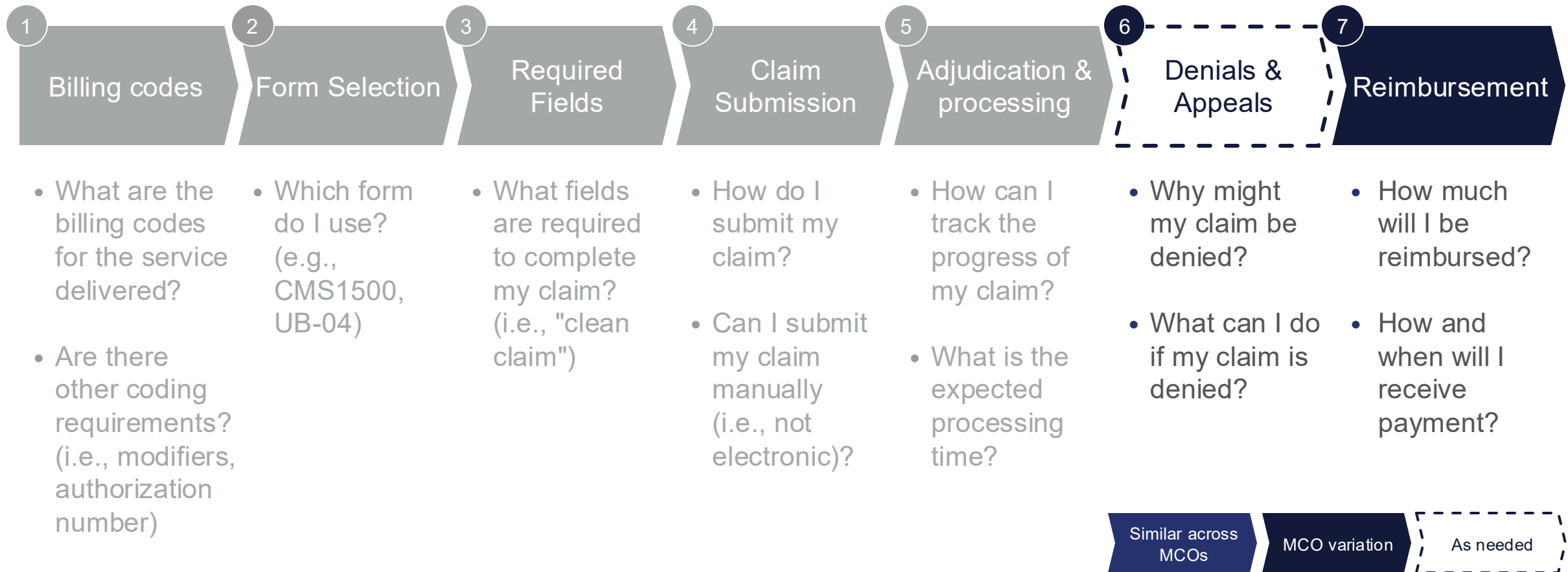
How to check the status of your claim

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

Last steps: Denials & Appeals, and Reimbursement



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 90-180 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

Reach out to Office of Managed Health Care if you can't reach a resolution



Office of Managed Health Care (OMHC)

- Addresses provider inquiries and/or complaints in relation to MCO:
 - Contracting & credentialing
 - Claims & reimbursement
 - Authorizations
 - Appeals
- Helps bring resolution between provider and MCO



Contact OMHC with details of your claim

- Email: MAHS.Provider-inquiries@dhs.nj.gov
- Include detail regarding your claim
- If multiple claims are impacted, the information should be summarized using an Excel file
- All information must be sent securely, if it includes Protected Health Information (PHI)

MCO Claims Submission Process

Fidelis Care



Fidelis Care New Jersey

Behavioral Health Integration – updated August 2026



FIDELIS CARE®

Confidential and Proprietary Information

To help ensure accurate claims submission....

Ensure that the billing provider submitted on the claim matches the provider identified on the authorization. Matching elements may include the billing/rendering provider NPI, provider ID, servicing provider, or other provider identifiers documented on the authorization, as applicable. If an authorization is required, be sure to include your Provider ID on the authorization request form.

If you are billing as individual providers, the individual's NPI should go in box 24J and 31. The group NPI should go in box 33.

Ensure that the rendering provider you are billing with is credentialed with the MCO.

If you are not credentialed with an MCO, you will need to request an authorization before rendering services.

If you are credentialed as an individual provider, please bill with your NPI 1 in box 24J and 31. The group NPI should go in box 33A (if applicable). If you are credentialed as a facility, please bill box 33 with NPI 2.

Include your authorization number (if applicable to the service) on the claim.

If you are unsure if an authorization is required, please refer to each MCO's authorization guidelines.

Timely Claims Submission

The existing process that is currently used for MLTSS, DDD, and FIDE-SNP will continue to be followed for members newly receiving integrated services outside of these special populations.

Providers must **submit claims within 180 calendar days from the date of service (DOS)** or the date of discharge for inpatient services.

Participating providers must **submit corrected claims within 365 calendar days** from the date of service or the date of discharge for inpatient services.

The following items **CAN** be accepted as proof if a “Clean” Claim was submitted timely:

A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Fidelis Care.

A Provider’s electronic submission sheet with all the following identifiers:

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

The following items are **NOT** acceptable as evidence of timely submission:

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

Electronic Claims Submissions

MCOs encourage providers to submit claims electronically via electronic data interchange (EDI) or direct data entry (DDE). Both are less costly than billing with paper and enable quicker claims processing.

Fidelis Care's preferred EDIT gateway is Availity. If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at 1-800-282-4548. Providers should submit Fee For Service claims to Fidelis Care Payer ID **14163**. Providers can also use their own vendor/clearinghouse to submit electronically.

Availity Essentials offers providers a web browser for direct data entry (DDE) at no cost to you. To register, submit the request to <https://www.availity.com/essentials-portal-registration/>

If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at 1-800-282-4548.

For inquiries related to your electronic submissions to Fidelis Care, please contact our EDI team at EDIBA@centene.com.

Paper Claims Submissions

Paper Claims Submissions: For timely processing of claims, Providers are encouraged to submit claims electronically. Claims not submitted electronically may be subject to penalties in outlined Agreement. For assistance in creating an EDI process, contact the appropriate MCO for specific guidance.

Paper claims must only be submitted on an original (red ink on white paper) claim form.

Any missing, illegible, incomplete or invalid information in any field will cause the claim to reject or process incorrectly

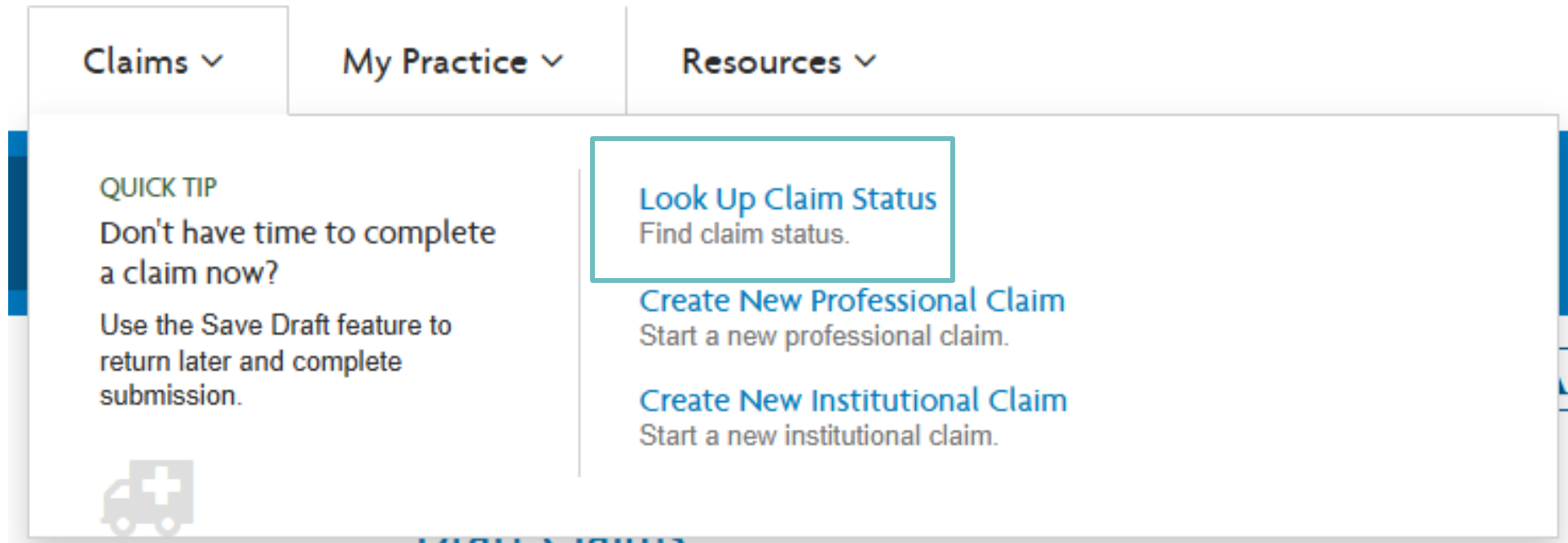
[CMS Fact Sheet about CMS-1500](http://www.cms.gov/files/document/837p-cms-1500pdf) www.cms.gov/files/document/837p-cms-1500pdf

From Submission to Resolution



Timing reminder: Original claims are due within 180 calendar days. Participating providers must submit corrected claims within 365 calendar days.

How to Check Claim Status on Fidelis Care Portal



**Please note that other MCOs will cover this in their individual trainings*

How to Check View of Claim Status on Fidelis Care Portal

HomeMy PatientsCare Management ▾Claims ▾My Practice ▾Resources ▾

Claims

▾ A A ▴

If you are experiencing issues submitting claims on the portal, you may also submit claims electronically via electronic data interchange (EDI) or direct data entry (DDE).

EDI: Change Healthcare manages all EDI for WellCare/Fidelis Care. Please contact Change Healthcare directly at 1-877-411-7271, or your vendor may call 1-800-527-8133.

DDE: ConnectCenter for physicians offers a free DDE web service for WellCare/Fidelis Care.

Sign up at: <https://connect.relayhealth.com> using vendor code 212750.

You can access your Explanation of Payment (EOP)/Remit on the [Payspan website](#).

Draft Claims

Drafts that have not been submitted are shown below. Open draft claim to complete or cancel.

Member Id	Date Started	Delete
No drafted claims found		

◀ ◀ 0 ▶ ▶ 3 ▾

No items to display

New Professional ClaimNew Institutional Claim

Search Submitted Claims

AppealsDisputes

Search Type

WCN Number ▾

Enter up to 10 values separated by commas

Service Date

Select ▾

Search

**Please note that other MCOs will cover this in their individual trainings*

34

NEW JERSEY
HUMAN SERVICES

Billing Codes and Claims Requirements

Horizon

Behavioral Health Medicaid Phase 2

Integration Billing Codes and Claims Requirements

- **Common coding and billing considerations for residential and OTP services**

What are the services under the BH Medicaid Phase 2 Integration?

Phase 2 – Residential & OTP

- **SUD short term residential:**

H0018 HF - short term residential
H0018 HF U1 - short term residential with methadone MAT
H0018 HF U2 - short term residential with non-methadone MAT
H0018 HV - short term residential room and board

- **SUD medically monitored inpatient withdrawal management:**

H0010 HF – residential detox (ASAM Level 3.7 WM)
H0010 HV - residential detox, room and board

- **SUD long term residential**

H0019 HF - long term residential
H0019 HF U1 - long term residential with methadone MAT
H0019 HF U2 - long term residential with non-methadone MAT
H0019 HV - long term residential room and board
H0019 HF U3 - long term residential with administration of buprenorphine or related buprenorphine products

- **Lab Codes:**

36415 - venous blood collection
82075 - Ethanol Breath assay
86580 - TB test, patch or intradermal
96372 - Injection only of drug or substance
81002 - Routine urinalysis
87426 - COVID test
80305 – Drug test presumptive optical observation

- **Opioid treatment programs (OTP)**

G2067 - Medication-Assisted Treatment (MAT) using methadone for opioid use disorder (allowed 1x a week Sun-Sat)
G2068 - Medication-Assisted Treatment (MAT) using oral buprenorphine for Opioid Use Disorder (OUD) (allowed 1x a week Sun-Sat)
G2069 - Medication-Assisted Treatment (MAT) using injectable buprenorphine administered (allowed 1x in a 28-day period)
G2073 - Medication-Assisted Treatment (MAT) service for opioid use disorder using naltrexone (allowed 1x in a 28-day period)
G2074 - Non-drug bundle for opioid use disorder (OUD) treatment (allowed 1x a week Sun-Sat)
G2076 - Intake activities for new patients
G2078 - Take-home supplies of methadone (allowed 4x in a 28-day period, cannot be billed without G2067)
G2079 - Take-home supply of oral buprenorphine (allowed 4x in a 28-day period, cannot be billed without G2068)
S9381 U1 - Opioid Treatment Transportation code for distance lesser than 50 Miles (allowed 1x a week Sun-Sat with Rev code 900-911, 914-919, 949, 944, 945)
S9381 U2 - Opioid Treatment Transportation code for distance greater than 50 Miles (allowed 1x a week Sun-Sat with Rev code 900 to 919 {except 912 and 913}, 949, 944, 945)
G0536 - Peers allowed during active treatment
J0577 - Supply and administration of buprenorphine extended-release (Brixadi), less than or equal to 7 days of therapy
J0578 -Supply and administration of buprenorphine extended-release (Brixadi), 8 to 28 days of therapy

Claim Submissions

For Core Medicaid, DDD, MLTSS, and DSNP

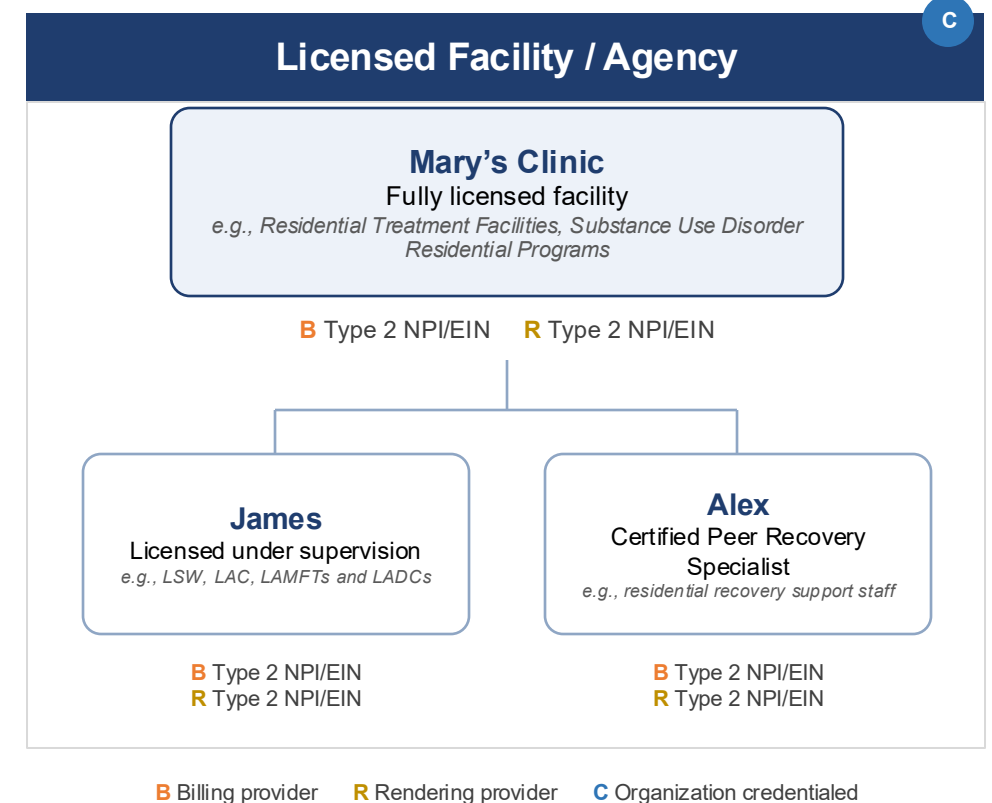
Claims Guidelines

- Claims for the newly integrated services should be submitted for dates of service beginning 1/1/2027 on a CMS 1500 Form or UB-04/CMS 1450 Form
- Claims for newly integrated services will follow the same procedures as for services already covered.
- Providers are encouraged to submit claims electronically via Availity Essentials.
- Payments for clean claims will be released on a weekly basis
- Medicaid members do not have copayments and/or coinsurance

Billing Requirements

For Behavioral Health and Substance Use Disorder Facilities/Clinics:

- Behavioral Health and/or Substance Use Disorder Facilities are programmatically licensed providers (e.g., residential treatment, partial care, IOP/outpatient clinics) that are licensed, credentialed and contracted as an organization.
- Claim submissions on a CMS 1500 Form, unless specified otherwise in the provider agreement.
- A type 2 organizational NPI is used in both the Billing (B) and Rendering Provider (R) fields, claims are not submitted under individual rendering practitioners.



Claims Guidelines (cont'd)

- Claims must be submitted within 180 calendar days of the date of service
- Claims should be submitted through Availity Essentials
- Claims must include your NPI, facility/clinic claims should include the TIN and NPI in both the billing and rendering fields
- Claims must include your taxonomy code. For CMS-1500 claims:
 - The taxonomy code should be identified with the qualifier “ZZ” in the shaded portion of box 24i
 - The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level
- Claims that do not contain these codes cannot be processed

Coordination of Benefits

- Each Managed Care Organization, or "MCO" for Medicaid and NJ FamilyCare members in New Jersey, is the “payor of last resort” on claims for services provided to members also covered by Medicare, employee health plans or other third-party medical insurance
- Upon receipt of payment, submit applicable claims for payment of deductibles and coinsurance amounts
- Each MCO will process for secondary reimbursement up to the primary contracted rate for the service.

Submitting Clean Claims

United Healthcare



Clean Claim- Required Claim Elements

Clean Claim- A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim. All required fields must be complete and legible.

All claim submissions must include, but are not limited to:

- Member's name, identification number and date of birth
- Provider's Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- Taxonomy Code
- A complete diagnosis (ICD-10-CM)
- Value, Rate Code, Revenue, Modifiers, etc.
- Date of Service
- Revenue Codes

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available on [CMS.gov](https://www.cms.gov)

1. Roster requirements vary by MCO. Not all MCOs require rostering

CMS 1500 Claim Form – Independent Medical Professionals

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Example of clean claim required fields

Boxes 1, 1a, 2, 3, 5, 6: Enter member demographics exactly as shown in eligibility and on the ID card.

Boxes 10 and 11d: Answer accident, employment and other coverage questions. Do not leave applicable indicators blank

Boxes 12–13: Use the patient/insured signature or “Signature on File,” when permitted.

Box 14: Enter the applicable onset/current illness date using the required date format.

Box 21: Report the valid ICD-10-CM diagnosis supported by the record.

Box 23: Enter the authorization number when the service requires prior authorization.

Required fields vary by bill type and service

[National Uniform Claim Committee \(NUCC\) 1500 Claim Form Reference Instruction Manual](#)

CMS 1500 Claim Form – Independent Medical Professionals

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA												PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA LONG OTHER													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)													
3. PATIENT'S BIRTH DATE SEX													
4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
5. PATIENT'S ADDRESS (No., Street)													
6. PATIENT RELATIONSHIP TO INSURED													
7. INSURED'S ADDRESS (No., Street)													
8. RESERVED FOR NUCC USE													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
10. IS PATIENT'S CONDITION RELATED TO:													
11. IS THE POLICY GROUP OR FECA NO.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE													
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE													
14. DATE OF CURRENT LINES OF SERVICE													
15. NAME OF REFERRING PHYSICIAN													
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION													
17. ADDITIONAL CLAIM INFORMATION													
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
19. OUTSIDE LAB?													
20. SUBMISSION CODE													
21. PRIOR AUTHORIZATION NUMBER													
22. BILLING PROVIDER INFO & PH													
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NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-9338-1197 FORM 1500 (02-12)

Example of clean claim required fields

Boxes 24A–24G: Report dates, POS, procedure code, applicable modifiers, diagnosis pointer, charge and units on every line.

Box 24J: Use the enrolled rendering provider NPI for the clinician who performed the service.

Boxes 25–26: Use the billing TIN and a unique patient account number.

Boxes 28 and 31: Total all line charges and include the provider signature or approved signature notation.

Boxes 32/32a: Report the service facility and NPI when required for the place of service.

Boxes 33/33a: Report the enrolled billing provider name, address and billing NPI exactly as contracted.

Required fields vary by bill type and service

National Uniform Claim Committee (NUCC) 1500 Claim Form
Reference Instruction Manual

CMS 1450 Form - Hospitals and Facilities

The form is a CMS 1450 form for Hospitals and Facilities. It contains various fields for patient information, billing details, and medical codes. A large 'Sample' watermark is diagonally across the center.

Example of clean claim required fields

FL 1, 5 and 56: Billing provider identity, TIN and NPI must match enrollment and contracting records.

FL 3a and 4: Use a unique control number and the correct 4-digit type of bill, including frequency.

FL 6: Statement dates must encompass the service dates reported on revenue lines.

FL 8b–11: Enter patient demographics exactly as shown in eligibility.

FL 12–17: Use valid admission, visit, discharge and patient status codes applicable to the encounter.

FL 18–36: Report condition and occurrence codes/dates only when applicable.

Required fields vary by bill type and service

[CMS-1450 | CMS](#)

CMS 1450 Form - Hospitals and Facilities

The image shows a sample of the CMS 1450 form, which is used for hospitals and facilities to submit claims. The form is divided into several sections, including patient information, insurance details, and a table for charges. A large diagonal watermark reading 'Sample' is overlaid across the form.

Example of clean claim required fields

FL 42–47: Use valid revenue/HCPSC combinations, applicable modifiers, service dates, units and charges.

FL 50 and 60: Identify UnitedHealthcare Community Plan and enter the member ID exactly as shown in eligibility.

FL 56: Report the enrolled billing NPI that corresponds to the billing provider in FL 1.

FL 63: Include the authorization number when required for the billed service.

FL 66–70: Use the correct ICD indicator and valid diagnosis codes supported by documentation.

FL 76: Report the attending provider name and NPI; add other provider fields when applicable.

Required fields vary by bill type and service

[CMS-1450 | CMS](#)

Most Common Claim Denial Reasons/Errors- Improve the Speed of Processing

- **Provider Not Contracted**
 - Providers are billing Revenue/CPT codes that they are not contracted to render. Providers must reference their current agreements.
- **Duplicate Claim Submitted & Previously processed**
 - Providers are submitting duplicate claims in lieu of corrected claims. Providers must ensure that the claim is identified as a “corrected claim” when resubmitting; by placing a 7 in the bill type third digit (UB04) or box 22 (HCFA)
- **Coordination Of Benefits**
 - Primary payer EOB is required when billing for secondary claim consideration. Providers must bill with primary EOB for secondary claim processing.
- **Missing or invalid Taxonomy**
 - Claims are submitted with either a missing or invalid taxonomy code. Providers must ensure that appropriate taxonomy code is appended prior to submission.
- **Rendering Provider Validation Issue (21st Century non-compliant)**
 - Rendering provider must be registered with NJ State and have a valid 21st Century Cures Act Medicaid ID. Providers should ensure that all NPIs billed (including group/facility) are registered with NJ state

Reminder: The biggest opportunities to reduce claim denials and payment delays are submitting clean claims, verifying eligibility and authorization requirements, and maintaining accurate provider demographic and billing information. .

What if I disagree with a claim denial or payment amount

Providers can request a **Formal Claim Appeal** by submitting the request on a Health Care Provider Application to Appeal a Claims Determination form: UHCprovider.com (Provider Forms > DOBI Claims Appeal Form)

Filing time frame for Appeals

- NJ FamilyCare/ Medicaid: Accepted within 90-calendar days from the PRA, EOB, or letter date
- UHC Dual Complete NJ-Y001 (HMO D-SNP): Par providers should follow their contract.
- Non-par providers must be received within 60 calendar days from the initial claim denial date

Submit by mail:

NJ FamilyCare/ Medicaid:
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claim Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

UHC Dual Complete NJ-Y001 (HMO D-SNP) :
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claim Appeals
P.O. Box 6103
Cypress, CA 90630-9998

Or Online:

UHCprovider.com

Click the Sign In button in the top-right corner. Click Claims & Payments > Look Up a Claim > Act on Claim > Create an appeal.

A determination will be rendered within 30 calendar days

Claims Payment, Denials, and Remittance Advice

Wellpoint

Wellpoint

Phase 2 – Behavioral Health Integration Training – Claim Submissions

Wellpoint | Agenda

- Claim Payments
- Claim Denials
- Remittance Advice Overview



Wellpoint | Claim Payments

- Payment is issued by electronic funds transfer (EFT) or paper check. EFT paired with electronic remittance is the fastest option and is enrolled through Availity.
- Every payment cycle produces a matching Remittance Advice / Explanation of Payment that itemizes each claim included in the deposit or check.
- The paid amount equals the contracted allowed amount, less member cost-share (deductible, copay, coinsurance), less any other-carrier payment and any contractual write-off.
- Payments are held or delayed when credentialing is not effective for the date of service, or when the tax ID and NPI on the claim do not match the information on file.

Wellpoint | Claim Denial Reasons

• Authorization number invalid or missing	• Illegible claim information
• Billed charges missing or incomplete	• Incomplete forms
• Claim information does not match authorization	• Payor or other insurer information missing or incomplete
• Coordination of benefits (COB) information missing or incomplete	• Place of service code missing or invalid
• Diagnosis code missing 4th or 5th digit	• Procedure/service code does not match authorization
• Diagnosis, procedure or modifier codes invalid or missing	• Provider name missing or invalid
• DRG codes missing or invalid	• Revenue codes missing or invalid
• Eligibility/enrollment is not valid on DOS	• Spanning dates of service do not match the listed days/units
• Employer identification number (EIN) missing or invalid	• Signature missing
• Explanation of benefits (EOB) missing or incomplete	• Third-party liability (TPL) information missing or incomplete
• Hospital, physician or health care professional identification number missing or invalid	• Type of service code missing or invalid

- Facility/clinic claims should include the TIN and NPI in both the billing and rendering fields

Wellpoint | Claim Denial Appeals

- **Claim appeals can be submitted in multiple forms, but it may vary across each MCO:**
 - Via the MCO Portal
 - Via the Provider Services Unit
 - Via a written letter
- Providers can submit a claim appeal electronically via the MCO portal indicating you would like the claim reprocessed for payment. The portal allows you to add comments and attach supporting documentation, if applicable.
- Providers can contact the Provider Services Unit and speak to a Representative directly to review the claim. It may have been denied for member termination; missing invoice or medical records; incorrect revenue or CPT code and/or modifier. The Representative can send the appeal on behalf of the provider.
- Providers can also mail in a letter appealing the claim denial with supporting documentation such as medical records and other pertinent information. MCOs will respond to the inquiry with a written response.

Wellpoint | Reading the Remittance Advice / Explanation of Payment

- Review of the Remittance Advice (RA) and Explanation of Payment (EOP):
 - Header — payer name, check or EFT trace number, payment date, and total paid. Quote the trace number whenever you call about a missing or partial deposit.
 - Identifiers — rendering and billing NPI, tax ID, member ID, and your patient account number. Confirm these match your billing system before researching a variance.
 - Claim detail lines — each service line shows billed charge, allowed amount, deductible, copay or coinsurance, contractual adjustment, and the amount paid.
 - Adjustment columns — a group code plus reason code account for every dollar of difference between what was billed and what was paid.
 - Summary page — payment totals, prior-period offsets, recoupments or refunds applied, and any interest paid on late claims.
 - Reconcile the RA against posted payments the week it arrives — dispute and appeal deadlines are measured from the RA date.

Claims Reconsiderations and Appeals

Aetna



**Aetna Better Health® of
New Jersey**

**Aetna Assure Premier Plus
(HMO D-SNP)**

Claims Reconsiderations & Appeals



Claims - Quick Reference Guide

Topic	Description	Medicaid, HMO-DSNP, or Both
Claims Form Types	CMS 1500 or UB-04 (also known as CMS 1450)	Both
Clean Claim	A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or a third party.	Both
BH Medicaid Claims Processing Timeframes	- Electronically Submitted – within 15 calendar days of receipt - Manually Submitted – within 30 calendar days of receipt - All claims – with 45 days of receipt	Both
Corrected Claims	Corrected claims must be submitted within 365 days from the date of service. Paper claims, clearly write “resubmission or corrected claim” to avoid duplicate. Electronic Claim, use Code 7 for corrected claim. Code 8 for void/cancel or prior claim.	Both
Timely Filing	Claims must be submitted within 180 calendar days from the date of service.	Both
Common Claims Barriers	5010 Requirements (Rendering NPI and pay-to NPI; Both are required) - NDC Codes Missing or Incomplete for drugs - Lack of Prior Authorization	Both
Balanced Billing	Balance billing is strictly prohibited. You cannot bill members for any services that are covered by NJ Medicaid.	Both
Coordination of Benefits Non-Integrated Primary Plan	Members must submit the primary insurance EOB along with claim for the secondary ABHNJ benefits to apply.	Medicaid
Coordination of Benefits FIDE Primary Plan	Using the member’s ID number from the plan ID card, you’ll only need to submit one claim. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits. Medicare processing timeframes apply.	HMO-DSNP
Remittances	You’ll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There’s no need to resubmit a secondary claim to Aetna.	HMO-DNSP

Grievance, Appeals and Claim Dispute Submissions

In-network and out-of-network providers have the right to appeal our claims determinations within 60 calendar days of receipt of the claim denial.

Providers can submit via Availity provider portal, phone, fax or mail

For Appeals, Grievance and/or Claims dispute submission relevant to the MCOs, please refer to said MCOs Provider Manual.

For example, for Aetna:

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-medicaid/provider/pdf/aetna_provider_manual.pdf

Thank you!

Key contact information for MCOs



Email:
Kate Mignone at
Aetna
katelyn.mignone@aetna.com



Email:
Michael Czajkowski,
Contract Negotiator
Michael.Czajkowski@fideliscarenj.com



Email:
BHMedicaid_@horizonblue.com



Email:
NJNetworkmanagement@Optum.com
or call the Provider
Service Line 1-888-
362-3368



Email:
provider.relations.NJ@carelon.com or by
phone by calling the
National Provider
Services Line at 800-
397-1630

Next steps and key contact information

Next steps

- 1 Review DMAHS Enrollment Guidance as part of forthcoming provider readiness packet
- 2 Reach out to DMAHS or Gainwell if you have any enrollment questions
- 3 Enroll in NJ Medicaid / NJFamilyCare



Contact information

DMAHS for general enrollment questions



Dmahs.behavioralhealth@dhs.nj.gov



[Behavioral Health Integration
Stakeholder Information](#)

Gainwell for questions related to NJMMIS



609-584-6036



[njmmisproviderenrollment@gainwelltechnologies.com](#)

Q&A

Appendix – MCO-specific details

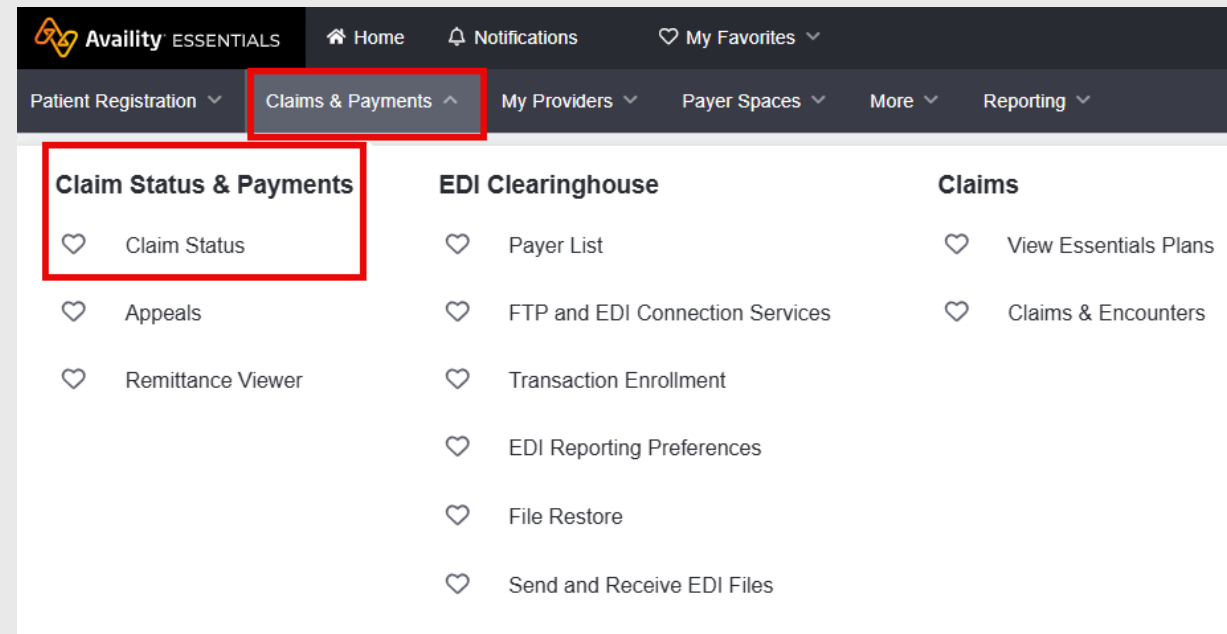
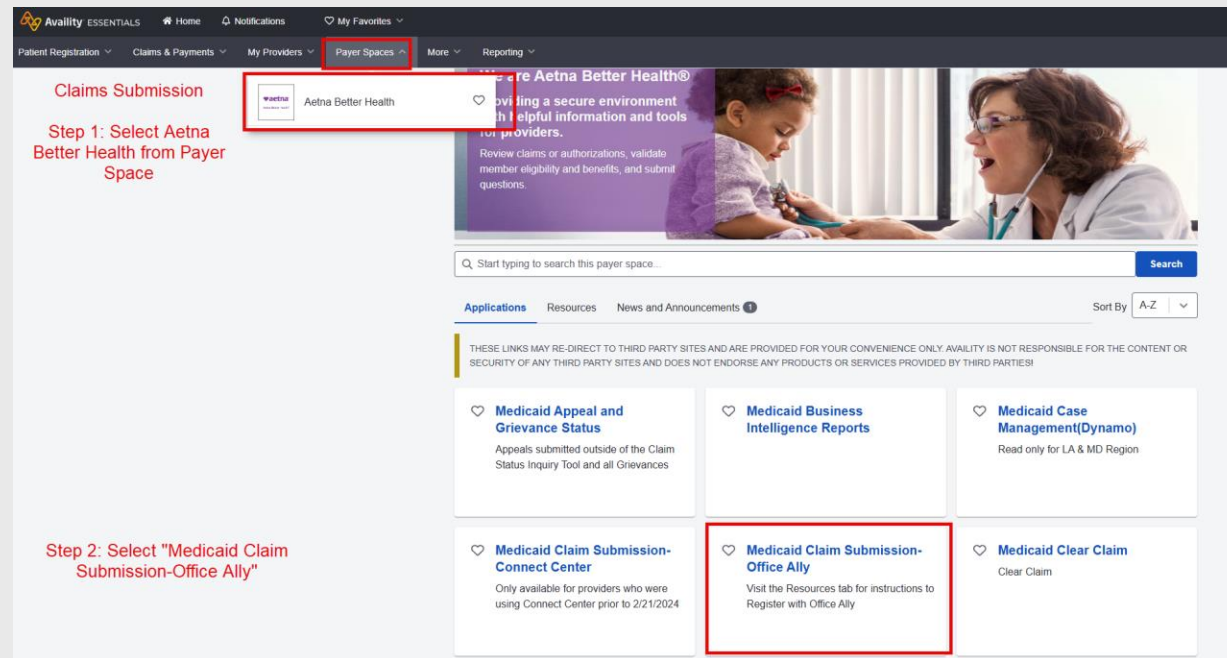


How to check claim status

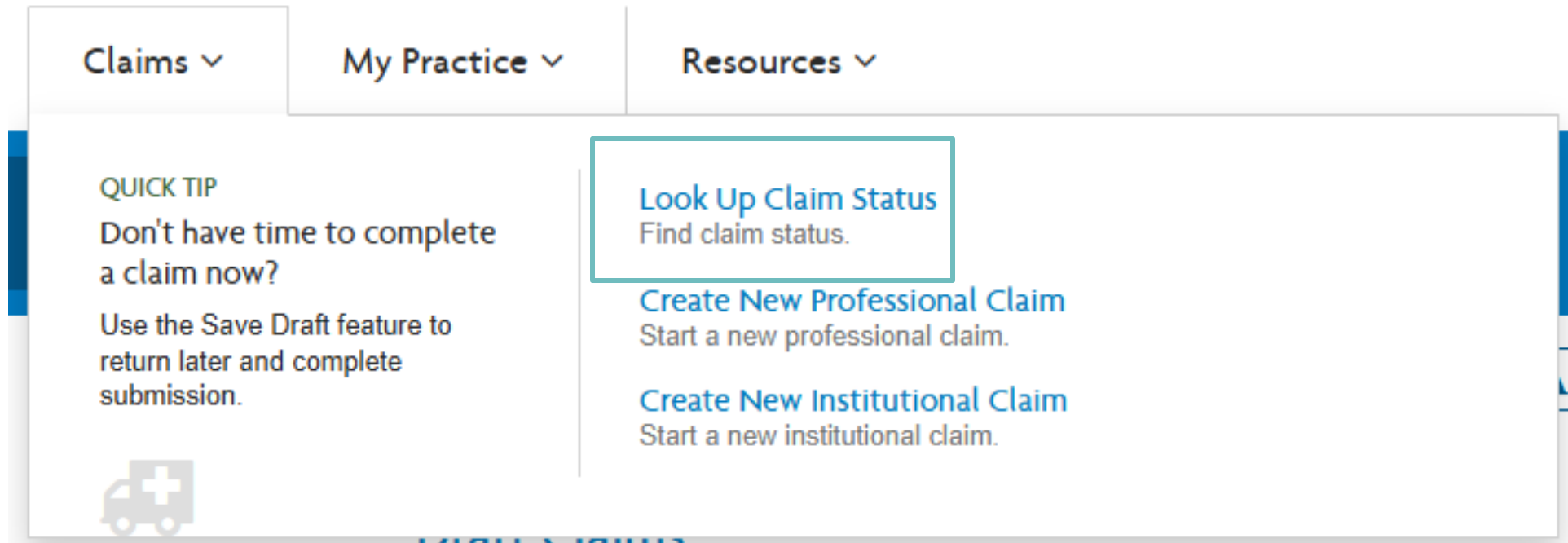
Aetna Provider Portal

Claims submission and status

[Link to Availity](#)



How to Check Claim Status on Fidelis Care Portal



How to Check View of Claim Status on Fidelis Care Portal

HomeMy PatientsCare Management ▾Claims ▾My Practice ▾Resources ▾

Claims

▾ A A ▴

If you are experiencing issues submitting claims on the portal, you may also submit claims electronically via electronic data interchange (EDI) or direct data entry (DDE).

EDI: Change Healthcare manages all EDI for WellCare/Fidelis Care. Please contact Change Healthcare directly at 1-877-411-7271, or your vendor may call 1-800-527-8133.

DDE: ConnectCenter for physicians offers a free DDE web service for WellCare/Fidelis Care.

Sign up at: <https://connect.relayhealth.com> using vendor code 212750.

You can access your Explanation of Payment (EOP)/Remit on the [Payspan website](#).

Draft Claims

Drafts that have not been submitted are shown below. Open draft claim to complete or cancel.

Member Id	Date Started	Delete
No drafted claims found		

◀ ◀ 0 ▶ ▶

3 ▾

No items to display

New Professional ClaimNew Institutional Claim

Search Submitted Claims

AppealsDisputes

Search Type

WCN Number ▾

Enter up to 10 values separated by commas

Service Date

Select ▾

Search

70

NEW JERSEY
HUMAN SERVICES

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...

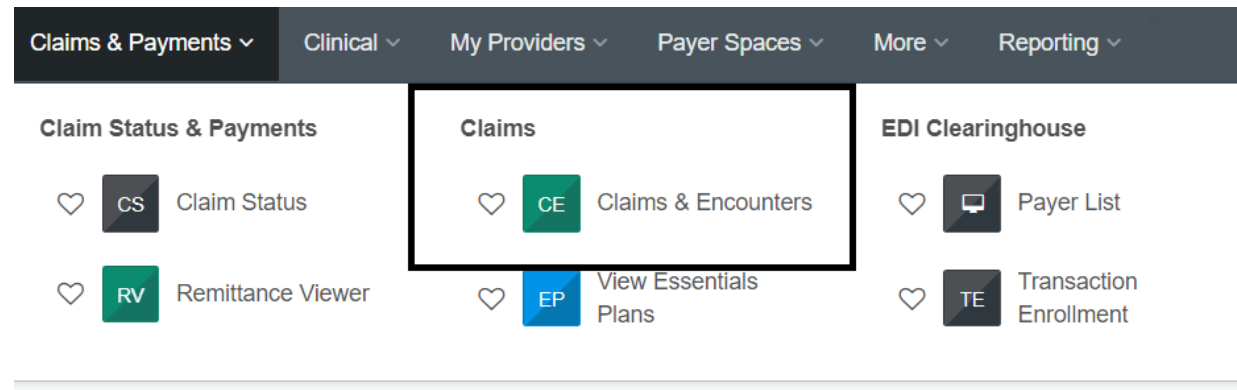
* Last Name	* First Name	Middle Name	Suffix
* Date of Birth	* Gender	* Relationship ?	
mm/dd/yyyy	Type to search...	Self	
* Address ?	Address 2 ?	Country ?	
		United States	

Submit claims using HNJB Portal

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

[Watch a demo](#) (requires registration)

Availity Demo



Availity Demo

Step 1

Plan and Patient Information

The user will fill out the insurance information as well as the type of claim they are filing (professional claims are the only claim option available). Next, they will fill out the patient information.

CE

Claims & Encounters

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

Give Feedback

INSURANCE COMPANY/BENEFIT PLAN INFORMATION

Organization

Claim Type

Payer

Responsibility Sequence [?](#)

Horizon BCBSNJ

Professional Claim

HORIZON NJ HEALTH

Primary

PATIENT INFORMATION

Select a Patient [✕](#)

Type to search...

* Last Name

* First Name

Middle Name

Suffix

* Date of Birth

* Gender

* Relationship [?](#)

mm/dd/yyyy

Type to search...

Self

* Address [?](#)

Address 2 [?](#)

Country [?](#)

United States

* City

* State

* Zip Code

Patient Amount Paid [?](#)

Type to search...

☐ Patient is deceased

Add Ancillary Claim/Treatment Information

Availity Demo

Step 2

Subscriber and Provider Information

Next, they will add the subscriber information and the provider information. They will be able to select the providers under their organization from the drop-down menu. They also have the option of adding rendering, supervising, referring providers as well as servicing facility. Please click “Add Rendering Provider” which is the dark gray box on the bottom right corner of this screenshot.

SUBSCRIBER INFORMATION

* Subscriber / Insured ID
Group Number
* Authorized Plan to Remit Payment to Provider?
Y - Yes
Add Secondary Insurance Plan

BILLING PROVIDER INFORMATION

Select a Provider
Type to search...

* Organization / Last Name
First Name
Middle Name

* NPI
* EIN
* SSN

Specialty Code
* Address
Address 2

Country
* City
* State
* Zip Code

☒ Pay-to address is the same as the billing address
Add Contact Information

Add Rendering Provider
Add Supervising Provider
Add Referring Provider
Add Service Facility Location Information

Availity Demo

Step 3

Claim Information and Diagnosis Codes

Additional claim information will be entered here. You can see fields for Patient Account Number, Place of Service, Assignment of Benefits, Diagnosis Codes and more.

CLAIM INFORMATION

* Patient Control Number / Claim Number ?	* Place of Service ?	* Frequency Type ?
	Type to search...	1 - Admit Through Discharge Claim (a)
* Provider Accepts Assignment ?	* Release of Information ?	* Provider Signature on File ?
A - Assigned	Y - Yes Provider has a Signed Statement Permitting Release of Medical Billing Da...	Yes
* Claim Filing Indicator	Prior Authorization Number	Medical Record Number
MC - Medicaid		
Care Plan Oversight Number	Clinical Laboratory Improvement Amendment Number	Spinal Manipulation Service Patient Condition Code
		Type to search...
Claim Note Reference Code		
Type to search...		

Availity Demo

Step 4

Line Detail Information

Here the provider will enter the service line information including procedure codes, dates of service, modifiers and charges. When all lines are completed, they can submit their claim.

LINES

1	* Service From Date ? mm/dd/yyyy Service To Date mm/dd/yyyy Place of Service ? Type to search... * ? Type to search... Procedure Code Procedure Description Modifier Emergency Indicator	* ? Type to search... Charge Amount * ? * ? UN - Unit Actions
2	* Service From Date ? mm/dd/yyyy Service To Date mm/dd/yyyy Place of Service ? Type to search... * ? Type to search... Procedure Code Procedure Description Modifier Emergency Indicator	* ? Type to search... Charge Amount * ? * ? UN - Unit Actions

+ Add a Line

Total: \$0.00

Clear Form

Continue

Availity Demo

Results

The user will receive confirmation that their claim was submitted successfully.

PC

Professional Claim

Give Feedback

Your claim has been sent to [REDACTED] which processes claims in batches. You will receive the responses for this claim in your Receives Files  mailbox.

Claim Number:	132
Submission Type:	Professional Claim
Submission Date:	09/18/2019
Date(s) of Service:	09/18/2019
Patient Name:	[REDACTED]
Subscriber ID:	[REDACTED]
Billing Provider Name:	[REDACTED]
Billing Provider NPI:	1234567893
Billing Provider Tax ID:	111222333
Total Charges:	\$100.00

Back to Request

Claims Disputes/Appeals

Guidelines to submit a claim dispute for Medicaid: <https://www.horizonnjhealth.com/for-providers/news/updates-and-announcements/updated-additional-guidance-for-submitting-hnjh-and>

Claims appeals must be received by Horizon NJ Health within 90 calendar days following receipt by the physician, facility or health care professional of the payer's claim determination

To submit a claim appeal to dispute the amount you have been reimbursed by Horizon NJ Health, send a HCAPPA form which is available at [horizonNJhealth.com/for-providers](https://www.horizonnjhealth.com/for-providers) and any supporting documentation to us using one of the following methods:

Horizon NJ Health
Claims Appeals
PO Box 63000
Newark, NJ 07101-8064
or
Fax: 1-973-522-4678

Claims Inquiries and Resources

Provider Manual – https://www.horizonnjhealth.com/securecms-documents/605/Provider_Manual.pdf

see Section 9, Billing Guide - for helpful information on HNJH claims submission

See section 9.1.5 for corrected claim information

Reference the claim number of the most recently adjudicated claim

For claims status inquiries, call 800-682-9091

To register or sign into Availity: https://essentials.availity.com/static/public/onb/onboarding-ui-apps/availity-fr-ui/#/login?auth_id=434d6559-f5be-4348-b6f0-7dcf70f9ce8d

To register for EDI – <https://www.horizonnjhealth.com/for-providers/resources/edi-eft-transactions/electronic-data-interchange-edi>

Contact EDI Technical Support to notify them of your intention to begin EDI transmissions

Electronic Funds Transfer (EFT) - Register and view details on EFT at the following link:

<https://www.horizonnjhealth.com/for-providers/resources/edi-eft-transactions/electronic-funds-transfer-eft>

Paper claims – If paper claims are necessary, submit original red and white paper claims only to the address below. All claims must be typed; handwritten claims are not accepted

**Horizon NJ Health, Claims Processing Department
PO BOX 24078, Newark, NJ 07101-0406**

Checking Claim Status on Provider Express Portal



Check the status of your claim on Provider Express

Step 1: Log in to Provider Express with your One Healthcare ID



Step 2: Enter Claim information for search

A screenshot of the 'Claim Inquiry' page in the Provider Express system. The page has a header with the 'Optum' logo and 'Provider Express' text. Below the header, there are tabs for 'Claim Entry', 'Claim Inquiry', 'My Submitted Claims', and 'My Submitted Adjustments'. The 'Claim Inquiry' tab is selected. The page contains a 'Select Provider' dropdown menu, a 'My Patients' section with a search bar, and a table of patient records. The table has columns for 'First Name', 'Last Name', 'Member ID', 'Date of Birth', and 'State'. There are five rows of patient data, each with a checkbox in the first column. Below the table, there is a 'Dates of Service' section with radio button options: 'Month / Year', 'Date Range', 'Previous 12 Months', and 'Previous 24 Months'. A 'Search' button is located at the bottom of the page.

How to Enroll for Optum Pay

Optum Pay™ is an electronic payments and statements (EPS) solution that integrates electronic funds transfer (EFT) and electronic remittance advice (ERA) with a unique payment number for faster, easier reconciliation. It is a free and practical service which allows you to receive your claim payments and remittance advices electronically instead of through the mail. Your claim payments will be deposited directly into your designated bank account, and you can access all your payment and remittance advice information via Provider Express - saving you time and money!

- 1 Visit optum.com/enroll and select “Enroll Now.” Then select “I am enrolling as a health care organization.”

First, tell us how you would classify your enrollment.

☐ I am enrolling as a Healthcare Organization. ←

☐ I am enrolling my 3rd Party Billing Service Company

Which option should I choose?

- 2 Select “I would like to enroll in direct deposit (ACH) only.”

☒ I am enrolling as a Healthcare Organization. [Change](#)

Great! Next, how would you like to receive your payments?

☒ I would like to enroll in direct deposit (ACH) only. ←

- 3 Enter your TIN (Tax Identification Number) or EIN (Employer Identification Number) and complete the CAPTCHA image field.

☒ I am enrolling as a Healthcare Organization. [Change](#)

☐ I would like to enroll in direct deposit (ACH) only. [Change](#)

Please enter your 9 digit Organizational Tax Identification (TIN):

Enter TIN or EIN

Congratulations, your TIN is eligible for enrollment!

Please be advised that in order to complete the online enrollment process, you will need to provide the following:

- ✓ Organization name, mailing information, and National Provider Identifier (NPI)
- ✓ Contact information, including the name, telephone number, and e-mail address for two members of your organization who will serve as administrators for your account.
 - Administrators are able to control user access to the account and add/update bank account info.
 - The primary contact should be an individual responsible for daily and routine matters.
 - The secondary contact should be a director of Accounting, Human Resources or the Finance Department.
- ✓ Banking information (if setting up ACH direct deposit)



How to file for claim disputes

How to file claim disputes (website, phone, mail fax, forms, etc.) with Fidelis Care

Claim payment disputes must include appropriate supporting documentation and may be submitted through the [Fidelis Care New Jersey Provider Portal](#).

Disputes may also be mailed to:

Fidelis Care

Attn: Claim Payment Disputes

P.O. Box 31370

Tampa, FL 33631-3370

The Fidelis Care Quick Reference Guide states that claim payment disputes must be submitted in writing within **90 calendar days of the date on the Explanation of Payment**.

Claims Submissions and Resubmissions

Please ensure **Payer ID# 46320** is listed on the claim.

Providers can submit claims in three ways:

Your Provider Claim Clearinghouse

- *Providers should verify their clearinghouse is compatible with ECHO using 837 file format.*

Availity

- To submit claims online via Availity, Select Payer Spaces, “Medicaid Claim Submission – Office Ally.” This link will take you directly to the Office Ally website where you can submit claims using their online claim entry feature or by uploading a claim file free of charge.

Paper Claims

- Mail to: P.O. Box 982967, El Paso, TX 79998-2967

Resubmissions

Corrected claims must be submitted within 365 days from the date of service. Paper claims, clearly write “resubmission or corrected claim” to avoid duplicate. Electronic Claim, use Code 7 for corrected claim. Code 8 for void/cancel or prior claim.



How to register for MCO Electronic Funds Transfer (EFT)

How to register for Fidelis Care's Electronic Funds Transfer (EFT)

Providers may register for Electronic Funds Transfer through PaySpan using the simplified provider registration process:

- Register online at [PaySpan Health](#)
- Call **1-877-331-7154** for assistance

The Fidelis Care training materials identify PaySpan as the vendor for electronic remittances and provide these registration contacts.



How to fill out claims submission forms – MCO specific details

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

Three sections on CMS 1500 form for NPI numbers

24J

32a

33a

PHYSICIAN OR SUPPLIER INFORMATION

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

NPIs must match MCO billing requirements

Three sections to enter NPI:

- 24J – Rendering provider
- 32a – NPI of licensed agency
- 33a – NPI of billing provider

If billing under a group:

- Licensed Agency NPI 24J
- Licensed Agency NPI 32a
- Licensed Agency NPI 33a

If billing individually:

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

*Box 31 include signature when rendering provider listed

Facility billing on UB04

UnitedHealthcare | Make sure NPI numbers match guidance from MCO - CMS 1450

Three sections on CMS 1450 ("UB-04") form for NPI numbers

The image shows a sample of the CMS 1450 (UB-04) form. Three sections are highlighted with orange boxes and labeled with numbers 56, 76, and 77:

- 56**: Billing provider NPI (Field 56 NPI)
- 76**: Attending provider NPI (Field 76 ATTENDING NPI)
- 77**: Operating provider NPI (Field 77 OPERATING NPI)

The form includes various other fields such as PAYER NAME, HEALTH PLAN ID, INSURED'S NAME, TREATMENT AUTHORIZATION CODES, and REMARKS. The bottom of the form contains the NUBC logo and the text "THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF."

NPIs must match MCO billing requirements

Three sections to enter NPI:

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

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

Billing as a facility:

- Facility NPI 56
- Attending provider 76
- Operating provider 77 if applicable



MCO resource and contact lists

Horizon | Resource and contact list

MCO contact for questions regarding claims:

- Phone: 888-362-3368

Preferred EDI gateway and contact for questions

- Availity Team
 - Phone: 800.282.4548, Monday-Friday 8:00am – 8:00pm
 - Chat function on Availity Webpage at www.Availity.com
- Register for EDI – <https://www.horizonnjhealth.com/providers/resources/edi-eft-transactions/electronic-data-interchange-edi>

MCO support desk phone / email contacts:

- Horizon BCBSNJ E-Services Support Desk:
 - 1-888-777-5075
 - HorizonEDI@horizonblue.com
- Horizon NJ Health EDI Technical Support — contact them to notify your intention to begin EDI transmissions at:
 - Phone: 1-888-334-9242
 - Operation Hours: Monday – Friday 8am-5pm EST
 - E-Mail: HorizonNJHealth_EDI@HorizonBlue.com

United Health Care | Resource and contact list

MCO contact for questions regarding claims:

- Phone: 888-362-3368

Preferred EDI gateway and contact for questions

- United is compatible with any EDI system
- EDI Support Desk:
 - Phone: 800-842-1109

MCO support desk phone / email contacts:

- United Provider Express Website / Portal Tech Support:
 - Phone: 1-866-209-9320
 - Operating hours: 7AM – 7PM CT, Monday - Friday
- United NJ Provider Relations
 - E-Mail: njnetworkmanagement@optum.com

