NEW JERSEY HUMAN SERVICES

Provider Claims Refresher Training

NJ FamilyCare Behavioral Health Integration

FEBRUARY 25, 2025

Housekeeping

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

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)

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

Materials and recording will be published and available on DMAHS website

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

This is a refresher from 10/24/2024 claims training; Materials/recoding from previous training be found on [DMAHS stakeholder website]

Agenda

Welcome and Phase 1 Implementation Updates Shanique McGowan, BH Program Manager, DMAHS	10:30–10:40
Overview of Claims Processes Geralyn Molinari, Director, Managed Provider Relations, DMAHS Steven Tunney, Director of Behavioral Health, DMAHS	10:40–10:55
MCO Round Robin Aetna, Fidelis Care, Horizon, UHC, Wellpoint	10:55–11:55
Next Steps Shanique McGowan, BH Program Manager, DMAHS	11:55–12:00
Q&A – Breakouts Shanique McGowan, BH Program Manager, DMAHS Aetna, Fidelis, Horizon, UHC, Wellpoint	12:00–12:30

NEW JERSEY HUMAN SERVICES

Recall | Many BH services are now billed through managed care

Services covered by managed care (MCOs)[1]

All Phase 1 Behavioral Health services

- 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
  - Ambulatory withdrawal management
  - Peers support services
  - SUD care management
- SUD partial care

Mental Health Partial care transportation and mileage

Services covered by fee-for-service (FFS)

- Any services provided to members who have presumptive eligibility or do not have an active MCO in the system
- Phase 2 services (e.g., residential, OTP) or Phase 3 Behavioral Health services

Note: Mental health IOP is not currently a NJ Medicaid covered service

1. Managed care also covers inpatient BH services; outpatient and residential BH services already covered by managed care for members enrolled in MLTSS / DDD / FIDE-SNP programs

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Since Phase 1 go-live, DMAHS and MCOs have been working to address claims issues

Issue	DMAHS / MCO response	This training will help you…
Erroneous denials and delays in claims processing, particularly for out-of-network providers and partial care transportation	MCO claims reprocessing and provider outreach is underway; DMAHS is clarifying process/codes for transportation	**Identify MCO and State contact information** for providers to outreach when experiencing claims denials
Providers receiving incorrect rate payments or rates below the fee-for-service (FFS) floor	DMAHS is currently working with MCOs to ensure use of accurate FFS rate schedule and reprocess claims paid below the floor	**Identify reference document for FFS rates** and **provide Office of Managed Care contact information and outreach guidance** that providers should follow when receiving incorrect rates
Provider submission errors (e.g., incorrect NPIs, erroneous patient details, invalid codes)	DMAHS is continuing to hold provider readiness trainings and post resources that offer clear guidance around claims submission processes	**Understand coding and claim form requirements** to ensure accurate billing and reimbursement

Update on Phase 1 Transition period

Considering these issues to date, to reduce provider burden and ensure continuity of care for members, **we are mandating that all MCOs extend the following transition-period policies for an additional 90 days, through June 30, 2025:**

- Payment of valid claims at the FFS floor to all out-of-network providers
- Auto-approval of all prior authorizations for all Phase 1 BH services

In addition to extending these policies, we will be continuing to work with MCOs to improve processes so that together we can better support you and ultimately better serve members

In addition to transition period polices, several additional policies for rates and claims introduced to improve provider experience for BH Integration

Deadlines	Shortened BH claims processing times	• Processing timelines must be aligned with the **following standards (similar to MLTSS)** - 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
Rates	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
Education	Mandated claims to be covered in MCO BH provider trainings	• Claims must be covered by MCOs in provider trainings - Can be covered in standalone training or as part of broader BH integration provider training
	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*

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

Member's Coverage

- Check member's insurance coverage
  - Commercial
  - Medicare
  - Medicaid
- Medicaid is the payer of last resort

Detail on next slide

Prior Authorization

- Prior Authorization Refresher Training on Mar 12 – *register here*
- PA guidance in Provider Readiness Packet

Service Delivery

- Your domain of expertise

Claims Process

- Focus of today

Detail in rest of presentation

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 BH services[1]

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
Note: Refer to DMAHS Coordination of Benefits Guidance for additional detail

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Medicaid claims process: Seven steps for providers

Billing codes	Form Selection	Required Fields	Claim Submission	Adjudication & processing	Denials & Appeals	Reimbursement
• What are the billing codes for the service delivered? • Are there other coding requirements? (i.e., modifiers, authorization number)	• Which form do I use? (e.g., CMS1500, UB-04)	• What fields are required to complete my claim? (i.e., "clean claim")	• How do I submit my claim? • Can I submit my claim manually (i.e., not electronic)?	• How can I track the progress of my claim? • What is the expected processing time?	• Why might my claim be denied? • What can I do if my claim is denied?	• How much will I be reimbursed? • How and when will I receive payment?

Medicaid coding requirements and forms for accurate billing

General coding requirements (i.e., same as FFS)

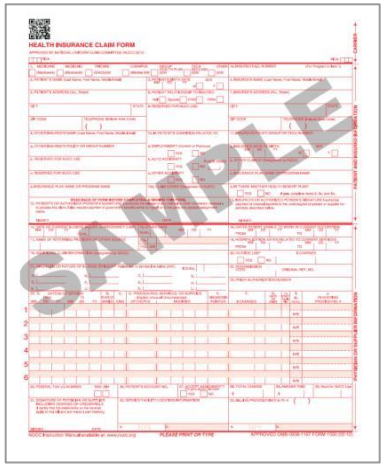
Diagnosis codes *Why is service is needed?*	ICD-10-CM codes for primary diagnosis
Procedure codes *What services were performed?*	CPT or HCPCS codes for procedures and services ICD-10-PCS for inpatient hospital procedures
Revenue codes *Where the services were provided?*	Rev codes for hospitals and facilities 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

Providers must also follow MCO-specific coding requirements (detail to come in MCO round robin)

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

CMS 1500 / 837P[1]

For independent medical professionals



Link to form

CMS 1450 ("UB-04") / 837I[2]

For hospitals and facilities

Link to form

Medicaid follows **National Correct Coding Initiative** (**NCCI**) **edits** to prevent improper coding and overbilling

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 eligible[1]
   - 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

MCO Round Robin

12 mins x 5 MCOs

- Introduce claims team
- Overview of MCO specific processes
- Quick demo of claims platform / portal
- Share training information / additional resources

NEW JERSEY HUMAN SERVICES

Aetna Better Health of NJ (ABHNJ)

Presenter

Liarra Sanchez

Manager of BH Network Relations

Aetna | Meet our claims & billing team

Christopher Toland
Senior Claims Manager,
Service Operations

- Management of claims operations and team
- Claims inventory management
- Claims quality oversight

Tish Brown
Claims Supervisor,
Service Operations

- Claims inventory management
- Oversight of claims processing procedures

Aetna | Our claims process

Required fields

- Information detailed on upcoming slide
- If a prior authorization is required, please request one:
  - Via Availity
  - Call 855-232-3596

Claims submission

- Providers can submit claims electronically or via mail
  - Electronic submission via Availity Provider Portal
  - By mail: P.O. Box 982967 El Paso, TX 79998
- Include Payor ID **46320**

Adjudication & processing

- Accepted claims are auto-adjudicated in Aetna's system
  - Claims that fail adjudication, are manually reviewed
  - Claim is moved from pay/deny status

Payment & Remittance

- Fully processed claim is finalized, remit is created, and payment is sent to the provider.
- ABHNJ has 3 check runs a week (Monday, Wed, and Friday)
- To check the status of a claim, review in the Availity provider portal, or call Provider Services at (855) 232-3596

Denials & Appeals

- If a claim denies, providers have **60 calendar days** from the remittance notice to appeal the decision
- Providers can submit an appeal by:
  - Availity Provider Portal
  - Phone – (855) 232-3596
  - Fax – (844) 321-9566
  - Mail – PO Box 81040, 5801 Postal Road, Cleveland, OH 44181
  - Email – NJAppealsandGrievances@AETNA.com

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Aetna | Common provider errors leading to denials

#	Error	How to avoid
A	Duplicate Claim Submission	• **Double-check** patient demographics, dates of service and codes to minimize errors • Regularly check status of submitted claims to avoid resubmitting claims that are already being processed
B	Incomplete claim submission	• Use a **checklist** to ensure all required fields are completed • Implement **Electronic Health Record (EHR)** system that flags incomplete sections
C	Incorrect diagnosis or procedure codes	• **Double-check coding** before submission. • Use **coding software** or **cross-referencing tools** that align diagnosis with procedure codes
D	Insurance coverage	• **Always verify** member eligibility. • **Ensure the primary insurer is billed first** prior to billing Aetna Better Health, if applicable
E	Prior Authorization	• If prior authorization is required, **ensure the number is included on the claim submission** • **Ensure you obtain an authorization** if it is required

Aetna | Billing requirements

Individuals / Group / Agency

Fully licensed practitioners can **bill independently** or **under group** on **CMS-1500**
Include the Type 1 NPI of the fully licensed practitioner as "rendering provider"

Billing Independently

- B Type 1 NPI / SSN
- R Type 1 NPI

Billing under Group

- B Type 2 NPI / EIN
- R Type 1 NPI

Mary
Fully licensed[1]
e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

- B Type 2 NPI / EIN
- R Type 1 NPI of supervisor or Type 2 NPI

James
Licensed under supervision[2]
e.g., LSW, LAC, LAMFTs and LADCs

- B Type 2 NPI / EIN
- R Type 1 NPI of OBAT prescriber / supervisor

Alex
OBAT navigator or Peer

- B Type 2 NPI / EIN
- R Type 1 NPI of supervisor or Type 2 NPI

Sarah
Not licensed
e.g., Interns or individuals holding a Masters of Counselling

Licensed Facility (Hospitals & Institutional Providers)

Facilities should submit claims using **UB-04** with the **facility (Type 2) NPI** as the billing and rendering provider

Mary
Fully licensed[1]
e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

- B Type 2 NPI / EIN
- R Type 2 NPI[3]

James
Licensed under supervision[2]
e.g., LSW, LAC, LAMFTs and LADCs

- B Type 2 NPI / EIN
- R Type 2 NPI

Alex
OBAT navigator or Peer

- B Type 2 NPI / EIN
- R Type 1 NPI of OBAT prescriber / supervisor

Sarah
Not licensed
e.g., Interns or individuals holding a Masters of Counselling

- B Type 2 NPI / EIN
- R Type 2 NPI

1. For BH this includes Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LCADC), or Advanced Practicing Nurse (APN); 2. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), Licensed Associate Marriage and Family Therapists (LAMFT) and Licensed Alcohol and Drug Counselor (LADC); 3. Some facility contracts allow for Type 1 NPI providers to bill as rendering on facility claims. Check your specific contract

B Billing provider
R Rendering provider

Aetna | Billing Required Fields

Individuals / Group

CMS-1500 Required Fields

- Type of Health Insurance (Item 1);
- Subscriber's/patient's plan ID # (Item 1a);
- Patient's name (Item 2);
- Patient's date of birth and sex (Item 3);
- Subscriber's name (Item 4);
- Patient's address (street or P.O. Box, city, ZIP code) (Item 5);
- Patient's relationship to subscriber (Item 6);
- Whether patient's condition is related to employment, auto accident, or other accident (Item 10);
- Subscriber's policy number (Item 11);
- Subscriber's birth date and sex (Item 11a);
- Insurance Plan name (Item 11c);
- Disclosure of any other health benefit plans (Item 11d);
- Patient's or authorized person's signature or notation that the signature is on file with the physician or provider (Item 12);
- Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (Item 13);
- Date of current illness, injury, or pregnancy (Item 14);
- Other Date (Item 15);
- Name of referring provider or other source (Item 17);
- Referring provider NPI number (Item 17b);
- Diagnosis codes or nature of illness or injury (Item 21);
- Treatment Authorization Number (Item 23);
- Date(s) of service (Item 24A);
- Place of service codes (Item 24B);
- EMG – emergency indicator (Item 24C);
- Procedure/modifier code (Item 24D);
- DX Pointer – diagnosis code (Item 24E);
- Charge for each listed service (Item 24F);
- Number of days or units (Item 24G);
- Rendering provider NPI (Item 24J);
- Physician's or provider's federal taxpayer ID number (Item 25);
- Total charge (Item 28);
- Signature of physician or provider that rendered service, including indication of professional license (Item 31);
- Name and address of facility where services rendered (Item 32);
- The service facility NPI (Item 32a);
- Physician's or provider's billing name and address (Item 33);
- Main or billing Type 1 NPI number (Item 33a).

Licensed Facility / Agency

C

CMS-1450 (UB-04) Required Fields

- Rendering Provider's name, address and telephone number (Item 1);
- Pay-to Provider's name, address and telephone number (Item 2);
- Patient control number (Item 3a);
- Type of bill code (Item 4);
- Provider's federal tax ID number (Item 5);
- Statement period (beginning and ending date of claim period) (Item 6);
- Patient's name (Item 8b);
- Patient's address (Item 9);
- Patient's date of birth (Item 10);
- Patient's sex (Item 11);
- Date of admission (Item 12);
- Admission hour (Item 13);
- Type of admission (Item 14)
- Source of admission code (Item 15);
- Discharge hour - (Inpatient Only) (Item 16);
- Patient-status-at-discharge code (Item 17);
- Revenue code (Item 42);
- Revenue/service description (Item 43);
- HCPCS/Rates (current CPT or HCPCS codes are required) (Item 44);
- Service date (Item 45)
- Units of service (Item 46);
- Total charge (Item 47);
- Payer Identification Name (Item 50);
- Main NPI number (Item 56);
- Subscriber's name (Item 58);
- Patient's relationship to subscriber (Item 59);
- Insured's unique ID (Item 60);
- Treatment Authorization Code (Item 63);
- Diagnosis qualifier (Item 66);
- Principal diagnosis code (Item 67);
- Admit diagnosis (Item 69);
- Provider name and identifiers (Item 76-79).

B Billing provider

R Rendering provider

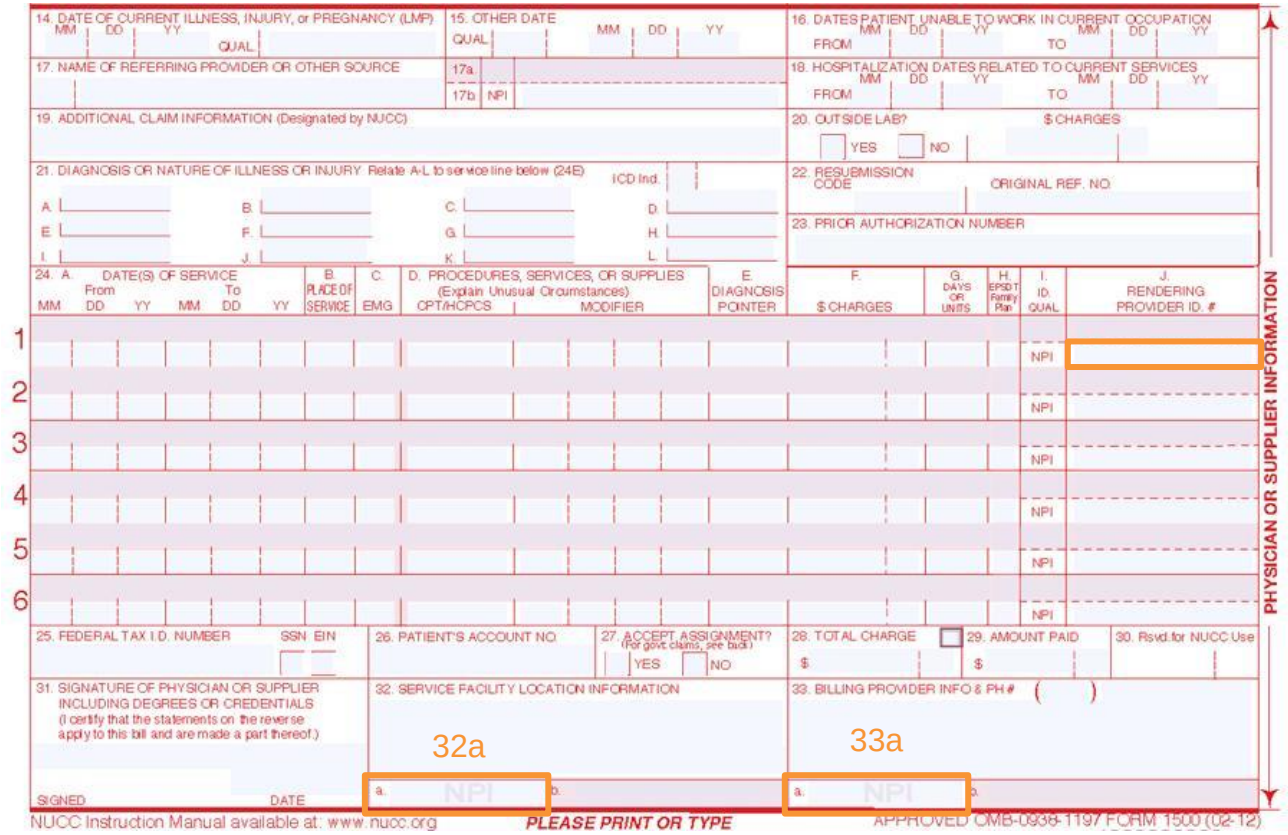
C Organization credentialed

C Individually credentialed

R Listed on roster

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

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

Three sections to enter NPI:

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

If billing as an individual:

- *Type 1 NPI in 24J, 32a, 33a*

If billing under a group:

- *Type 1 NPI of practitioner in 24J*
- *Type 2 NPI in 32a, 33a*

If billing as a clinic/agency:

- *Type 2 NPI of clinic/agency in 24J, 32a, 33a*

Note: The NPI in Box 24J should match the NPI in Box 31

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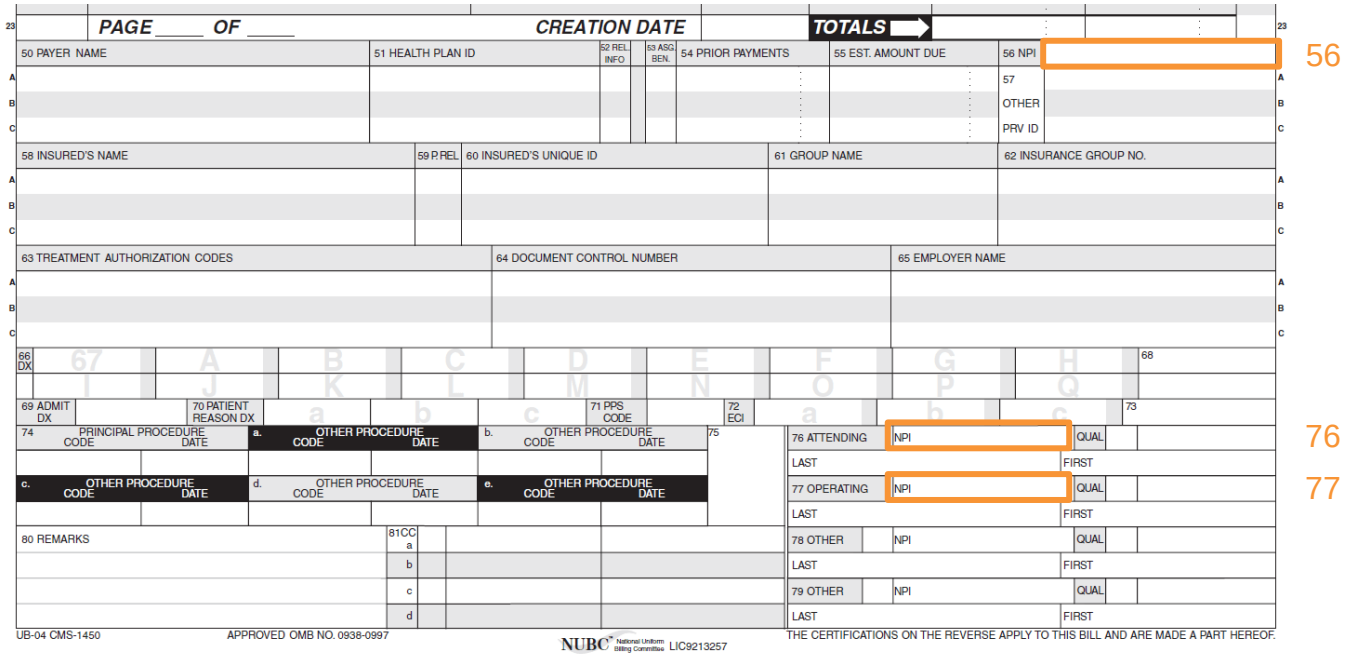
Aetna | Make sure NPI numbers match guidance from MCO - CMS 1450

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



56

76

77

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 fields:

- Field 56: *Billing Provider's Type 2 NPI*
- Field 76: *Provider/Agency NPI that delivered the service (required if applicable, i.e.: OBAT)*
- Field 77: *Not required*

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Aetna | Additional key MCO-specific guidelines and updates

Interim guidelines for partial care transportation:

- *There is no interim process change for ABHNJ*
- *Providers should follow the standard claims submissions process reviewed on previous slides. The following codes are configured and can be utilized:*
  - *A0090*
  - *A0425*
  - *A0120*

Process for telehealth billing:

- *Providers should follow the standard claims submissions process reviewed on previous slides but use place of service 02 (POS 02) along with the "95" modifier which indicates telehealth services are being rendered.*

Out of network billing guidelines for Phase 1 transition period:

- *Providers should follow the standard claims submission process reviewed on previous slides.*
- *Out of network providers will require an authorization for all services rendered after the 180-day transition.*

Timeline for reprocessing claims:

- *Approximately two weeks.*

EFT:

- *Echo "Single Payor" is Aetna's free EFT system.*

Aetna | Upcoming trainings and resources

Upcoming trainings

When	Training Topic	Target audience	Link
March 26 12:00 pm	**BH Integration Training** Integration Overview for BH providers new to ABHNJ	BH Providers	Register

Additional resources

For further information on submitting claims with us, please contact:

Liarra Sanchez
Manager, Network Relations
609-455-8997
SanchezL7@Aetna.com

Links:

- Access Availity Claims Portal Here
- ABHNJ Provider Manual
- MCO Quick Reference Guide
- New Provider Orientation
- ABHNJ Provider Website

FIDELIS CARE®

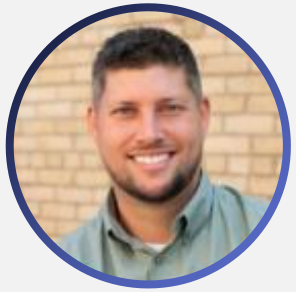
Presenter

Stacy Felder

Operations Analyst

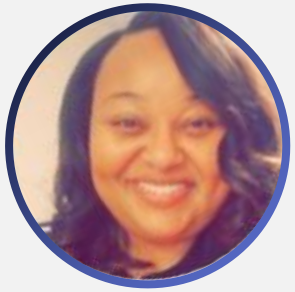
NEW JERSEY HUMAN SERVICES

Fidelis Care | Meet our claims & billing team



Christopher Anderson
Director, Business Operations

- Claims and Business Operations Oversight



Keyana Brown
Director, Business Operations

- Market Business Operations Oversight

Diana Crews
Director, Claims Operations

- Claims Processing Oversight

Fidelis Care | Our claims process

Required fields

Proper identifiers:

- Member Info
  - Name, DOB, address, Fidelis Care ID #
- Provider Info
  - Name, TIN, NPI
  - Member DOS (Date of Service)
  - Rendering Provider
  - Billing Provider
  - Place of Service
  - ICD-10 Diagnosis Codes

Claims submission

- Claims can be submitted electronically through provider's own clearing house or for PAR Providers on the Fidelis Care portal.
- Include Payer ID 14163
- Questions with claims submissions can be directed to **EDIBA@centene.com**

Adjudication & processing

Systems will double check all identifiers:

- Provider Information
- Member Information
- Member Benefits
- Bill type
- Service Type
  - Service Billed
  - Date of service
  - Diagnosis Codes
  - CPT/Rev code billed
  - Quantity Billed
- Adjudication can take up to 15 days

Payment & Remittance

- Posting time can take up to 10 days after adjudication has been finalized.
- Remittances are available from our vendor Payspan once claims have finalized/post. You can register online at payspanhealth.com or call 1-877-331-7154.
- Paper Checks are sent out within 2 business days after posting; EFT is usually available within 24 hours.

Denials & Appeals

Disputes for payment policy related issues must be submitted to Fidelis Care in writing within **90 days** of the date of denial on the EOP; or via the Fidelis Care portal for PAR Providers.

Information on disputes and appeals can be found on p.6 of the Quick Reference Guide, found on the plan website.

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Fidelis Care | Common provider errors leading to denials

#	Error	How to avoid
A	Denials for Ambulance mileage claims	• Ambulance claims must be billed with the base code Z0330, along with the mileage code A0425 UC. The mileage code cannot be billed on its own.
B	Incomplete claim submission	• Use a **checklist** to ensure all required fields are completed • Implement **Electronic Health Record (EHR)** system that flags incomplete sections
C	Incorrect diagnosis or procedure codes	• **Double-check coding** before submission. • Use **coding software** or **cross-referencing tools** that align diagnosis with procedure codes
D	Duplicate Services Billed	• If a correction on a claim is needing to be submitted, use submission code 7 in box 22 of the CMS 1500. If you feel a denial is in error, reach out to the Provider Service line at 1-888-453-2534 or contact your provider rep.
E	Medicare EOB Denial	• If member has Medicare as primary and the code is covered by Medicare, this must be submitted to Medicare and the EOB must be submitted to Fidelis Care when submitting the claim. *(If billing A0425 by itself, this can result in a Medicare EOB denial if not billed with the Z0330 base code.)*
F	Modifier is Not Typical for Procedure	• This can occur on the mileage claims if not billing with the base code Z0330 on the CMS 1500 form with the mileage code.

Fidelis Care | Billing requirements

Individuals / Group

Independently
(Use NPI credentialed with)

Can be Type 1 NPI OR Type 2 NPI/EIN (whichever NPI provider credentialed with Fidelis Care)

Mary
Fully licensed[1]
e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

Under Group

- B — Type 2 NPI/EIN
- R — Type 1 NPI

James
Licensed under supervision[2]
e.g., LSW, LAC, LAMFTs and LADCs

Alex
OBAT navigator or Peer

Sarah
Not licensed
e.g., Interns or individuals holding a Masters of Counselling

- Can credential as individual practitioner or a group practice
- All fully licensed practitioners required to individually credentialed whether practicing independently or in a group (Medicaid ID#'s are required to credential with the Plan)
- Do not require credentialing or rostering of individuals licensed to practice under supervision, however any individual without an NPI cannot bill.
- Only group and fully licensed practitioners shown in network directory

Licensed Facility / Agency

C

Mary
Fully licensed[1]
e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

- B — Type 2 NPI/EIN
- R — Type 1 NPI

James
Licensed under supervision[2]
e.g., LSW, LAC, LAMFTs and LADCs

Alex
OBAT navigator or Peer

Sarah
Not licensed
e.g., Interns or individuals holding a Masters of Counselling

- Credential at facility/agency level by location using ancillary application per NPI
- Facility/agency must hold state license
- If the facility has multiple licenses and/or locations these must be included in the credentialing, all required information should be on the "Facility Roster" Spreadsheet. (Your Provider Rep can assist with this)
- Only fully credentialed facility/agency shown in network directory

1. For BH this includes Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LCADC), or Advanced Practicing Nurse (APN); 2. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), Licensed Associate Marriage and Family Therapists (LAMFT) and Licensed Alcohol and Drug Counselor (LADC)

B Billing provider
R Rendering provider
C Organization credentialed
C Individually credentialed
R Listed on roster

Fidelis Care | Billing requirements – Notes

Individuals / Group

Notes

- Box 31 is for Rendering Provider's signature: Last Name, First Name
- Box 32 Address MUST be physical address where services were rendered.
  - Address can NEVER be a POC Box
  - Address is required when different from the Bill To Address in box 33
  - Address is not required if the place of service is 12 or 15 (Home or Mobile Unit)
- Box 33 is Bill to Provider: requires mailing address (where provider wants the payments to go)
- Box 33a requires NPI of the Bill to Provider
- Box 33b is for Taxonomy code preceded with "ZZ" qualifier of the Bill to Provider

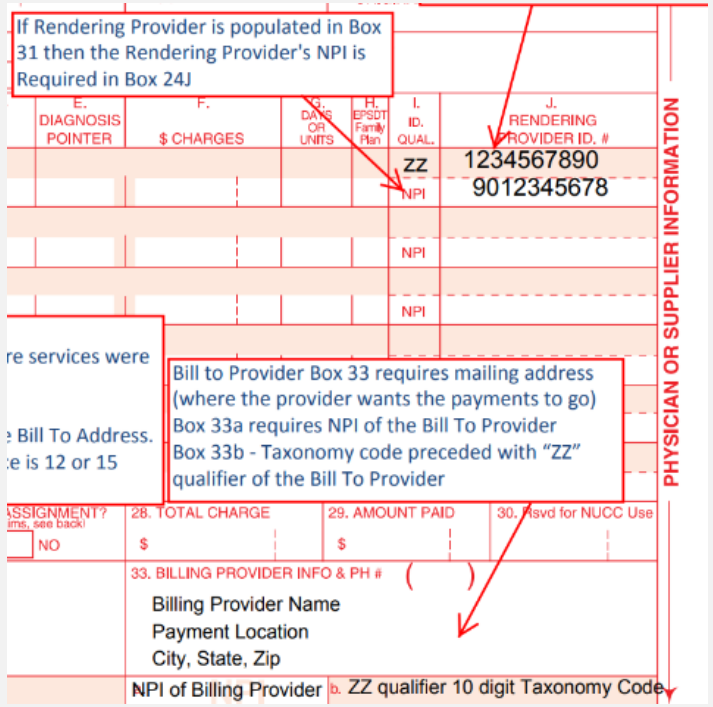
- NOTE: If it is an independent Provider, they can be the rendering and billing provider

Licensed Facility / Agency

C

Notes

Rendering Provider NPI should be entered in box 24J, this will differ from billing NPI in box 33.



B Billing provider

R Rendering provider

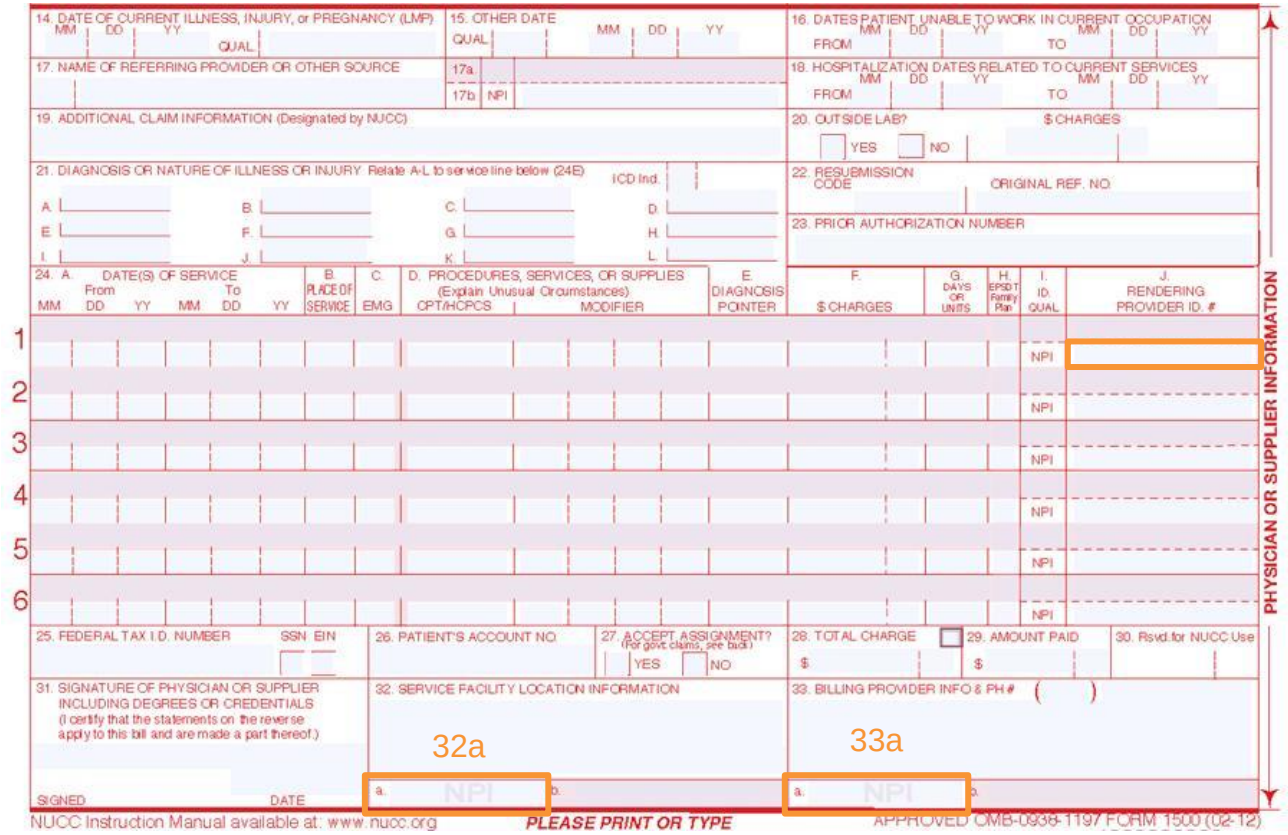
C Organization credentialed

C Individually credentialed

R Listed on roster

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

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

Three sections to enter NPI:

- 24J – Rendering provider NPI
  - ***Rendering provider signature in box 31***
- 32a – Service location NPI
- 33a – Billing provider NPI

If billing as an individual:

- *NPI of practitioner in 24J and 33a*

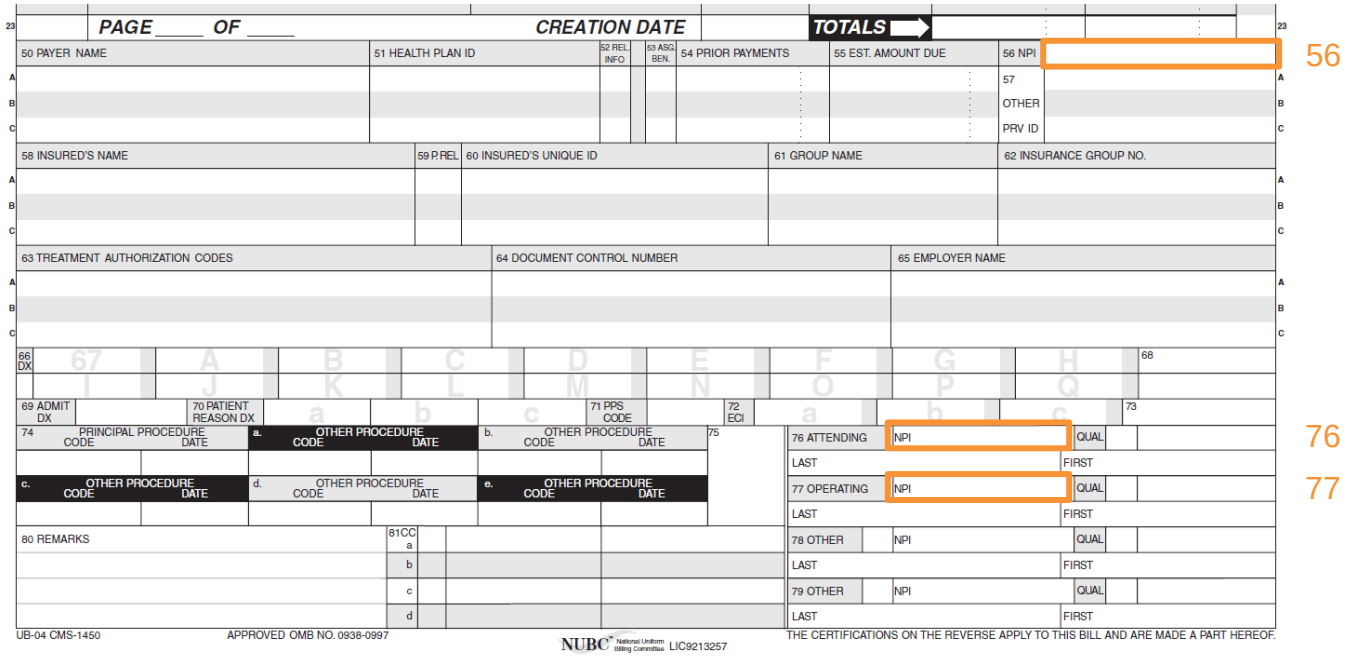
If billing under a group:

- *Rendering provider who is on roster and credentialed with Fidelis Care must have NPI in 24J*
- *Group (or Billing NPI) in box 33a*
- *Box 32a required if address is different from Billing Provider address in box 33*

NEW JERSEY HUMAN SERVICES

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

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



56

76

77

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:

- Field 56: *Facility NPI*
- Field 76: *Attending physician NPI*
- Field 77 *is not a requirement for Fidelis Care*

NEW JERSEY HUMAN SERVICES

Fidelis Care | Additional key MCO-specific guidelines and updates

Interim guidelines for partial care transportation:

- *Transportation must include the base code of Z0330 and then the mileage code and modifier of A0425 UC on the CMS 1500 form.*

Process for telehealth billing:

- *Modifier 95 should be included with CPT which will stipulate telehealth and be processed accordingly.*

Out of network billing guidelines for Phase 1 transition period:

- *Out of Network providers will need to request authorizations for any date of service after **June 30**. All Out of Network providers will also need to obtain a Single Case Agreement for payment which can be done by contacting the Fidelis Care Contracting team once the Out of Network Provider has an approved authorization.*

Systems issues regarding claims processing:

- *Fidelis Care was denying claims with dates of service on or before 1/15/25 that were billed with Place of Service 10 (Telehealth). Fidelis Care has updated its claims system to accept claims with Place of Service 10 as of (1/15/2025) and any impacted claims have been reprocessed.*

Fidelis Care | Upcoming trainings and resources

Upcoming trainings

When	Training Topic	Target audience	Link
March. 27th **12:30-1pm**	**Provider Orientation** Introduction to our network	Newly Credentialed Providers	(Link to Meeting)
March 27th **3:30 pm**	**Behavioral Health Integration Provider Training Overview** Overview of requirements to become a provider and expectations.	FFS BH providers joining managed care	(Link to Join Meeting)

Additional resources

Fidelis Care NJ BH Team:

- Provider Network Specialist: Melanny.Zerna@fideliscarenj.com
- Contract Negotiator II: Evelyn.Mora@fideliscarenj.com
- Contract Negotiator I: Michael.Czajkowski@fideliscarenj.com
- Snr Dir, Population Health & Clinical Ops: Lisa.Dolmatz@fideliscarenj.com
- Manager, Behavioral Health: David.Houston@fideliscarenj.com

Links:

- Fidelis Care Provider Manual
- Fidelis Care Quick Reference Guide
- New Provider Portal Training
- Behavioral Health Virtual Provider Training
- Provider Portal

Presenter

Edward Elles

Director of Behavioral Health

Horizon NJ Health | Meet our claims 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

Reynelda Boggs
Provider Resolution Analyst II, GP Operations

- Responsible for coordinating the resolution of complex claims issues

Gina Swezda
Provider Resolution Analyst II, GP Operations

- Responsible for coordinating the resolution of complex claims issues

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Our claims process

Required fields

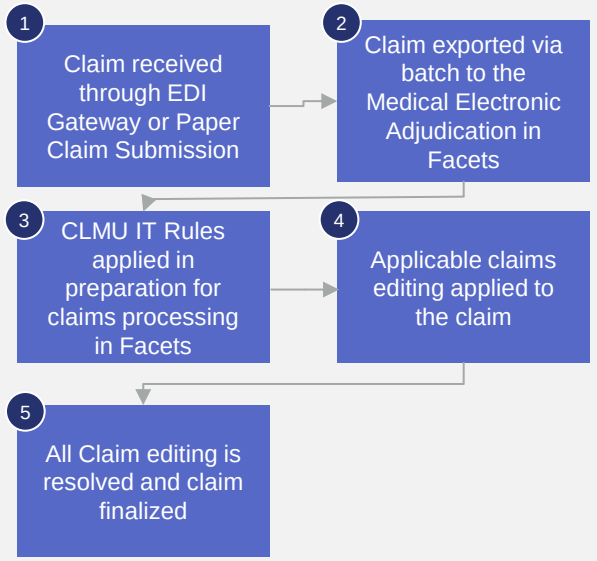
- Key required fields include:
  - Horizon NJ Health Member ID (YHZ#), Name, DOB
  - Provider Name, TIN, Rendering NPI
  - DOS, Service, Diagnosis, Units
- Refer to **full list of required fields** for CMS 1500 and UB-04 - *see later slide*

Claims submission

- Submit claims **within 180 days** from Date of Service or Date of Discharge
- **Electronic[1]:**
  - 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

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Common provider errors leading to denials

#	Error	How to avoid
A	Rendering NPI is incorrect	• Ensure the NPI1 is billed for group and individual practices in the rendering NPI fields, and the NPI2 is billed for ancillary facilities in the rendering and billing NPI fields
B	Incomplete claim submission	• Use a **checklist** to ensure all required fields are completed • Implement **Electronic Health Record (EHR)** system that flags incomplete sections
C	Incorrect diagnosis or procedure codes	• **Double-check coding** before submission. • Use **coding software** or **cross-referencing tools** that align the correct diagnosis (primary vs. secondary) with procedure codes
D	Service is not covered	• Ensure the appropriate modifiers are billed (i.e. UC with CPT A0425)
E	Resubmit with EOB from primary carrier	• Please be mindful that Commercial insurance (including Medicare Advantage plans) EOBs are still required

Horizon NJ Health | Common provider errors leading to denials

#	Error	How to avoid
F	Member is not eligible for service	• Ensure the member is enrolled at time of service
G	Billed charges missing or incomplete	• Ensure the charges are more than $0.00
H	Not the Member's PCP	• Ensure the correct taxonomy code for Behavioral Health is billed
I	Definite Duplicate Claim	• Please allow time to receive payment/denial of original claim before resubmission

Horizon NJ Health | Billing requirements

Individuals / Group

Independently

- B: Type 2 NPI/EIN or Type 1 NPI/SSN/EIN
- R: Type 1 NPI

Under Group

- B: Type 2 NPI/EIN
- R: Type 1 NPI

Mary
Fully licensed[1]

e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

James
Licensed under supervision[2]

e.g., LSW, LAC, LAMFTs, Psychology Permit Holders

- B: Refer to Independently/ Under Group as listed above
- R: Type 1 NPI of supervisor

Alex
OBAT navigator or Peer

- B: Refer to Independently/ Under Group as listed above
- R: Type 1 NPI of OBAT prescriber/supervisor

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling (Supervised billing is not permitted for non licensed clinicians)

- B: Supervised billing is not permitted
- R: Supervised billing is not permitted

Licensed Facility / Agency

C

Mary
Fully licensed

e.g., OTP Clinics, Outpatient/Substance Use Disorder Facilities, Freestanding Psychiatric Hospitals

- B: Type 2 NPI/EIN
- R: Type 2 NPI/EIN

James
Licensed under supervision

e.g., LSW, LAC, LAMFTs and LADCs

- B: Type 2 NPI/EIN
- R: Type 2 NPI/EIN

Alex
OBAT navigator or Peer

- B: Type 2 NPI/EIN
- R: Type 2 NPI/EIN

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

- B: Type 2 NPI/EIN
- R: Type 2 NPI/EIN

1. For BH this includes Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LCADC), Psychiatrists, Psychologist, and Advanced Practicing Nurse (Psychiatric Nurses).
2. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), Licensed Associate Marriage and Family Therapists (LAMFT) and Psychology Permit Holders

B Billing provider | R Rendering provider | C Organization credentialed | C Individually credentialed | R Listed on roster

Horizon NJ Health | Billing requirements – Notes

Individuals / Group

Notes

- Professional claims must be submitted on a CMS 1500 form include the rendering and billing NPI as well as the EIN.
- Claims for the BH Integration services should be submitted to Horizon NJ Health for dates of service beginning 1/1/2025
- Claims for newly carved in services will follow the same procedures as for services already covered by Horizon NJ Health
- Providers are encouraged to submit claims electronically.
- Horizon NJ Health's payer ID: 22326
- Horizon NJ Health will pay clean claims as follows:
  - 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
- HNJH members do not have copayments and/or coinsurance

Licensed Facility / Agency

C

Notes

- Facility/clinic claims must be submitted on a CMS 1500 form unless your contract states otherwise. The claim must include the facility/clinic EIN and NPI in both the billing and rendering fields
- Claims for the BH Integration services should be submitted to Horizon NJ Health for dates of service beginning 1/1/2025
- Claims for newly carved in services will follow the same procedures as for services already covered by Horizon NJ Health
- Providers are encouraged to submit claims electronically.
- Horizon NJ Health's payer ID: 22326
- Horizon NJ Health will pay clean claims as follows:
  - 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
- HNJH members do not have copayments and/or coinsurance

B Billing provider

R Rendering provider

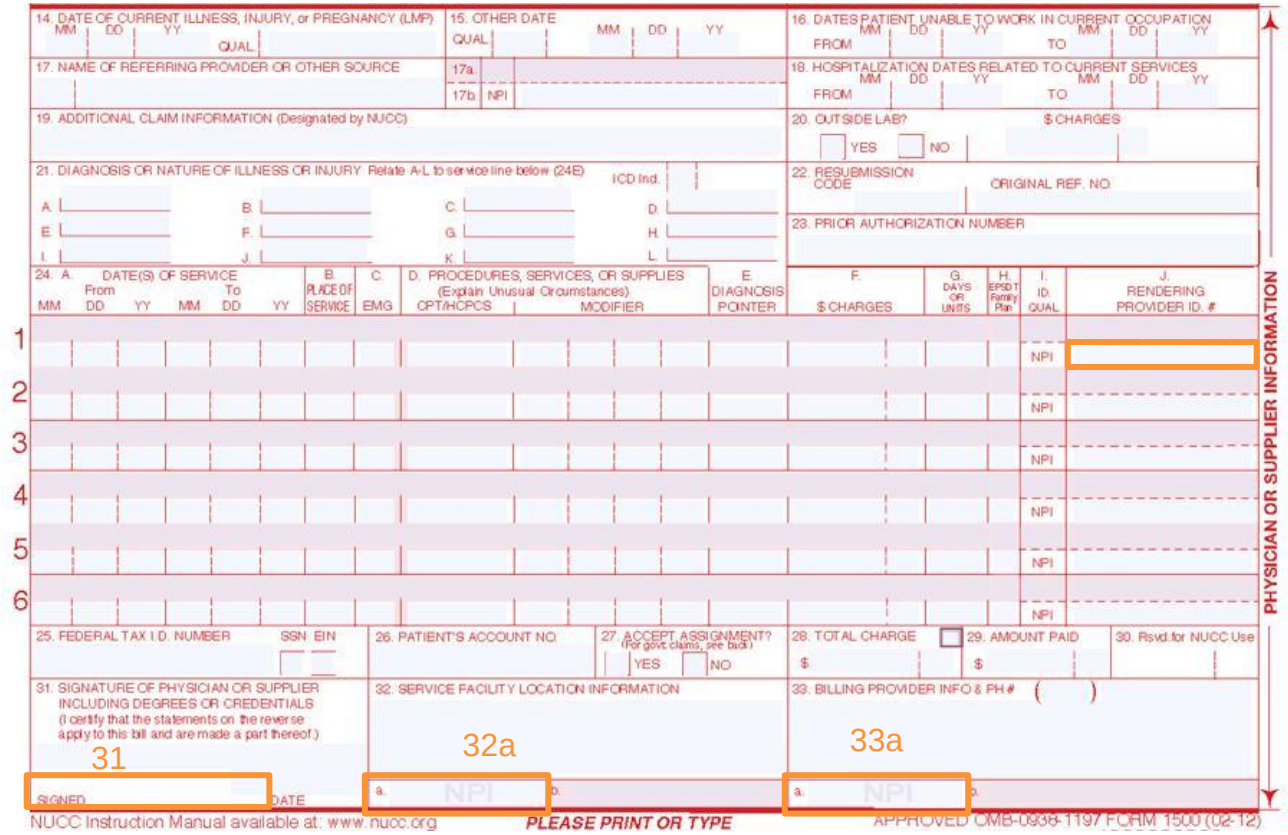
C Organization credentialed

C Individually credentialed

R Listed on roster

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

Three sections on CMS 1500 form for NPI numbers



24J

NPIs must match MCO billing requirements

Three sections to enter NPI:

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

If billing individually (solo practice):

- *24J, 32a, 33a – Providers should enter their Type 1 NPI (if provider has a Type 2 NPI, enter Type 2 NPI in 32a, 33a)*

If billing under a group:

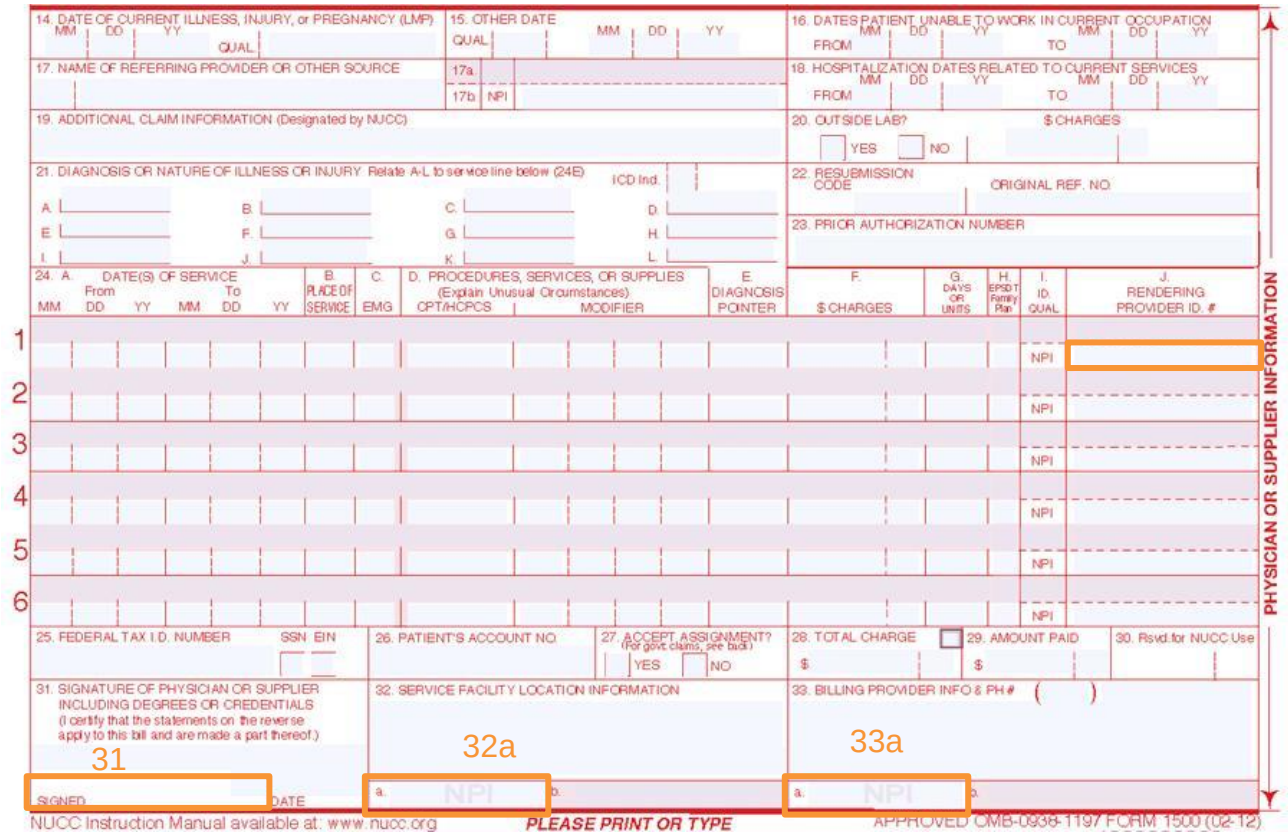
- *24J – Providers should enter their Type 1 NPI*
- *32a – Providers should enter their Type 2 NPI*
- *33a – Providers should enter their Type 2 NPI*

Note: Enter the electronic signature of the rendering provider in box 31

NEW JERSEY HUMAN SERVICES

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

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

Three sections to enter NPI:

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

If billing as a facility*:

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

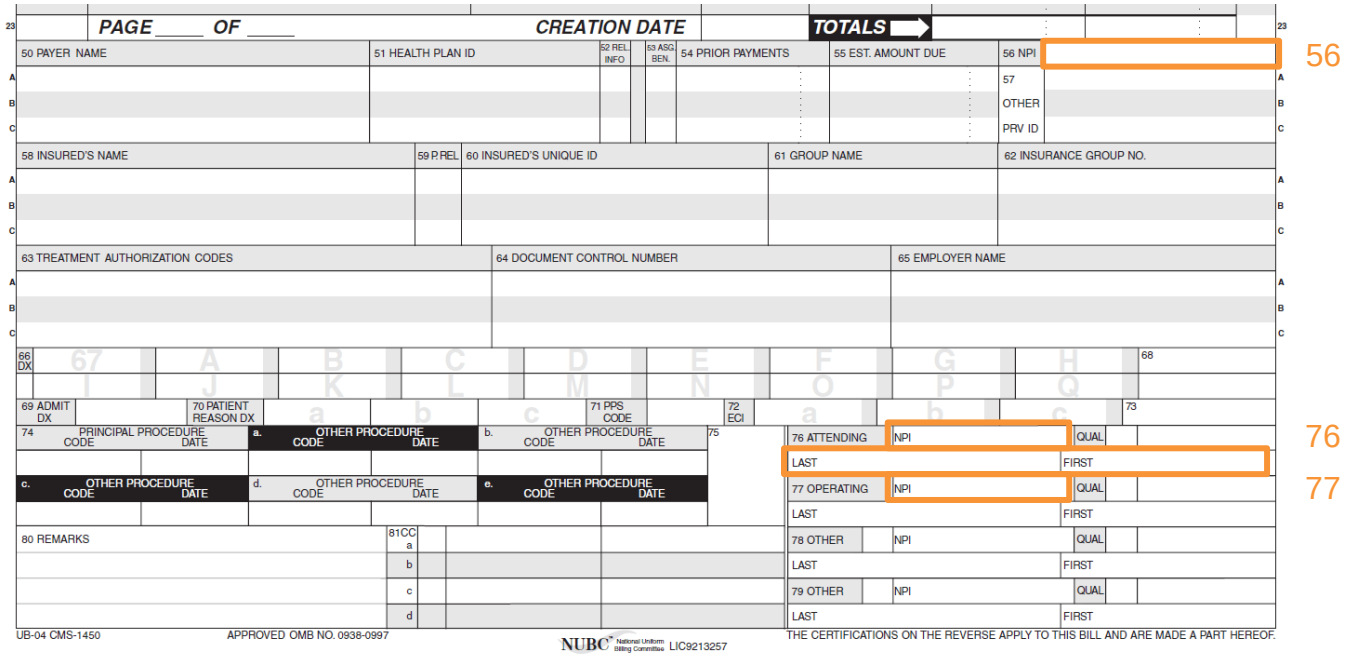
Note: Enter the facility name for the signature in box 31

* Claims should be submitted on a CMS 1500 form unless your contract states otherwise

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Make sure NPI numbers match guidance from MCO - CMS 1450

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



56

76

77

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:

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

Note: Enter the electronic signature of the attending provider in box 76

Horizon NJ Health | Additional key MCO-specific guidelines and updates

Interim guidelines for partial care transportation:

- *Code A0120UC has replaced Z0330. Providers can now submit claims for the A0120UC electronically. There are no changes to A0425 which can continue to be submitted electronically.*

Process for telehealth billing:

- *Telehealth claims should be submitted with a GT or 95 modifier.*
- *See our Telemedicine and Telehealth policy at: https://www.horizonnjhealth.com/for-providers/resources/policies/reimbursement-policies-guidelines/telemedicine-and-telehealth*

Out of network billing guidelines for Phase 1 transition period:

- *No Authorizations are required for Phase 1 BH services thru 6/30/25 for in network and out of network providers.*

Systems issues regarding claims processing:

- *Horizon is in the process of turning off some bundling logic that resulted in denials. In the meantime, claims are being manually handled to avoid any additional impacts and claims already denied will be reprocessed.*
- *Another system issue was that Horizon had place of service restrictions set on transportation services. This has already been corrected and claims are being reprocessed.*

Horizon NJ Health | Upcoming trainings and resources

Upcoming trainings

When	Training Topic	Target Audience	Link
3/4/2025; 12:00pm	BH Medicaid Integration Training	Professional	Register
3/6/2025; 1:00pm	BH Medicaid Integration Training	Ancillary	Register

Additional resources

For further information on credentialing with us, please contact: BHMedicaid_@horizonblue.com

Links:

- Credentialing Application Link
- HNJH Provider Manual
- HNJH Quick Reference Guide
- New Provider Orientation

United Healthcare

Presenter

Scheanell Holland

NJ Network Manager

NEW JERSEY HUMAN SERVICES

UnitedHealthcare | Meet our claims & billing team

Lisa Bahr
Director, Claims

Wendy Salas
Associate Director, Claims

Wesley Lopez Mckenzie
Manager, Claims

Leigh Huffman
Sr. Claims Business Processor Consultant

UnitedHealthcare | Our claims process

Required fields

Required but not limited to the following:

- Member's name's
- Identification Number
- Date of birth
- Providers Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- Taxonomy code
- Complete diagnosis (ICD-10-CM)
- Value code
- Rate code
- Revenue code
- Modifiers
- Date of service
- Duration / units
- If authorization obtained/required include authorization number. If authorization not obtained and required contact 1-888-362-3368

Claims submission

Electronic Submission

- Electronic Data Interchange (EDI)
  - All claims should be billed using either EDI 837I (Institutional) / UB04 or EDI 837P (Professional)
  - Payer ID: 87726
- Provider Express.com
  - Outpatient, clinicians and groups billed on 1500 form

Paper Submission

- Original 1500 version 02/122 (formerly CMS-1500)
- UnitedHealthcare Community Plan P.O. Box 5250, Kingston, NY 12402

Adjudication & processing

- Claim received by UHC
- Routed to the appropriate claim platform
- Clean claims may:
  - auto adjudicate; or
  - route to a claim's processor for manual review and processing
- Claim status can be checked via the Provider Express Portal- Claim Inquiries & Claim Adjustments (video)
- Claims must be submitted within **180 days** from the date of service
- If coordination of benefits UHC secondary payer – 60 days from the date of the primary insurer's EOB or 180 days from the date of service whichever is later
- Clean claim TAT 15 calendar days

Payment & Remittance

- Direct deposit/EFT within 2 business days
- PRA aligns with the EFT
- Paper check are mailed in 7-10 days

Denials & Appeals

- Online via UHCprovider.com
- Mail

Filing time frame for Appeals

- NJ FamilyCare/ Medicaid: **Within 90 days from the determination date**
- UHC Dual Complete NJ-Y001 (HMO D-SNP):
- Par providers should follow contract
- Non-par providers must be received within 60 days

UnitedHealthcare | Common provider errors leading to denials

#	Error	How to avoid
A	A12 - Service not contracted	• Refer to your contract and/or fee schedule prior to claim submission to ensure codes are listed on your fee schedule and eligible for reimbursement of the specific codes being billed. Confirm provider is contracted and eligible to bill under current UHCCPNJ agreement.
B	Ei9 – State is responsible for transportation services (except MH PC transportation)	• Billing appropriate code combination and services based on outpatient contract for partial care services • Refer to procedure master listing - MCO Behavioral Health Integration-CY2025 https://www.njmmis.com/documentDownload.aspx?document=MCOBHIPhase1ServiceAndCodesCY2025.pdf ➢ Example: A0090 is a non covered transportation code
C	A27 – Send primary EOB	• When UHHCPNJ is the secondary payor ensure primary EOB included with claim submission

UnitedHealthcare | Billing requirements

- For facilities billing on a UB04, the attending physician NPI is required

Individuals / Group

Independently

- B Type 1 NPI/SSN
- R Type 1 NPI

Under Group

- B Type 2 NPI/EIN
- R Type 1 NPI

Mary
Fully licensed[1]

e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

James
Licensed under supervision[2]

e.g., LSW, LAC, LAMFTs and LADCs

- B Type 2 NPI/EIN
- R Type 1 NPI of OBAT prescriber

Alex
OBAT navigator or Peer

- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

Licensed Facility / Agency

C

Mary
Fully licensed[1]

e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

- B Type 2 NPI/EIN
- R Type 2 NPI

James
Licensed under supervision[2]

e.g., LSW, LAC, LAMFTs and LADCs

- B Type 2 NPI/EIN
- R Type 2 NPI

Alex
Peer

- B Type 2 NPI/EIN
- R Type 2 NPI

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

- B Type 2 NPI/EIN
- R Type 2 NPI

1. For BH this includes Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LCADC), or Advanced Practicing Nurse (APN); 2. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), Licensed Associate Marriage and Family Therapists (LAMFT) and Licensed Alcohol and Drug Counselor (LADC)

B Billing provider | R Rendering provider | C Organization credentialed | C Individually credentialed | R Listed on roster

UnitedHealthcare | Billing requirements – Notes

Individuals / Group

Notes

Individually credentialed rendering / billing individually
Group credentialed rendering / billing under group
Group credentialed non-rostered rendering / billing under group

Non-rostered group entity
These claims are for services listed on your group contracted fee schedule
1) Group/agency name (Box 31)
2) The NPI number (Box 24J)
3) The group/agency name, address, and phone number (Box 33)
4) The group/agency NPI number (Box 33a)

*Do not put the name of the rendering clinician on the claim form

It is important to bill with the CPT codes shown on the group/agency fee schedule for claims to be processed and paid correctly

- Outpatient claims must be billed on a 1500

  National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual National Uniform Claim Committee - 1500 Instructions (nucc.org)

Licensed Facility / Agency

C

Notes

Facility credentialed rendering / billing under facility
Agency / clinic credentialed rendering / billing under agency / clinic
Agency / clinic credentialed licensed rostered rendering / billing under agency /clinic

- Inpatient claims must be billed on a UB- 04

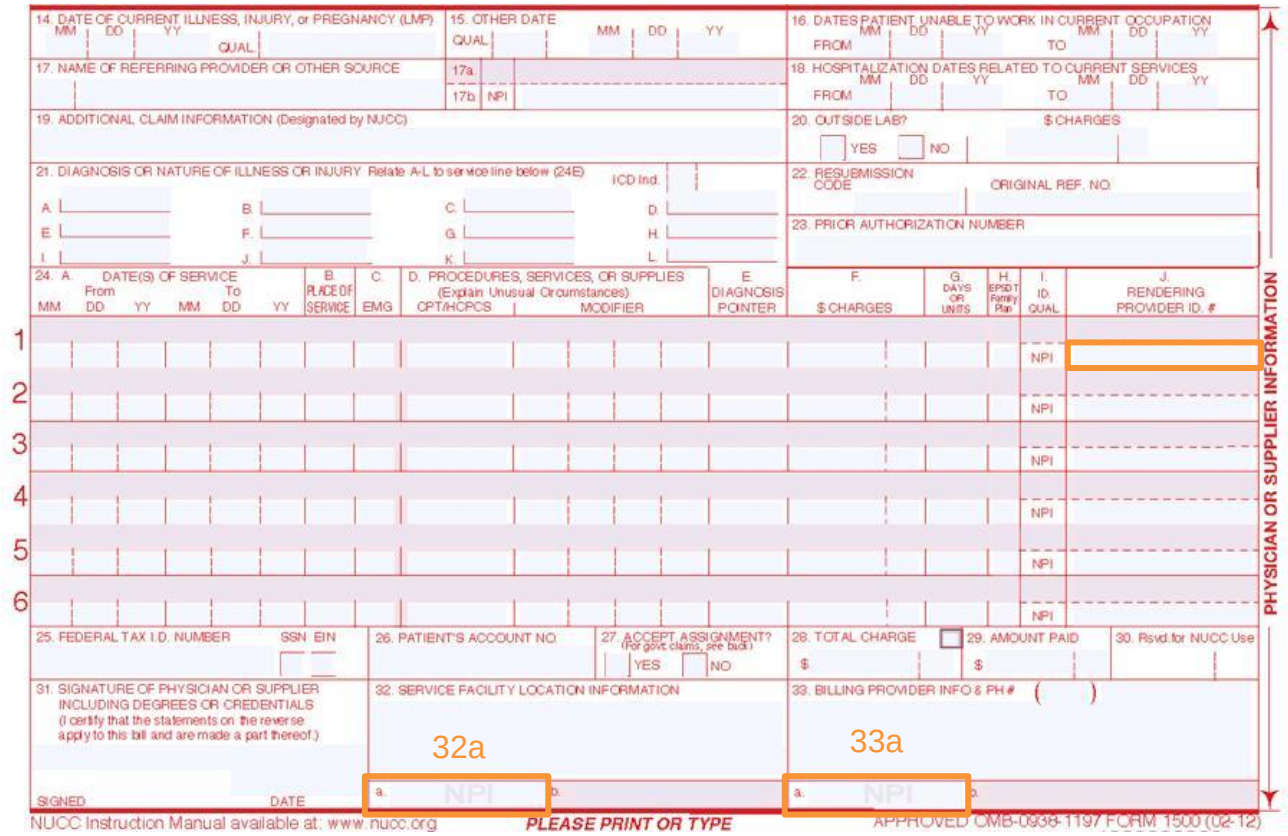
  Centers for Medicare & Medicaid Services (CMS) 1450 UB-04 Claim Form Institutional paper claim form (CMS-1450) | CMS

- **Clean Claim Definition-** A claim with no defect or impropriety (including any lack of any required substantiating documentation) or 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 & legible

B Billing provider
R Rendering provider
C Organization credentialed
C Individually credentialed
R Listed on roster

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

Three sections on CMS 1500 form for NPI numbers



24J

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 individually:

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

If billing under an agency:

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

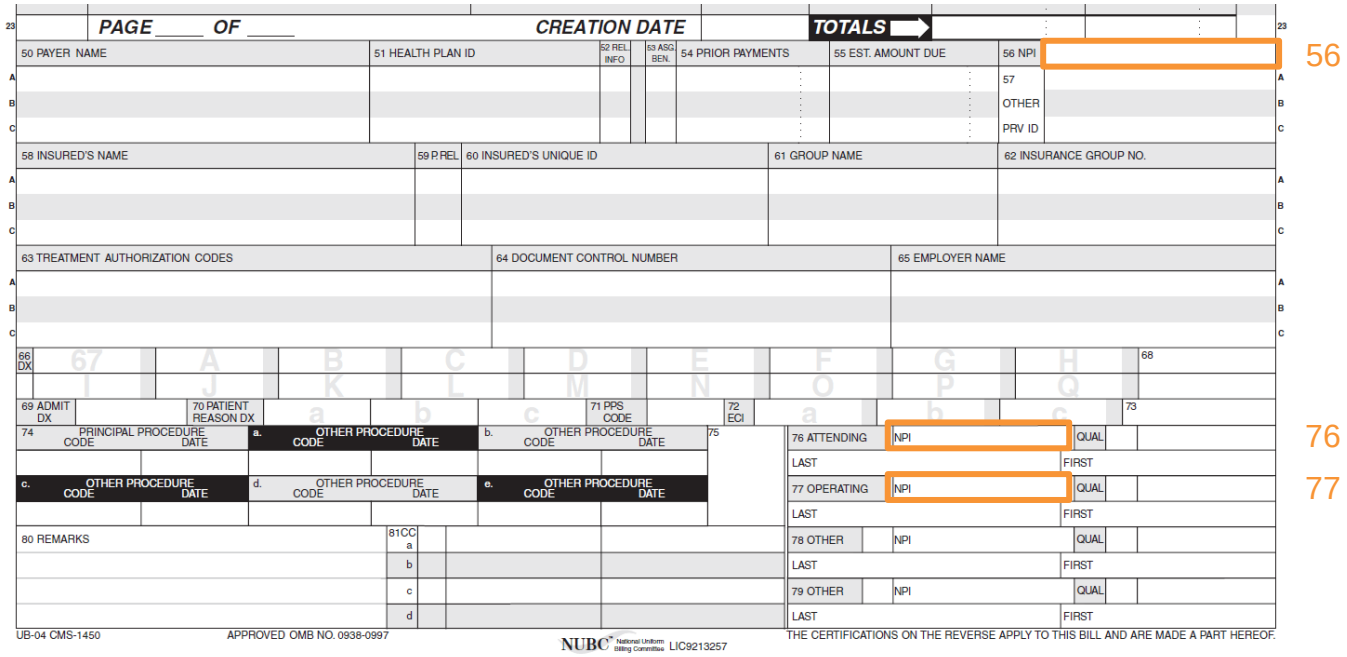
Note: Box 31 include signature when rendering provider listed

*Facility billing on UB04

NEW JERSEY HUMAN SERVICES

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

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



56

76

77

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:

- Field 56: *Facility NPI*
- Field 76: *Attending provider*
- Field 77: *Operating provider if applicable*

NEW JERSEY HUMAN SERVICES

UnitedHealthcare | Additional key MCO-specific guidelines and updates

Interim guidelines for partial care transportation:

- *UHCCPNJ accepts claims billed with Z0330 and/or A0120 (load fee) and A0425 (mileage) for MH Partial Care transportation services.*

Process for telehealth billing:

- *Please refer to Provider Express for process/policies Telemental Health*

Out of network billing guidelines for Phase 1 transition period:

- *As of 1/1/25 accepting Phase 1 BH services for UHCCPNJ members*
- *Phase 1 BH services will pay without authorization through 06/30/2025*
- *All NJ State FFS authorizations have been entered in our system.*
- *Providers will receive written authorization letters as authorizations are entered*
- *During this 180-day transition period we encourage you to request continued authorization to become familiar with our prior authorization process ProviderExpress.com*
  - *Authorizations will be administrative (medical necessity not applied) through 06/30/2025*
- *Effective 7/1/25 authorization requests will include medical necessity review, services requiring prior authorization will need authorization*

Systems issues regarding claims processing:

- *Providers may have received incorrect system denials for Phase 1 BH services through 1/13/25. Those claims have been reprocessed.*
- *No current system issues impacting claims processing*
- *To ensure MH partial care transportation claims are paid appropriately refer to NJMMIS website:* https://www.njmmis.com/documentDownload.aspx?document=MCOBHIPhase1ServiceAndCodesCY2025.pdf

UnitedHealthcare | Upcoming trainings and resources

Upcoming training

Available upon request email NJNetworkmanagement@optum.com with subject line "Provider Training Request"

Additional resources

For further information on submitting claims with us, please contact: **Claims Provider Service line - 1-888-362-3368**

Links:

- Claims Submission Portal: Optum - Provider Express Home
- Provider Manual: New Jersey Medicaid Provider Network Manual Addendum (providerexpress.com)
- Quick Reference Guide: Behavioral Health Quick Reference Guide (providerexpress.com)
- New Provider Orientation: NJ Medicaid Mental Health and Substance Abuse Provider Training 2025 (providerexpress.com)
- Claim Adjustment Reason Codes(CARC)- https://x12.org/codes/claim-adjustment-group-codes
- Remittance Advice Remark Codes(RARC)- https://x12.org/codes/remittance-advice-remark-codes

Wellpoint

Presenter

Rhonnda Talton

Provider Network Manager, Sr.

NEW JERSEY HUMAN SERVICES

Wellpoint | Meet our claims & billing team

Jason Friedman
Director, Provider Solutions

Eyreny Mekhaiel
GBD State Operations Director

Michael Giaimo
Business Change Manager, Sr.

Wellpoint | Our claims process

Required fields

- Claims must include:
  - member information
  - CPT-4, HCPCS or rev codes
  - ICD-10 Diagnosis codes
  - rendering provider NPI
  - tax ID
  - authorization # (as applicable)
  - NDC #
  - Itemized invoices
  - other pertinent information

Claims submission

- Claims must be submitted with 180 days from the date of service.
- Claims are submitted via www.Availity.com
- Claim can be mailed to:
  - Wellpoint NJ Claims Dept, PO Box 61010, Virginia Beach, VA 23466-1010

Adjudication & processing

- Claims can be tracked via Availity.
- Claims submitted electronically are processed with within 15 days from receipt of claim
- Claims submitted manually are processed within 30 days.
- Claims are processed daily for payment.

Denials & Appeals

- A claim might be denied for member termination, no authorization, incorrect billing codes, missing NDC#, or COB.
- Providers can appeal the claim via Availity within 90 day from the denial date.
  - Written letter (same address as submission).

Wellpoint | Common provider errors leading to denials

#	Error	How to avoid
A	Member not eligible	• Check member's eligibility prior to rendering services
B	Primary Insurer Carrier EOB required	• Submit Primary Insurer's EOB with Wellpoint claim
C	No authorization (as applicable)	• Submit authorization # on claim as applicable. • Note: prior auths are not required during first 180 days of implementation 1/1/25 to 6/30/25. Effective 7/1/25, provider must obtain auth and bill with auth # as applicable.
D	Incomplete claim submission	• Wellpoint claims are submitted via Availity • Utilize Availity claims submission tutorials as needed
E	Incorrect diagnosis or procedure codes	• Provider should double-check coding before submission. • Provider can utilize coding software or cross-referencing tools that align diagnosis with procedure codes.

Wellpoint | Billing requirements

Individuals / Group

Independently

- B Type 1 NPI/EIN
- R Type 1 NPI

Under Group

- B Type 2 NPI/EIN
- R Type 1 NPI

Mary
Fully licensed[1]

e.g., LPCs, LCSWs, LMFTs, LCADCs and APNs

James
Licensed under supervision[2]

e.g., LSW, LAC, LAMFTs and LADCs

- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

Alex
OBAT navigator or Peer

- B Type 2 NPI/EIN
- R Type 1 NPI of OBAT prescriber

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

Licensed Facility / Agency

C

- B Type 2 NPI/EIN
- R Type 1 NPI

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Fully licensed[1]

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Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

1. For BH this includes Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselor (LCADC), or Advanced Practicing Nurse (APN); 2. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), Licensed Associate Marriage and Family Therapists (LAMFT) and Licensed Alcohol and Drug Counselor (LADC)

- B Billing provider
- R Rendering provider
- C Organization credentialed
- C Individually credentialed
- R Listed on roster

Wellpoint | Billing requirements – Notes

Individuals / Group

C

Notes

- Solo providers and Provider Groups submit claims with the Provider name, tax identification number, and rendering NPI number.
- Provider fills out the HCFA 1500 for office visits and OP services according to CMS guidelines.
- Provider submits form in Availity
- Electronic claims are processed within 15 days
- Paper claims are processed within 30 days

Licensed Facility / Agency

C

Notes

- Facilities/Agencies bill under the tax identification number and facility/agency NPI number.
- Provider fills UB-1450 form for IP services according to CMS guidelines.
- Provider submits form in Availity
- Electronic claims are processed within 15 days
- Paper claims are processed within 30 days

B Billing provider

R Rendering provider

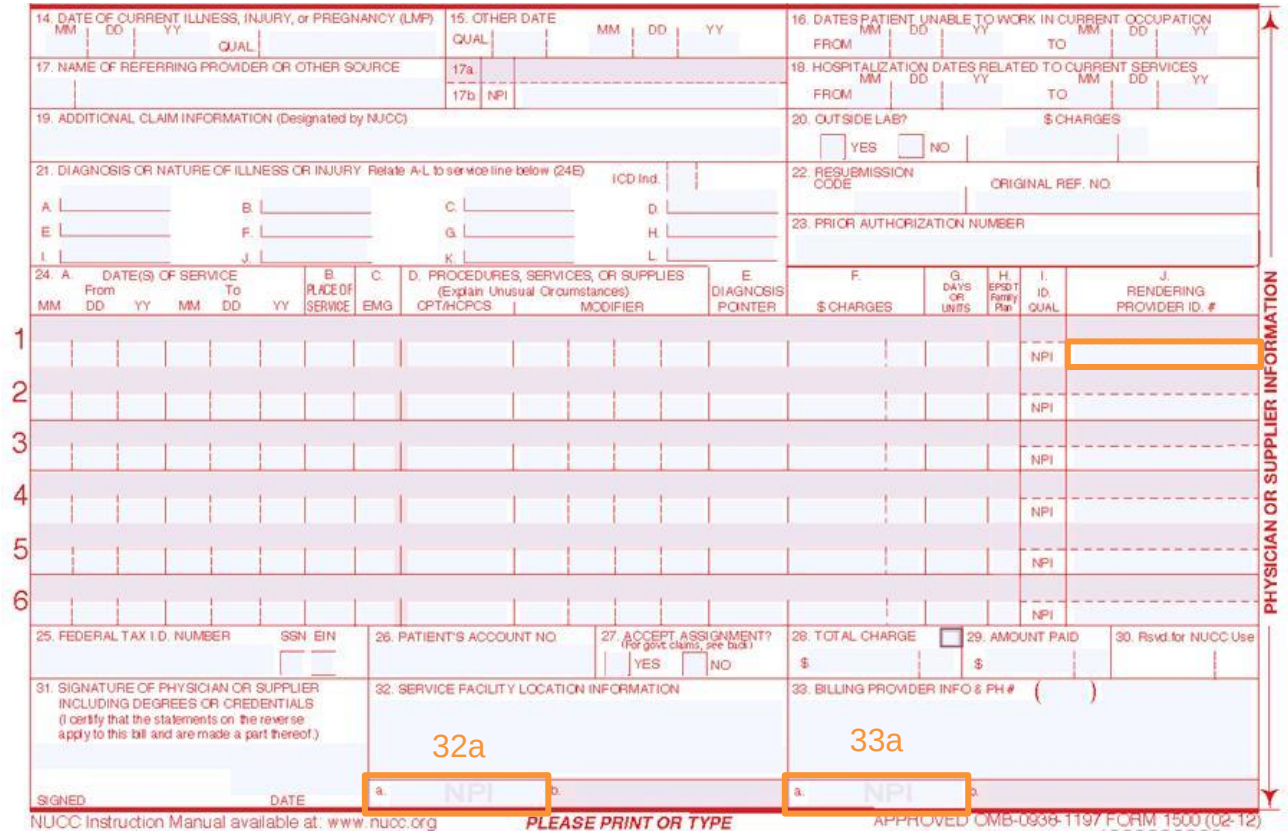
C Organization credentialed

C Individually credentialed

R Listed on roster

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

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

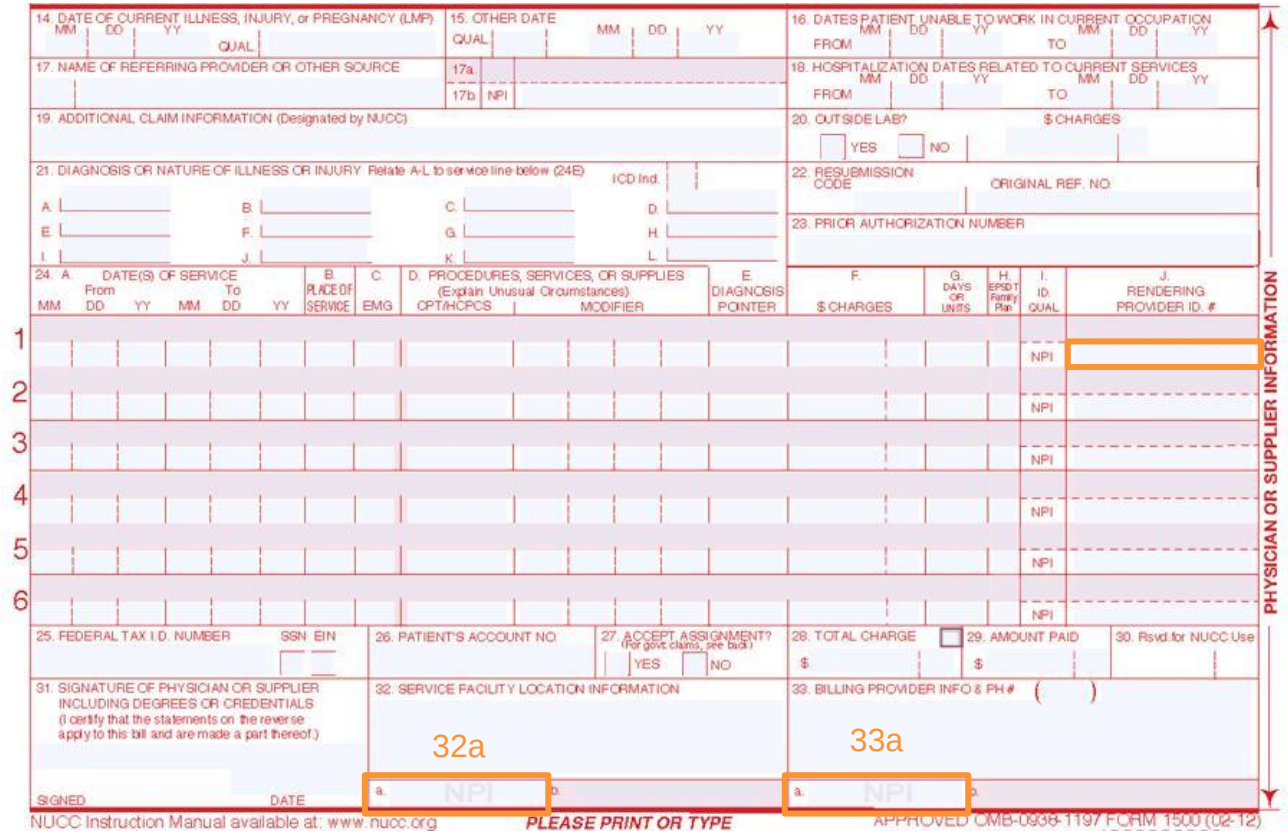
Four sections to enter NPI:

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

MCO instructions on next page

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

Three sections on CMS 1500 form for NPI numbers



24J

NPIs must match MCO billing requirements

If billing under a group:

- *24J – Enter NPI of the provider who rendered services.*
  - *If the provider is billing as member of a group, the rendering individual provider's NPI may be entered.*
- *31 – Rending 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 – NPI where services were rendered if different from billing address listed in field 33.*
- *33a – Group Billing NPI*

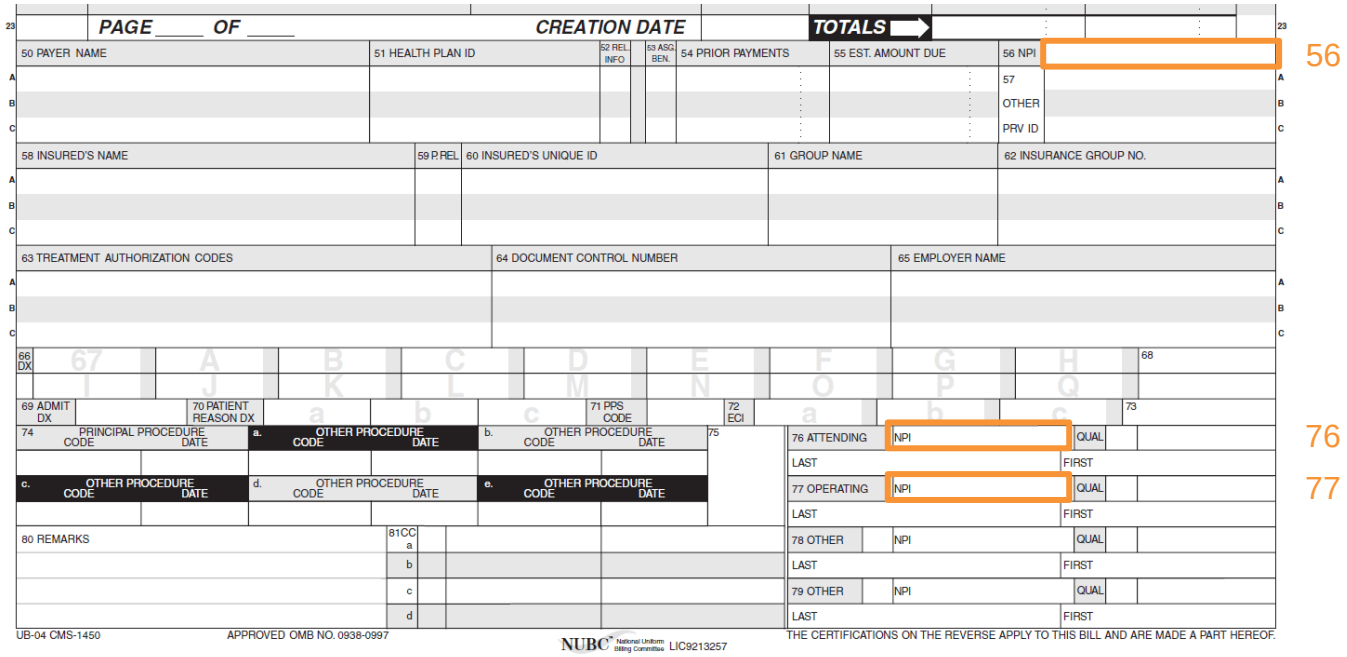
If billing individually:

- *Type 1 NPI of practitioner in 32a, 33a, and 24J; field 31 is not applicable if billing electronically*

NEW JERSEY HUMAN SERVICES

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

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



56

76

77

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:

- Field 56 – *NPI of billing provider*
- Field 76 – *Attending provider name and NPI*
- Field 77 – *Operating provider name and NPI*

NEW JERSEY HUMAN SERVICES

Wellpoint | Additional key MCO-specific guidelines and updates

Interim guidelines for partial care transportation:

- *A0425 UC – add-on of MH Partial Care transportation (bundled mileage)*
- *A0120 UC – add-on of MH Partial Care transportation (load fee)*
- *Z0030- not valid for Wellpoint (this has been communicated to DMAHS)*

Process for telehealth billing:

- *Bill claims for telehealth with the appropriate modifier 95.*
- *Use standard billing guidelines for modifiers and place of service*

Out of network billing guidelines for Phase 1 transition period:

- *No authorization required for services 1/1/25 to 6/30/25. No SCA needed during first 180 days.*
- *Wellpoint NJ encourages providers to request authorizations prior to 6/30/25 to ensure authorizations are on file for services beginning 7/1/25.*

Systems issues regarding claims processing:

- *Wellpoint reviews Behavioral Health claims daily to ensure accuracy. Any erroneous errors are reprocessed, where applicable.*

Wellpoint | Upcoming trainings and resources

Upcoming trainings

Date	Time	Topic	Link
March 25, 2025	12:00pm	Wellpoint Community Care Provider Webinar	Link

Additional resources

For further information on submitting claims with us, please contact:

Availity Support
1-800-AVAILITY (1-800-282-4548)
Create a Case / Chat with Support

Resource links:

- Claims Submission Portal
- Wellpoint Provider Manual
- Wellpoint Quick Reference Guide
- Wellpoint BH Quick Reference Guide
- New Provider Orientation

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 website

The BH website has the following materials for providers:

- Provider readiness packet
  - Offers detailed program guidance and additional readiness guidance
- Prior DMAHS training materials and recordings
- Additional resources with information on program processes

Member's Managed Care Organization

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

Aetna **Fidelis Care** **Horizon**

United **Wellpoint**

Refer to key MCO points of contact here or also in provider readiness packet

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

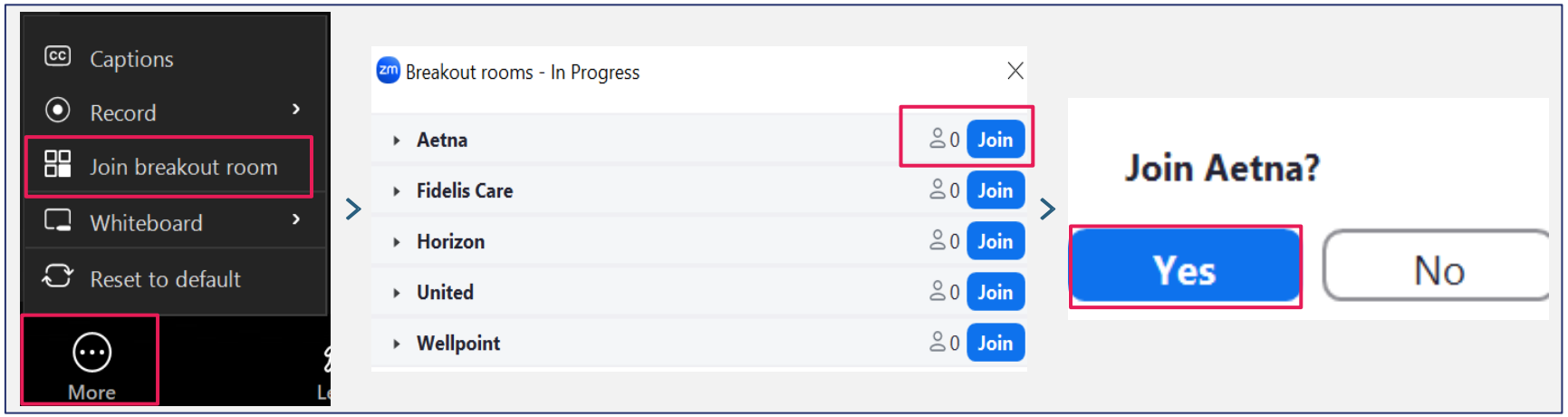
Q&A

DMAHS or MCO claims questions

Choose your breakout room

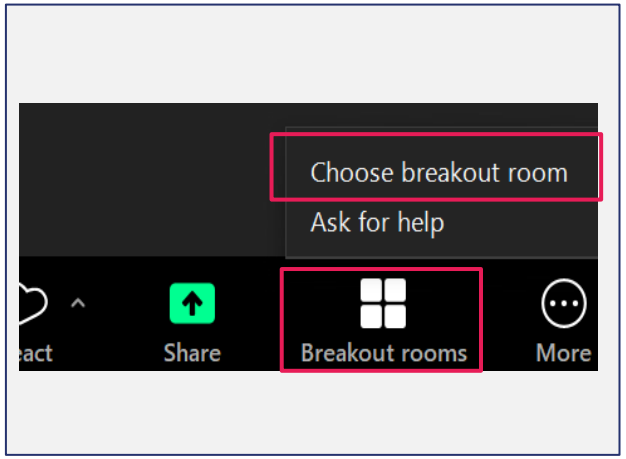
To join a breakout room:

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



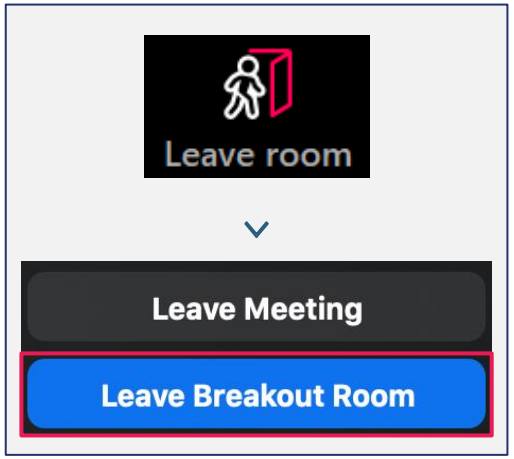
To switch to another MCO room:

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**"



Appendix

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

Required fields

"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	Aetna	Fidelis Care	Horizon	United	Wellpoint
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					

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 *Submit via provider portals or electronic data interchange*	Paper *Submit by mail only to specified address for each MCO*
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, 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 **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]

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

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

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

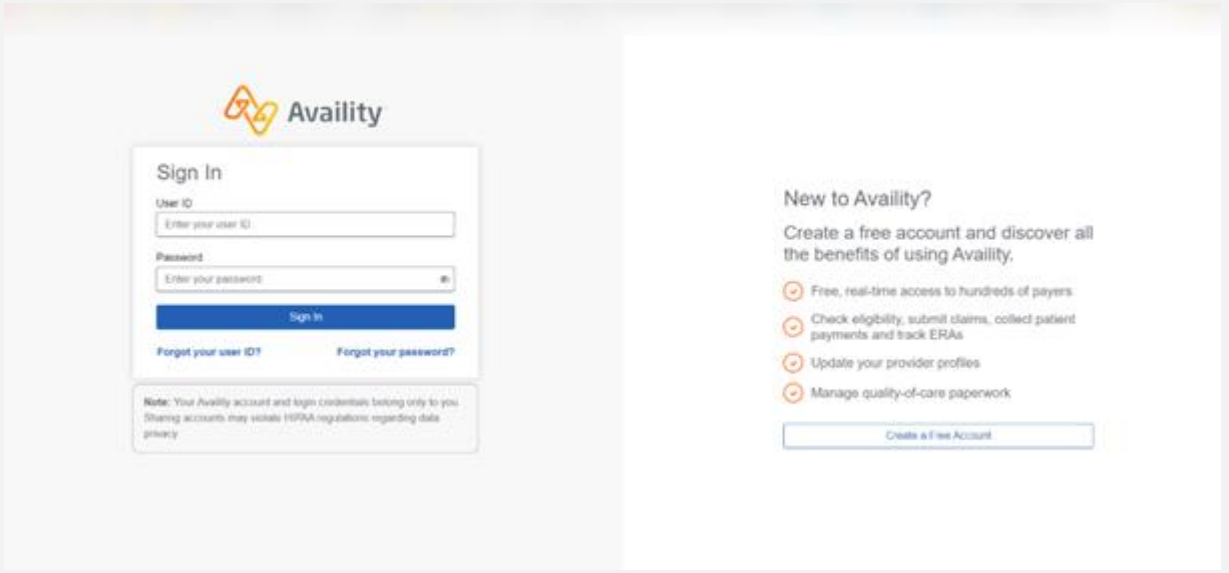
Electronic: Most MCOs offer faster payments via electronic remittance, such as ACH transfers

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

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

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.

Aetna
Claims portal demo



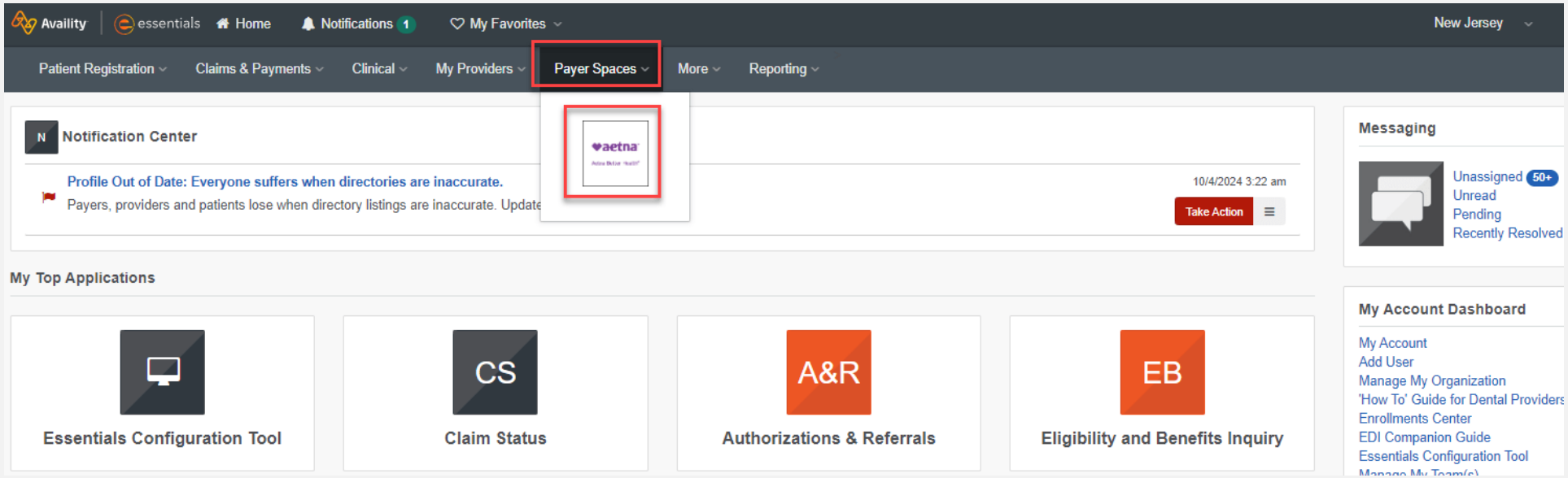
NEW JERSEY HUMAN SERVICES

1

Submit claims using Aetna Better Health of NJ Portal: [Access Availity Here]

2

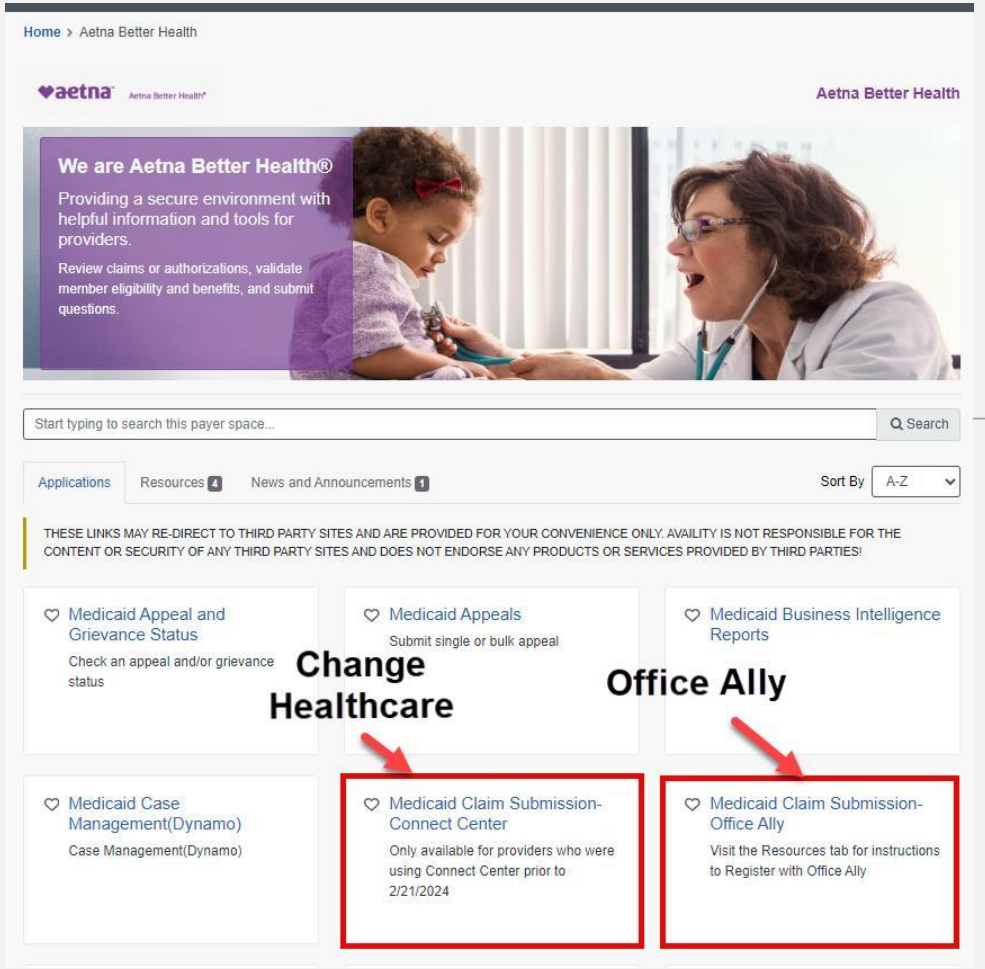
Once provider is logged into Availity they can go to NJ and then the payer spaces and select “Aetna Better Health”.



NEW JERSEY HUMAN SERVICES

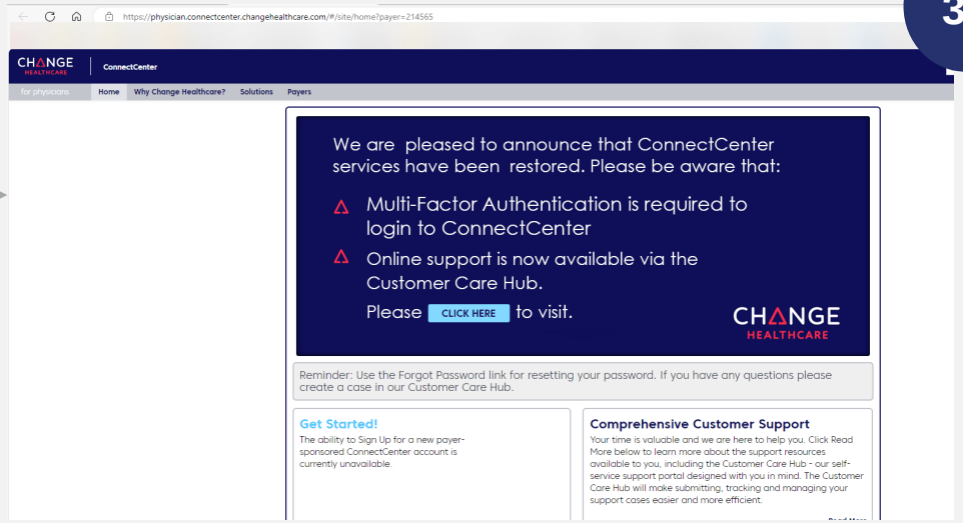
3

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



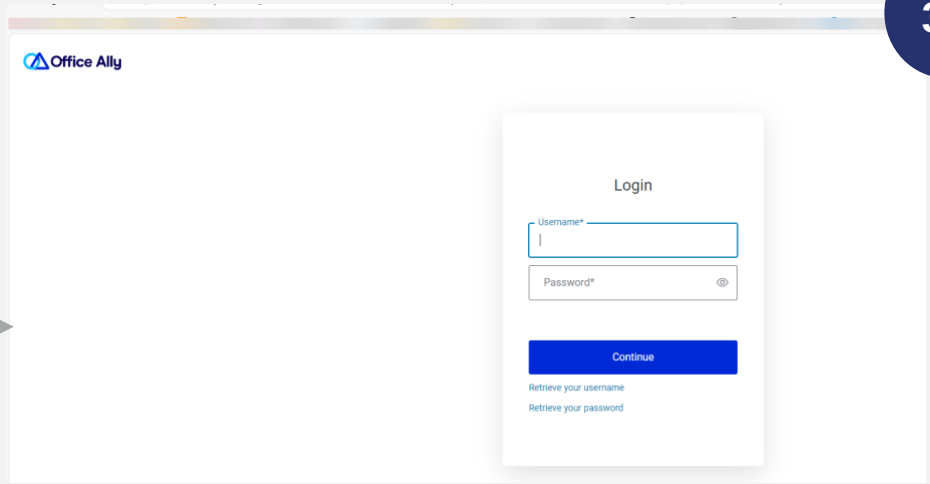
Change Healthcare website log in

3a



Office Ally website log in

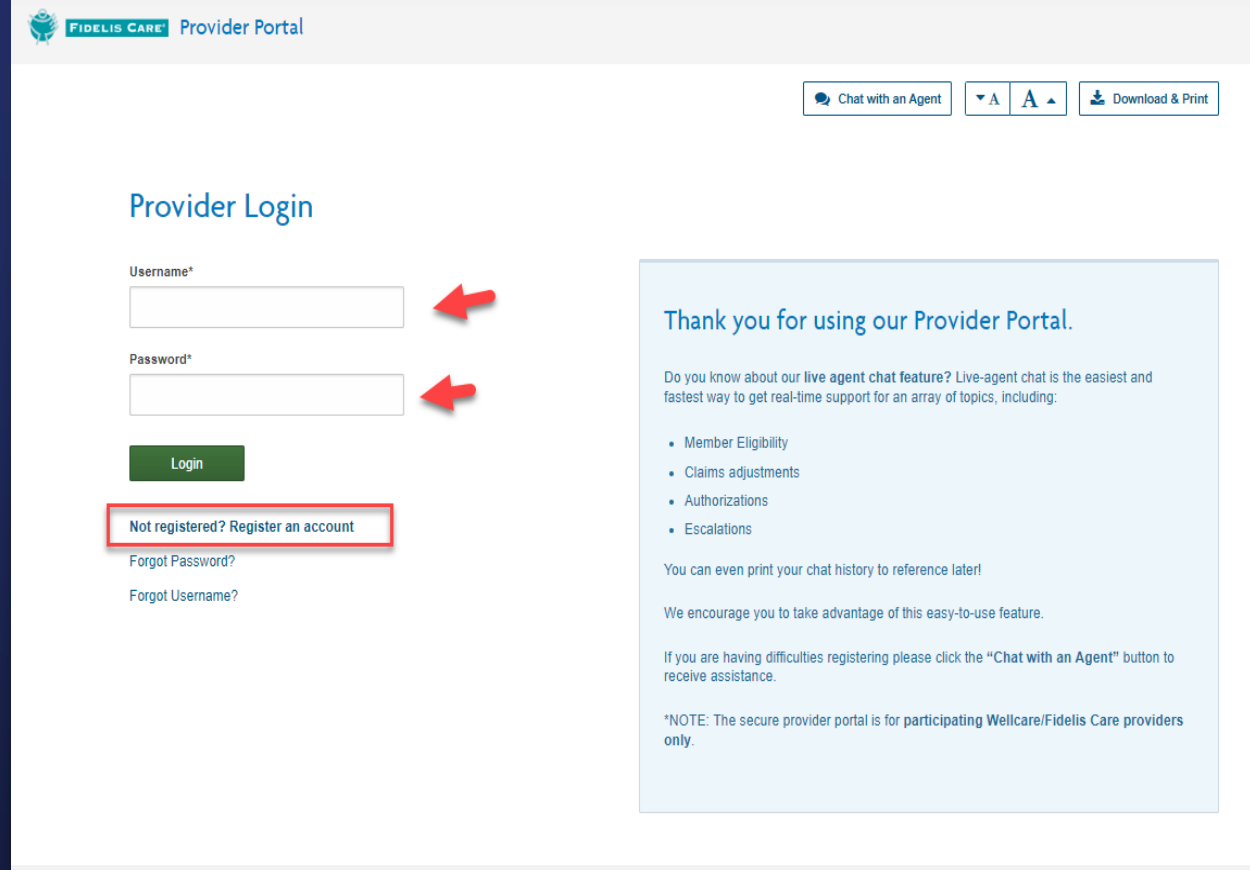
3b



NEW JERSEY HUMAN SERVICES

Fidelis Care Claims portal demo

Fidelis Care portal Login

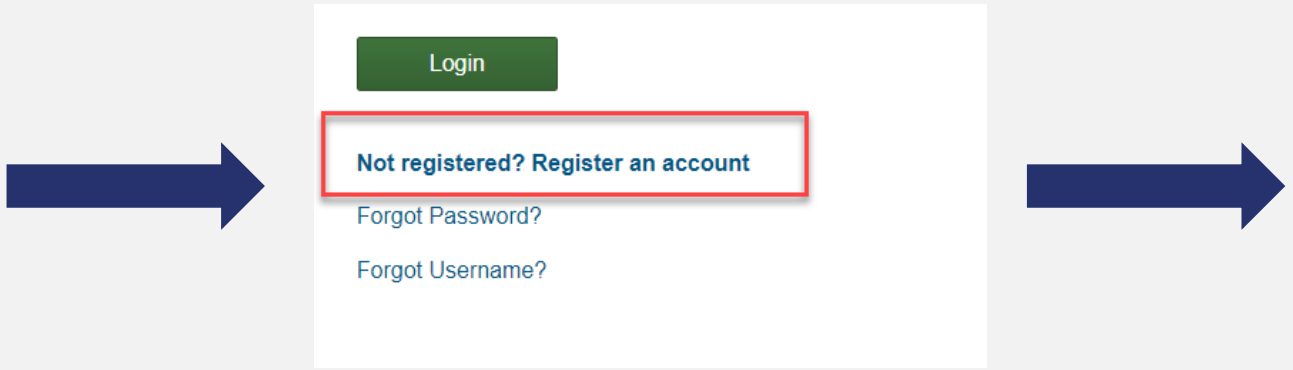


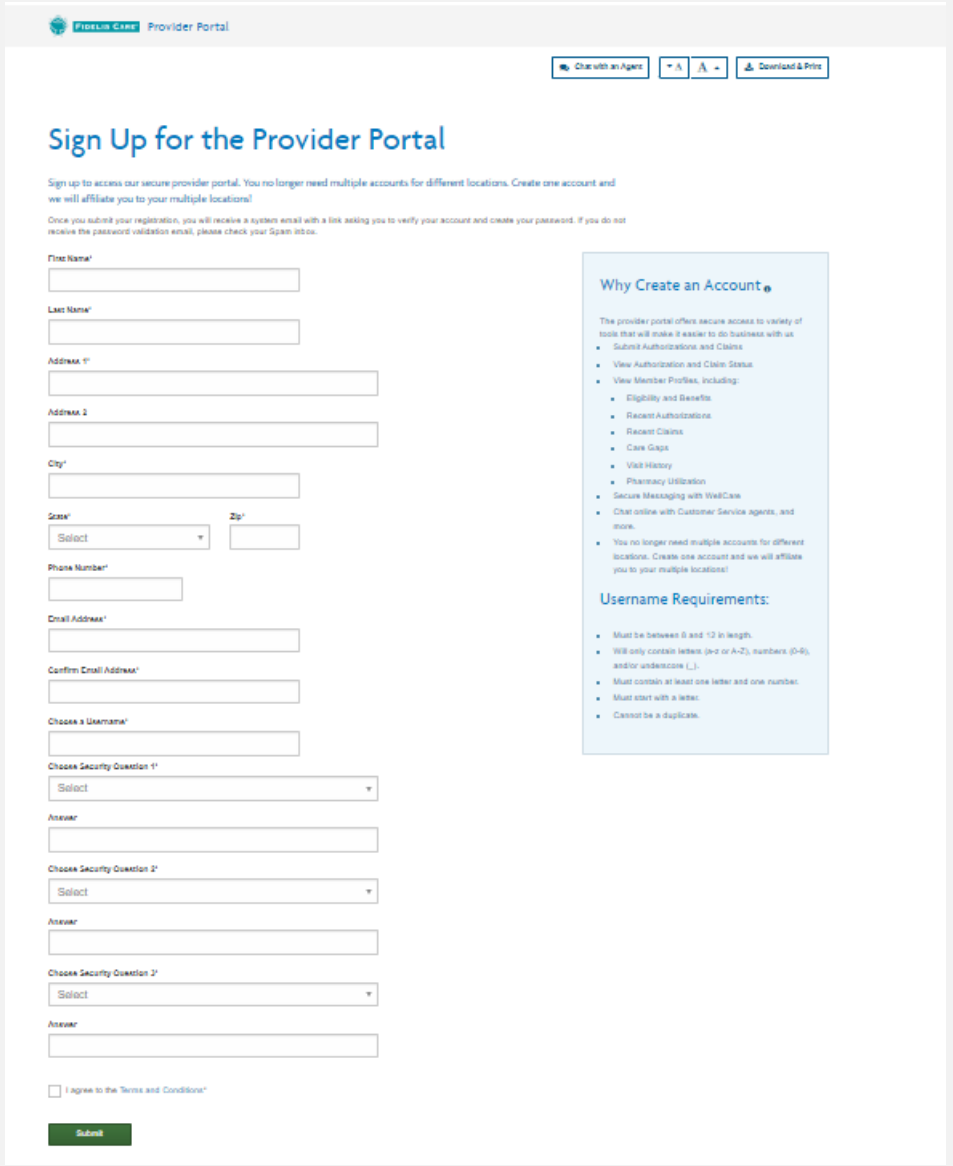
Full Claims Submission training video

Additional Provider Portal Overview Training Guides

NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal





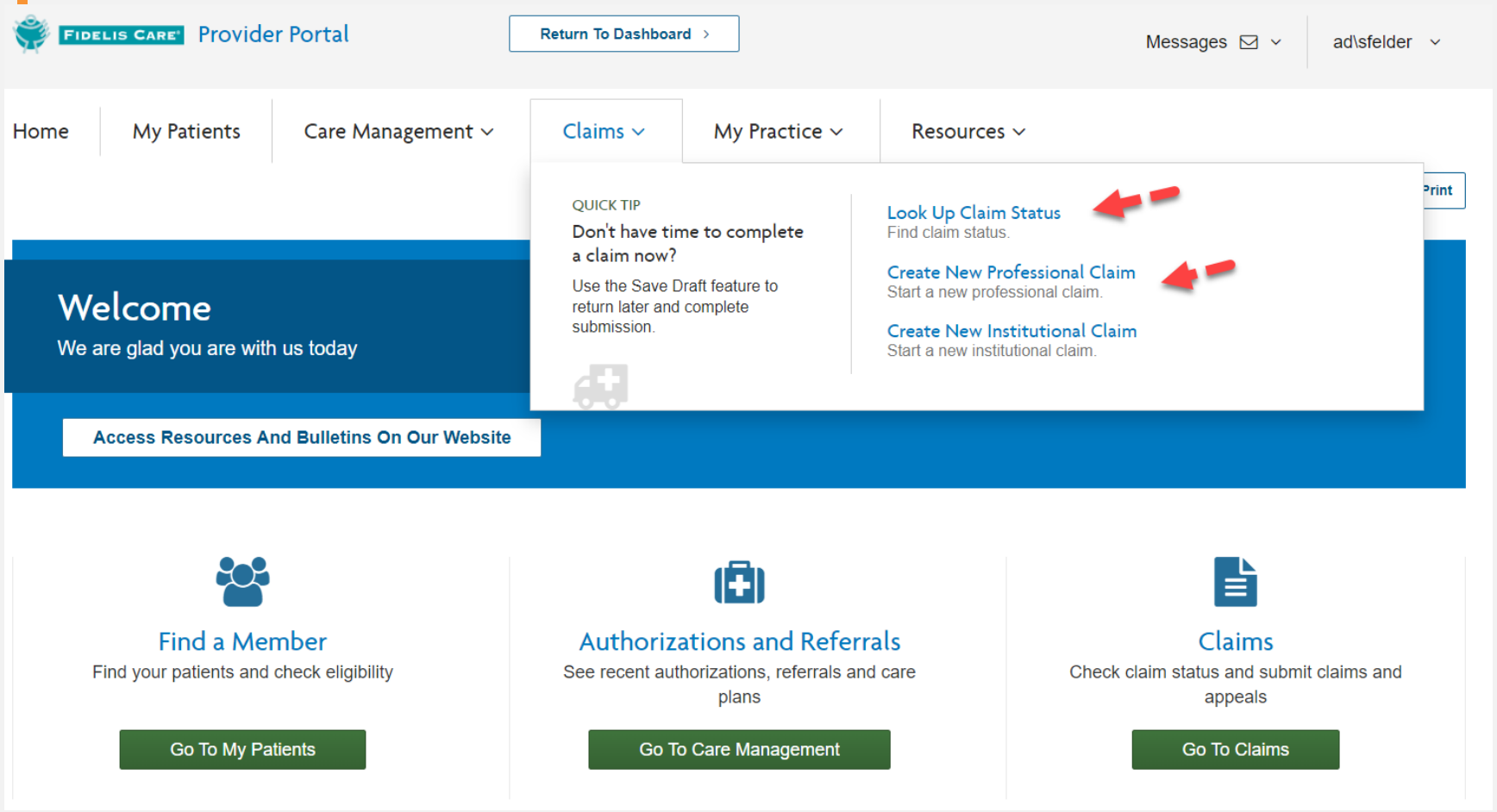
Fidelis Care Portal Process

- If provider does not have a portal login, they can click the “NOT REGISTERED” link as shown above and it will take them to the Sign Up page for the portal.
- Once the page is completed and submitted, they will get an email to verify the email address entered.
- Once this is completed, they will need to reach out to their portal admin (in their office) or their Provider Rep to assign their username to the TIN.

NEW JERSEY HUMAN SERVICES

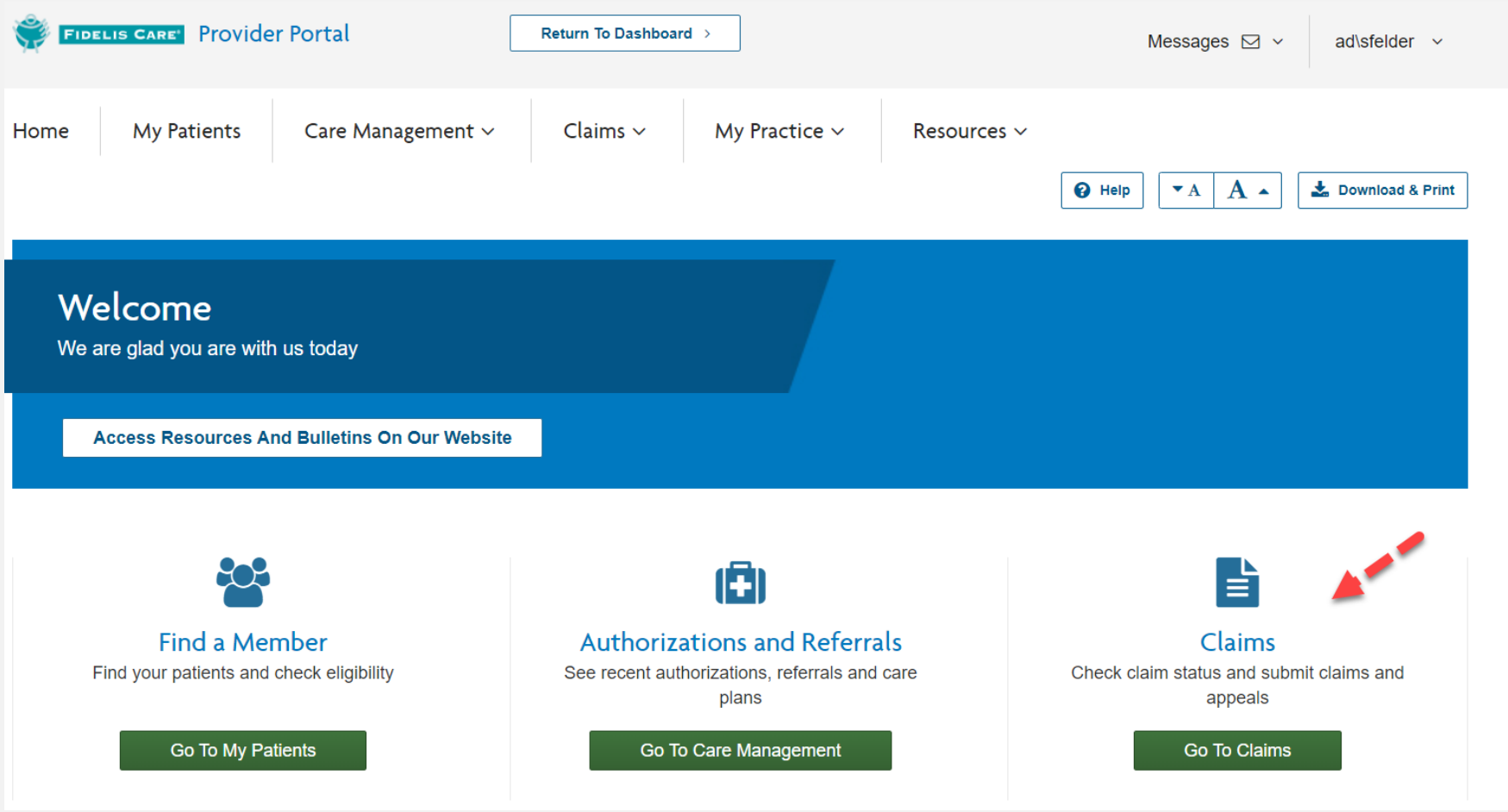
Fidelis Care NJ | Claims Portal

You can Select Claims by hovering over the top tool bar



NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal



Or at the bottom of the home page

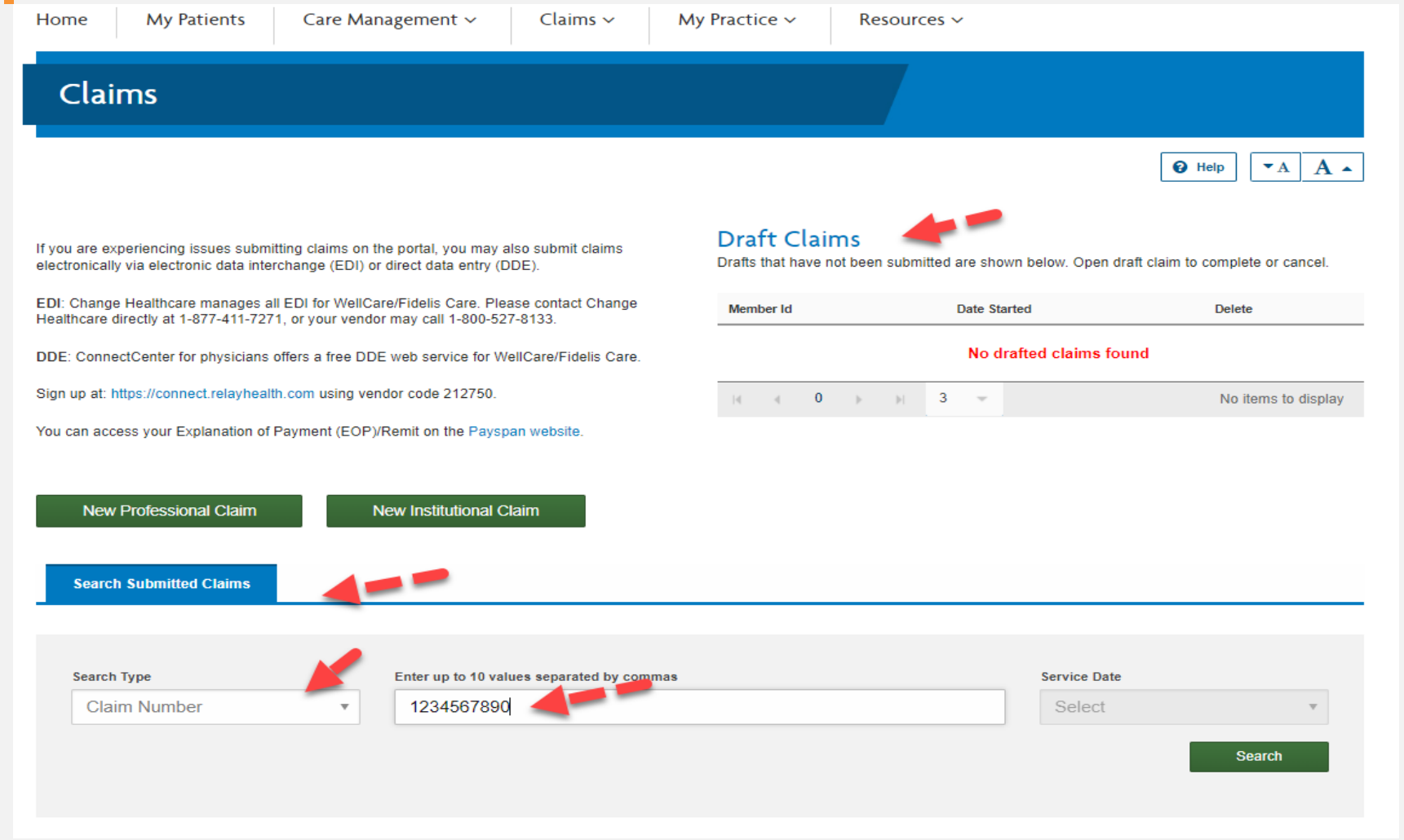
Fidelis Care NJ | Claims Portal

Check claim Status

Use drop down to select Search Type

Search Type Criteria:

- Fidelis Care Claim Numbers are 10 digits long
- You can also search by Member ID and Date of service.



NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal

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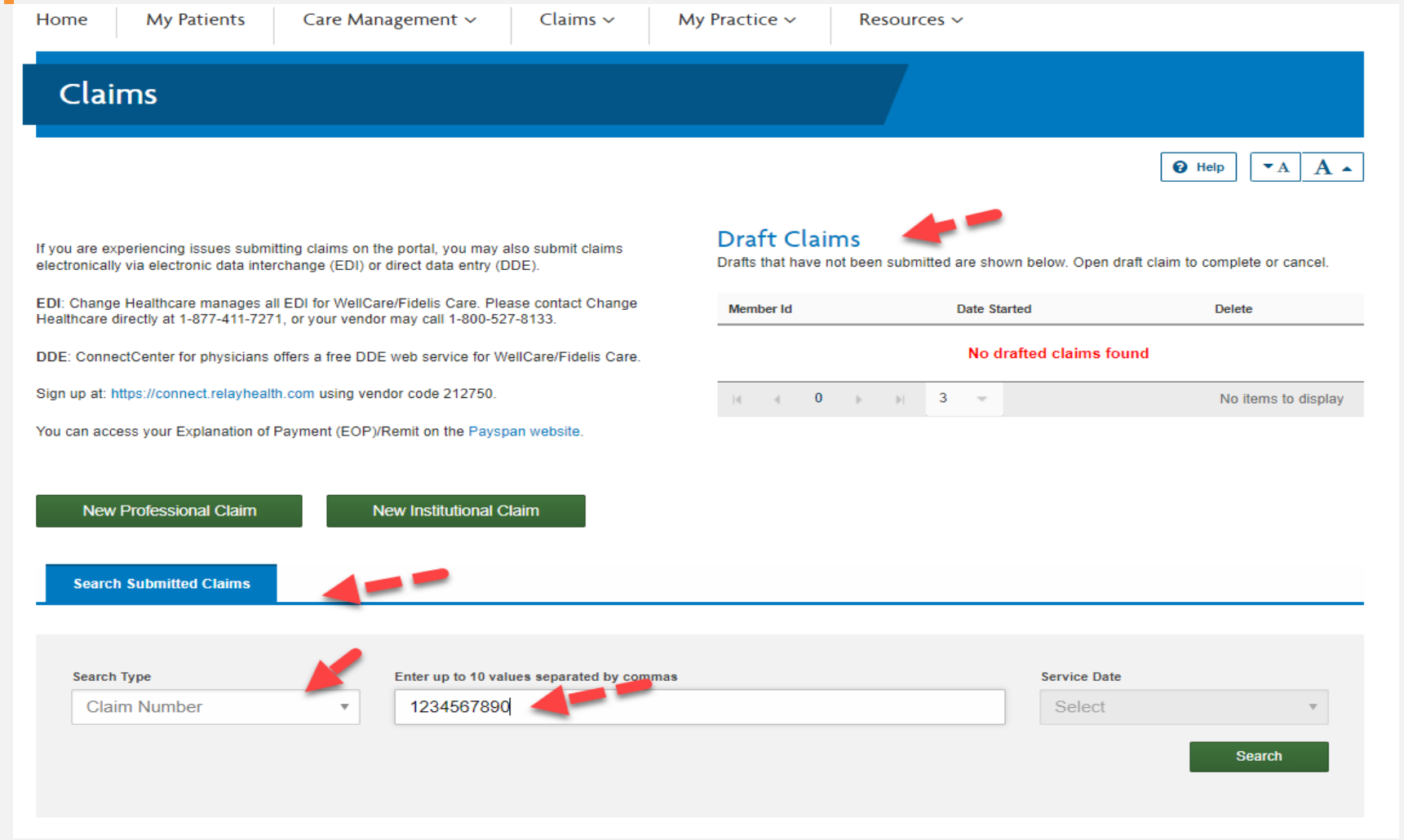
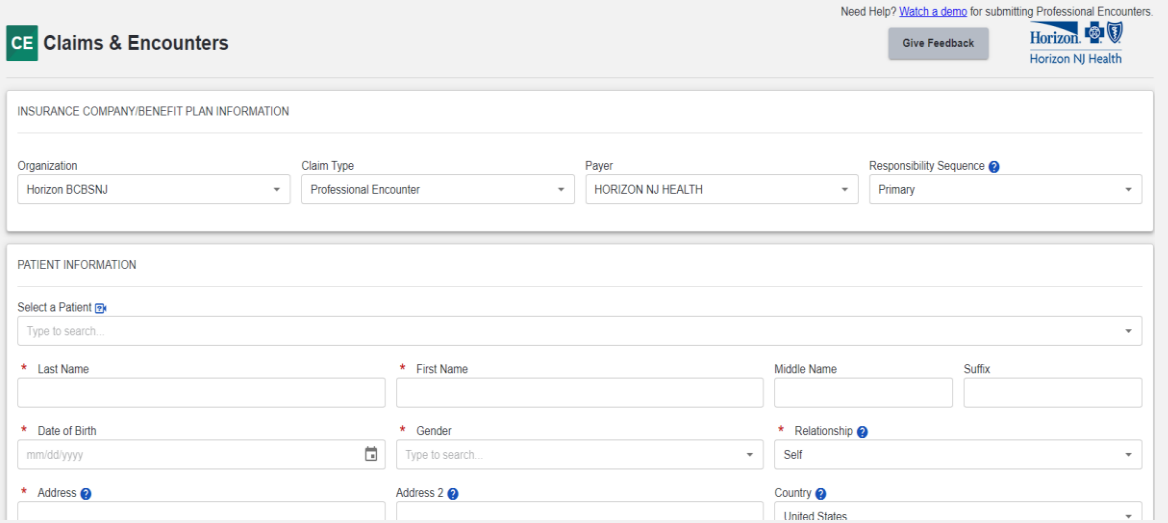


NEW JERSEY HUMAN SERVICES

Horizon NJ Health Claims portal demo

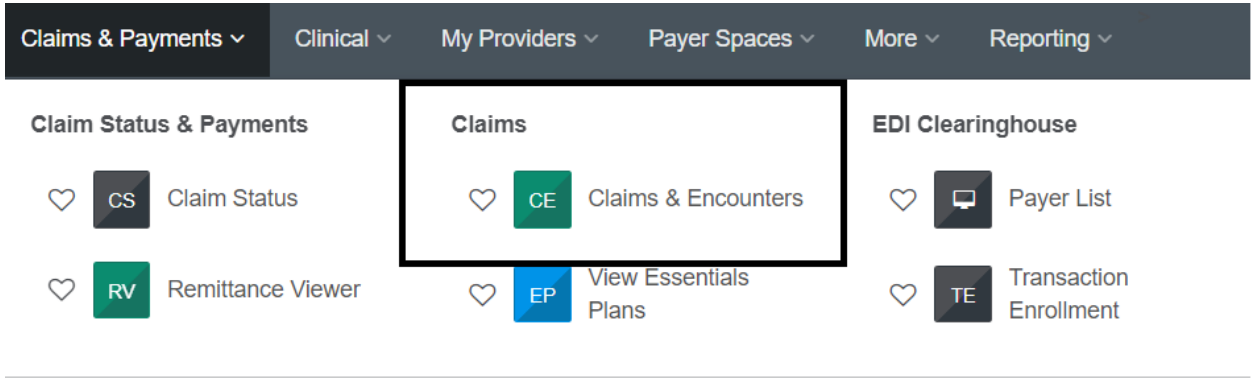


Submit claims using HNJH Portal
https://www.availity.com/

Watch a demo

NEW JERSEY HUMAN SERVICES

Availity Demo

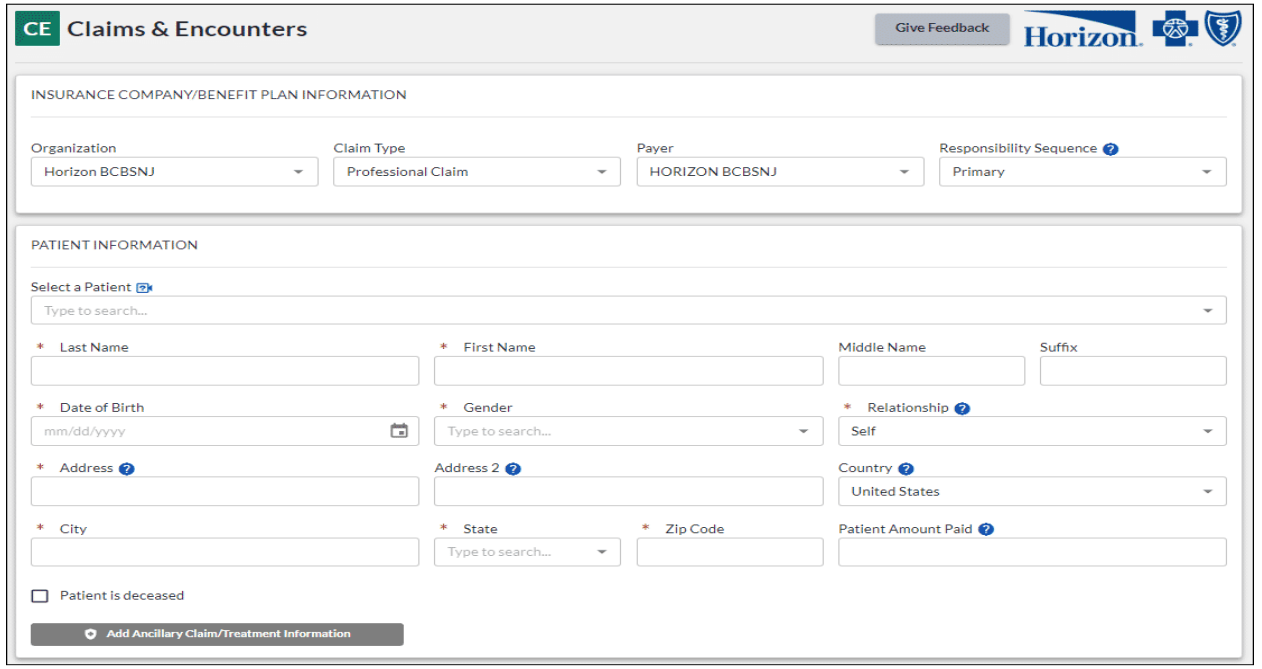


Availity Demo

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.



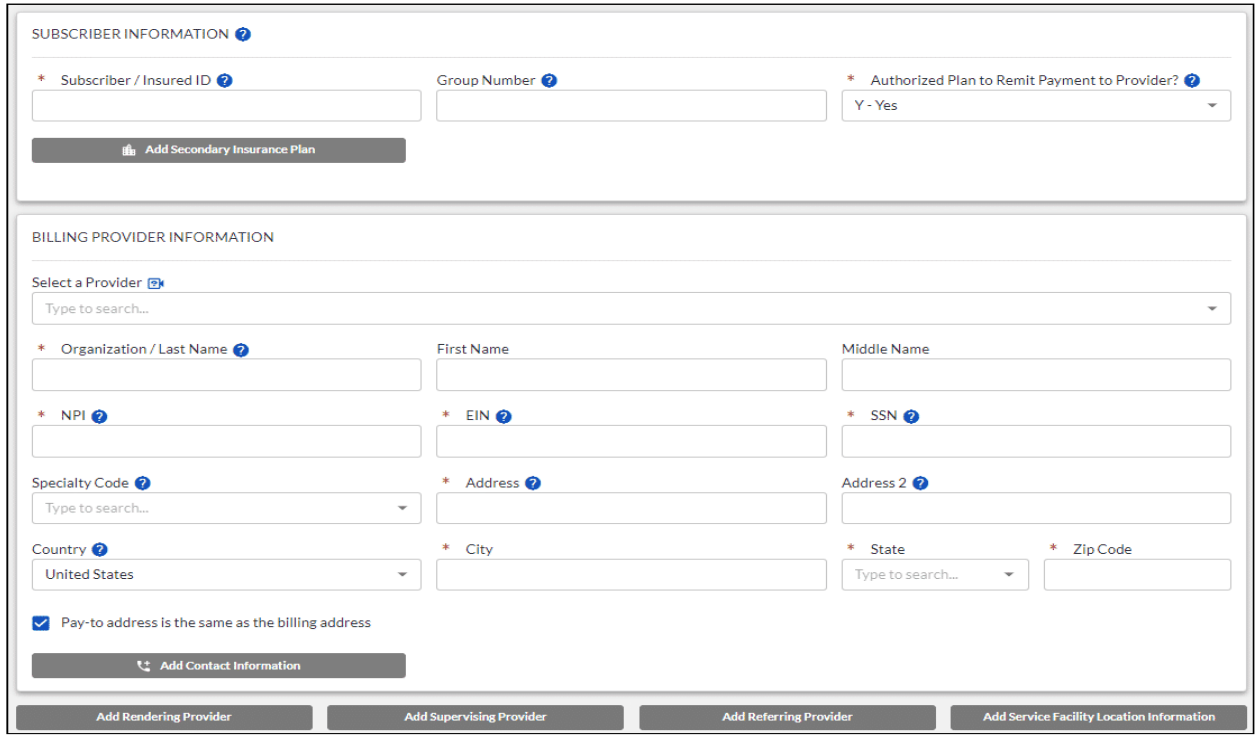
NEW JERSEY HUMAN SERVICES

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 provider's under their organization from the drop down menu. They also have the option of adding rendering, supervising, referring providers as well as servicing facility.



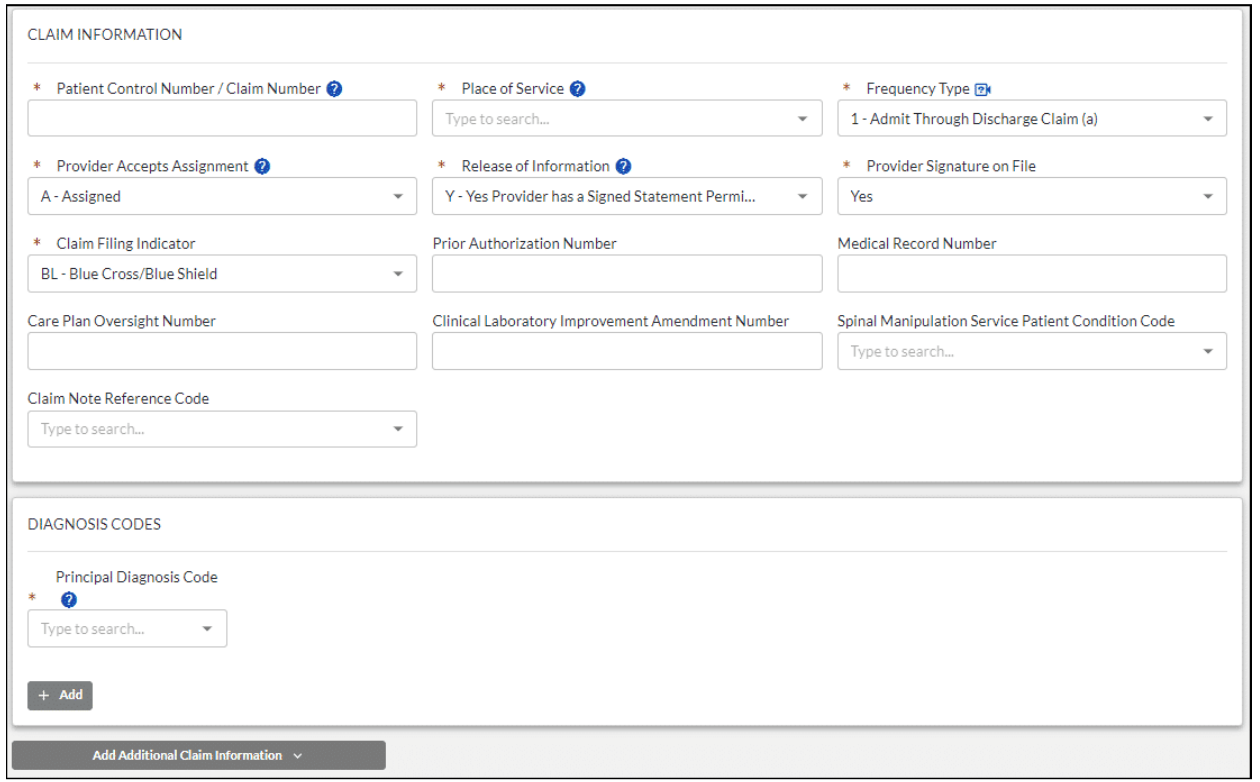
NEW JERSEY HUMAN SERVICES

Availity Demo

Step 3

Claim Information and Diagnosis Codes

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



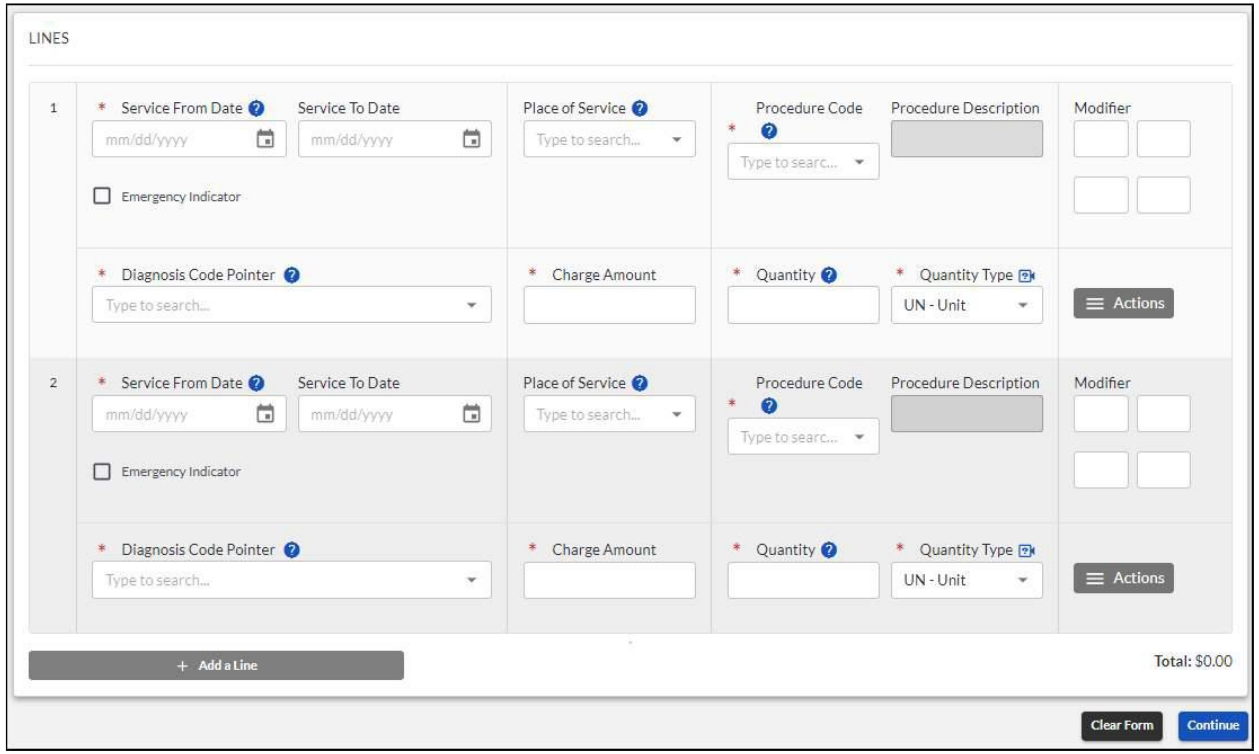
NEW JERSEY HUMAN SERVICES

Availity Demo

Step 4

Line Detail Information

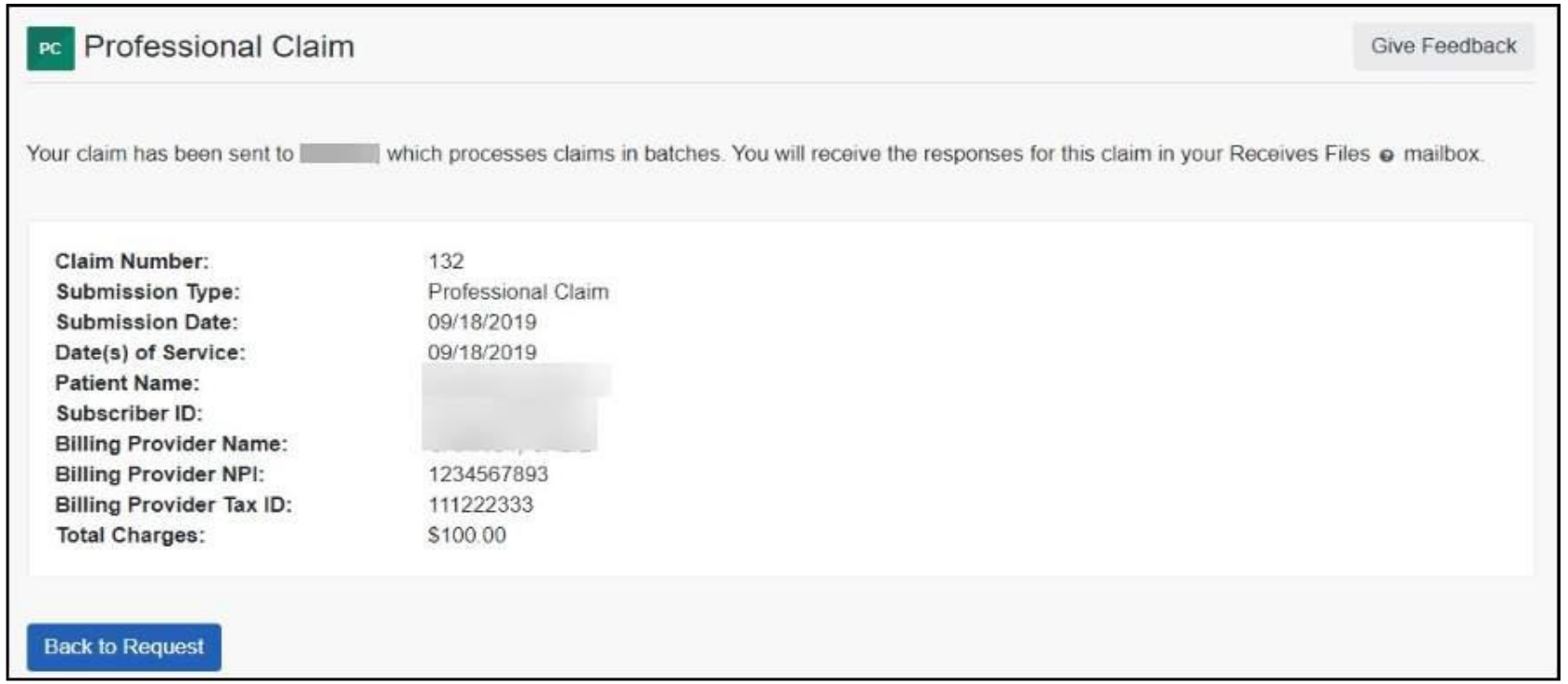
Here the provider will enter the service line information including procedure codes, dates of service, modifiers and charges. When all lines are completed, they can submit their claim.



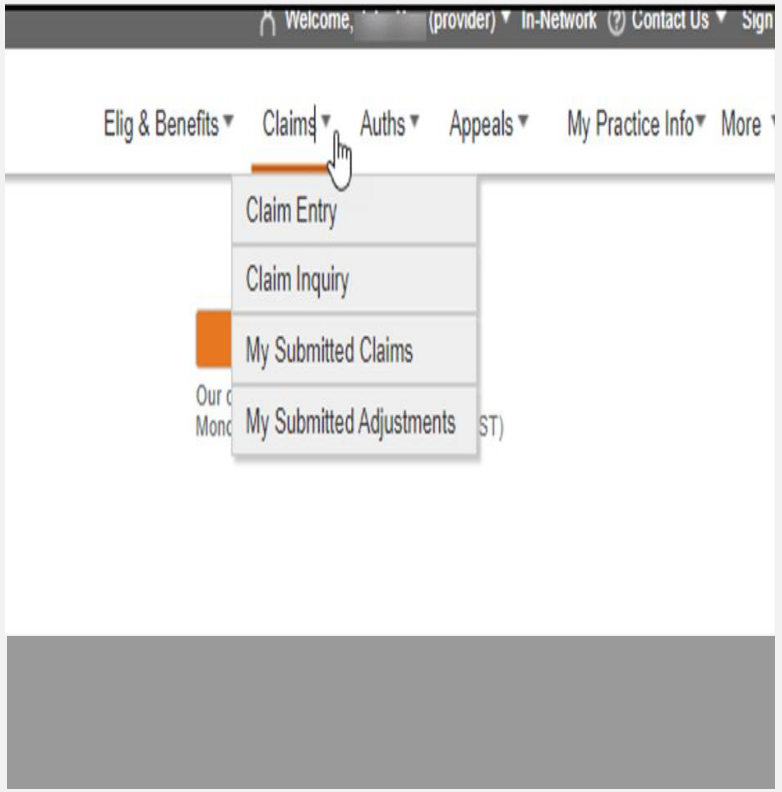
Availity Demo

Results

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



UnitedHealthcare Claims portal demo



Submit claims using Providerexpress.com

[Claim Entry on Provider Express]

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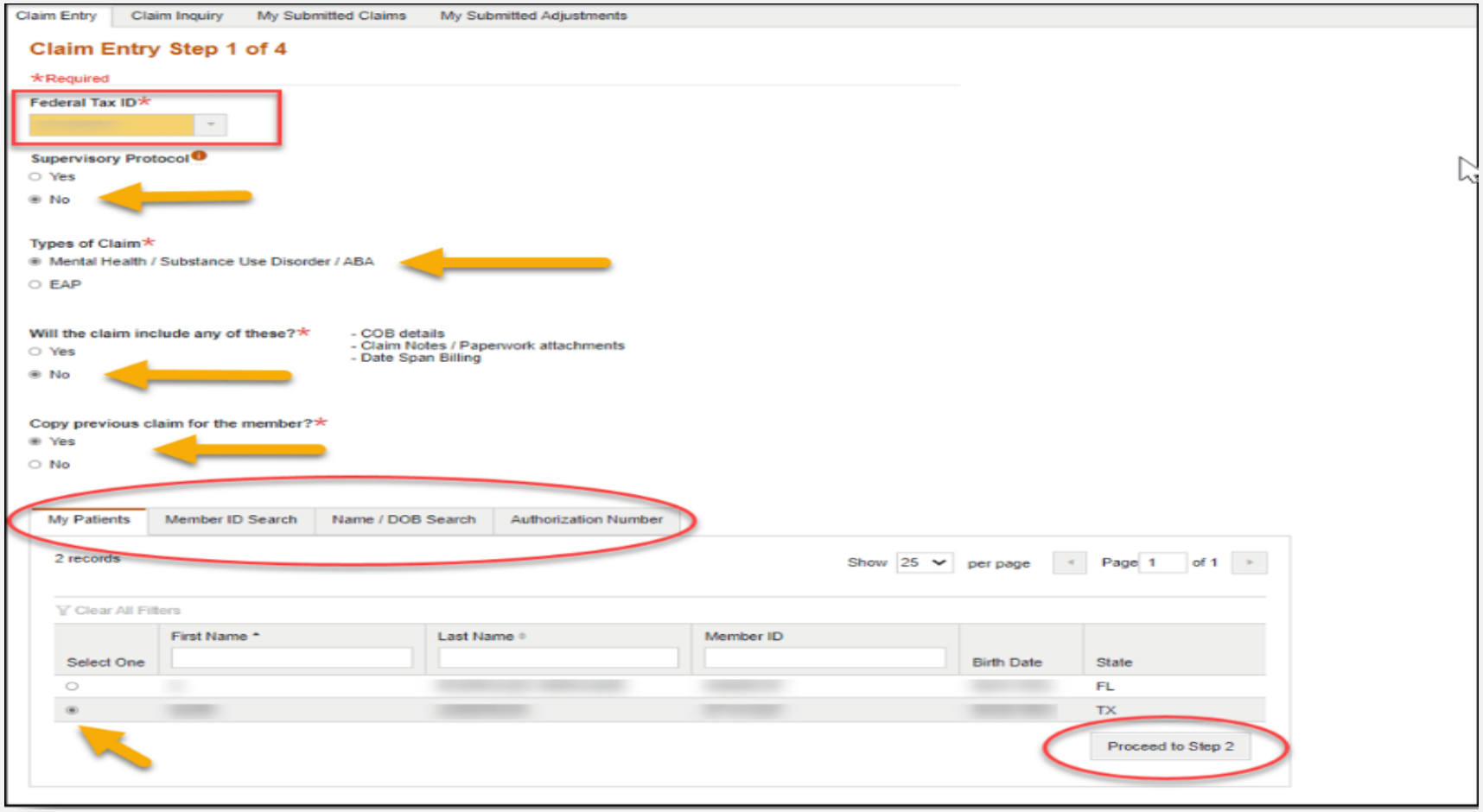
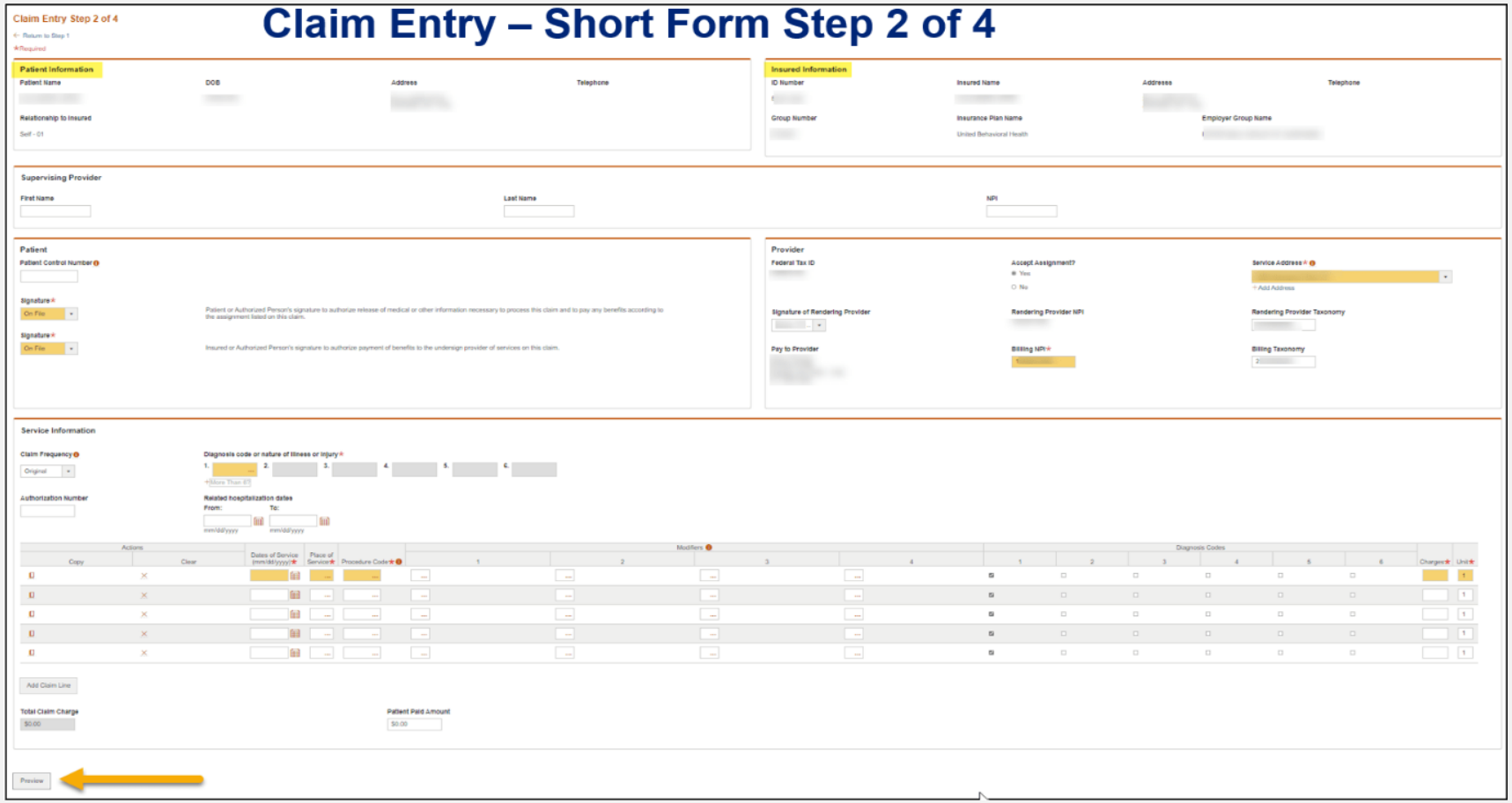
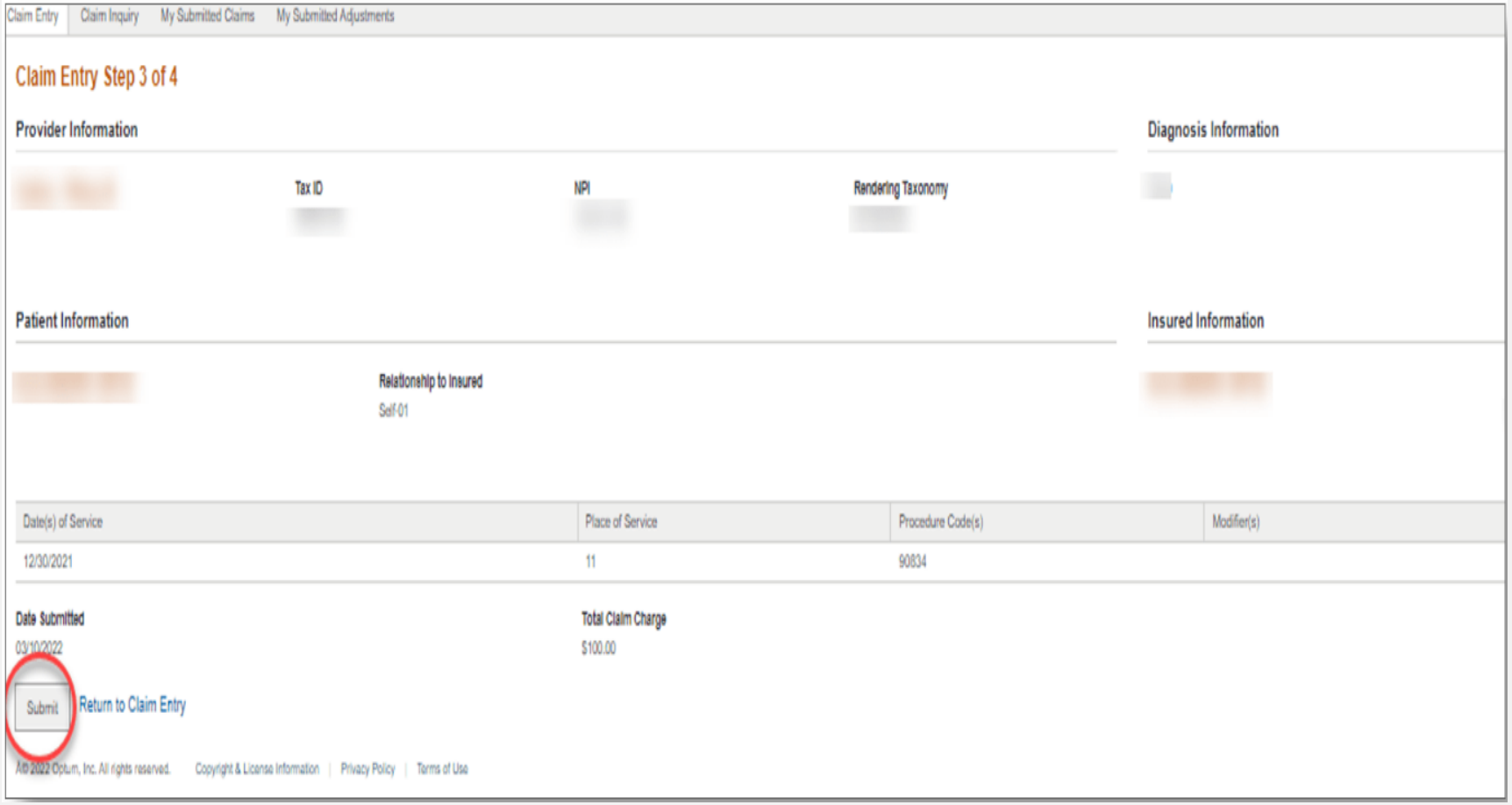
UnitedHealthcare | Claims Portal



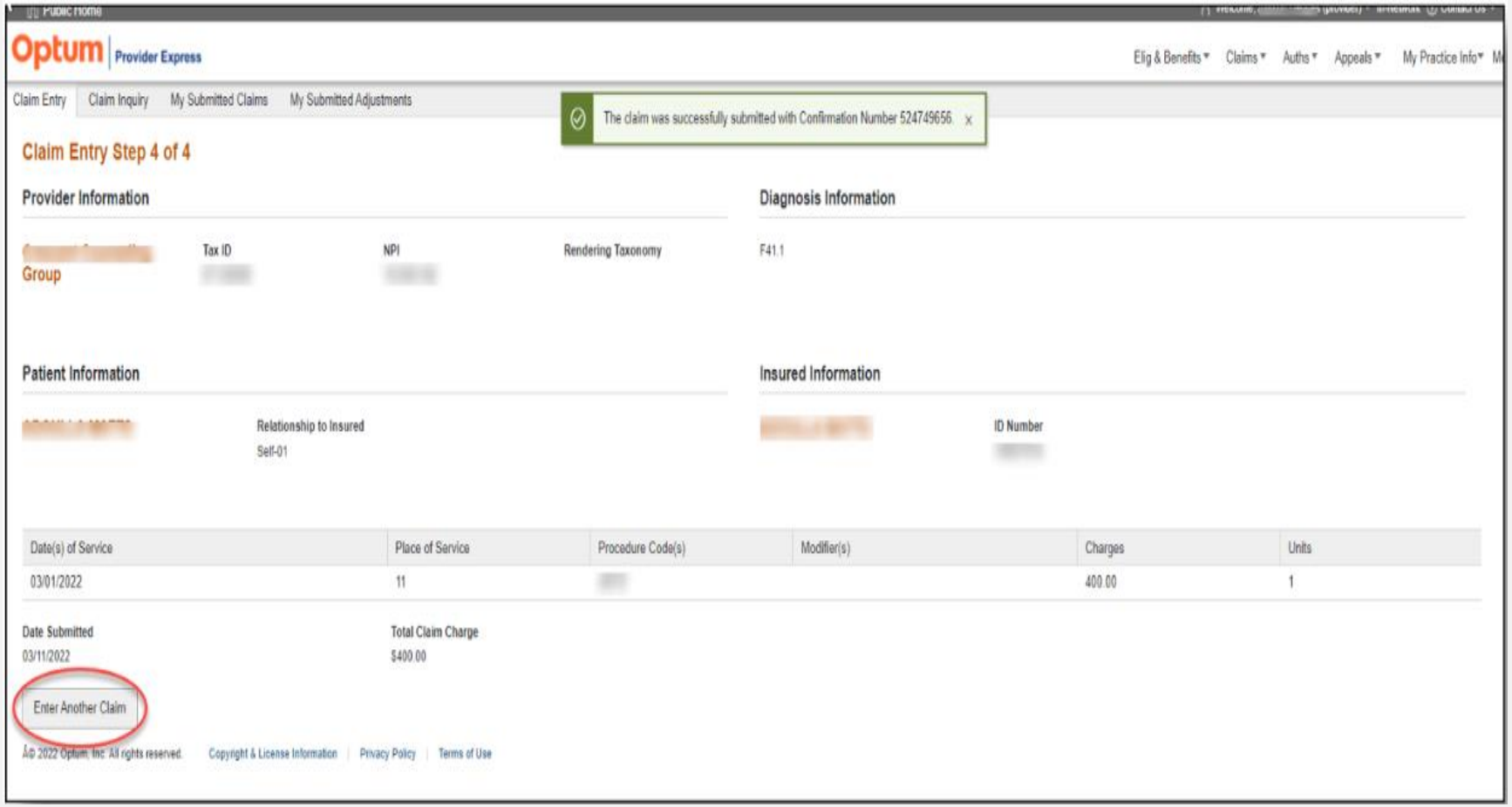
UnitedHealthcare | Claims Portal



UnitedHealthcare | Claims Portal



UnitedHealthcare | Claims Portal



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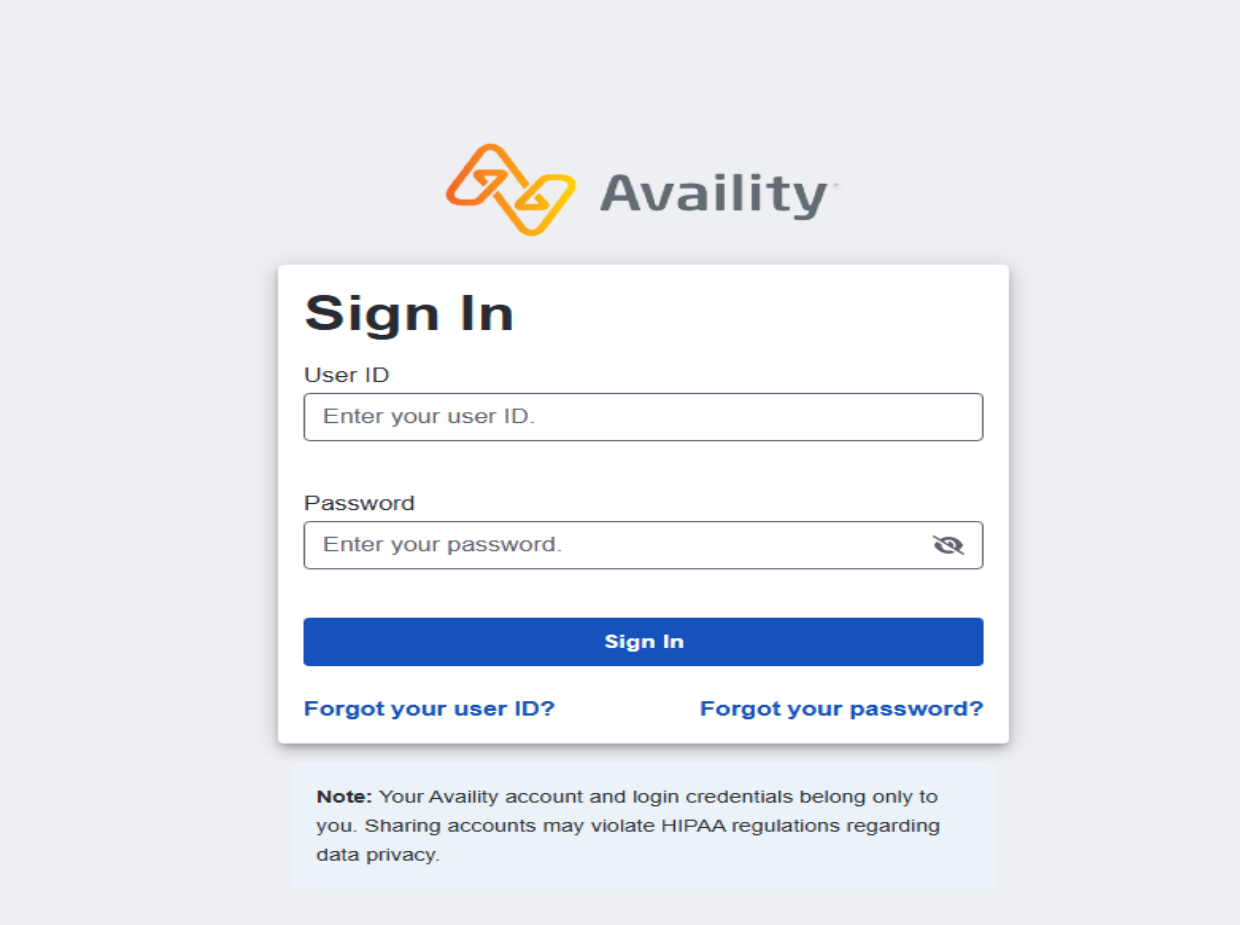
Wellpoint
Claims portal demo

Availity®

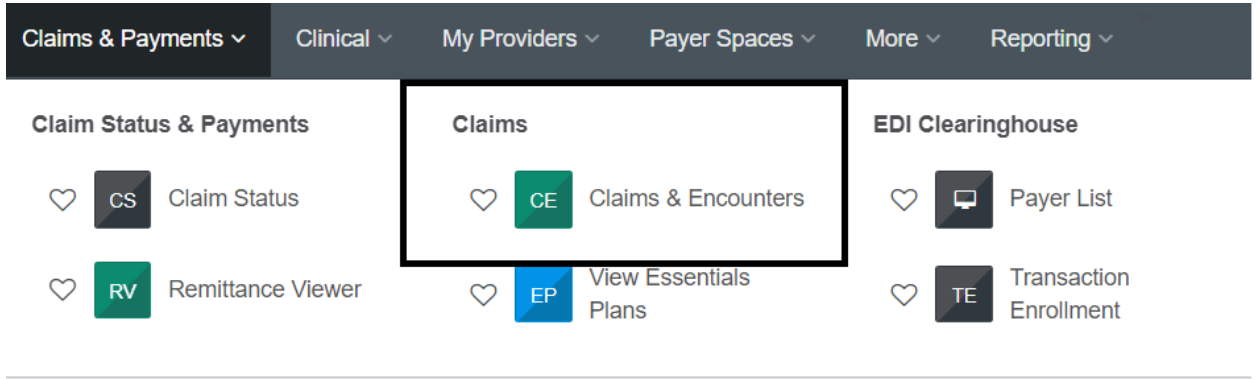
Submit claims using Availity

NEW JERSEY HUMAN SERVICES

Availity Claim Submission – Sign In



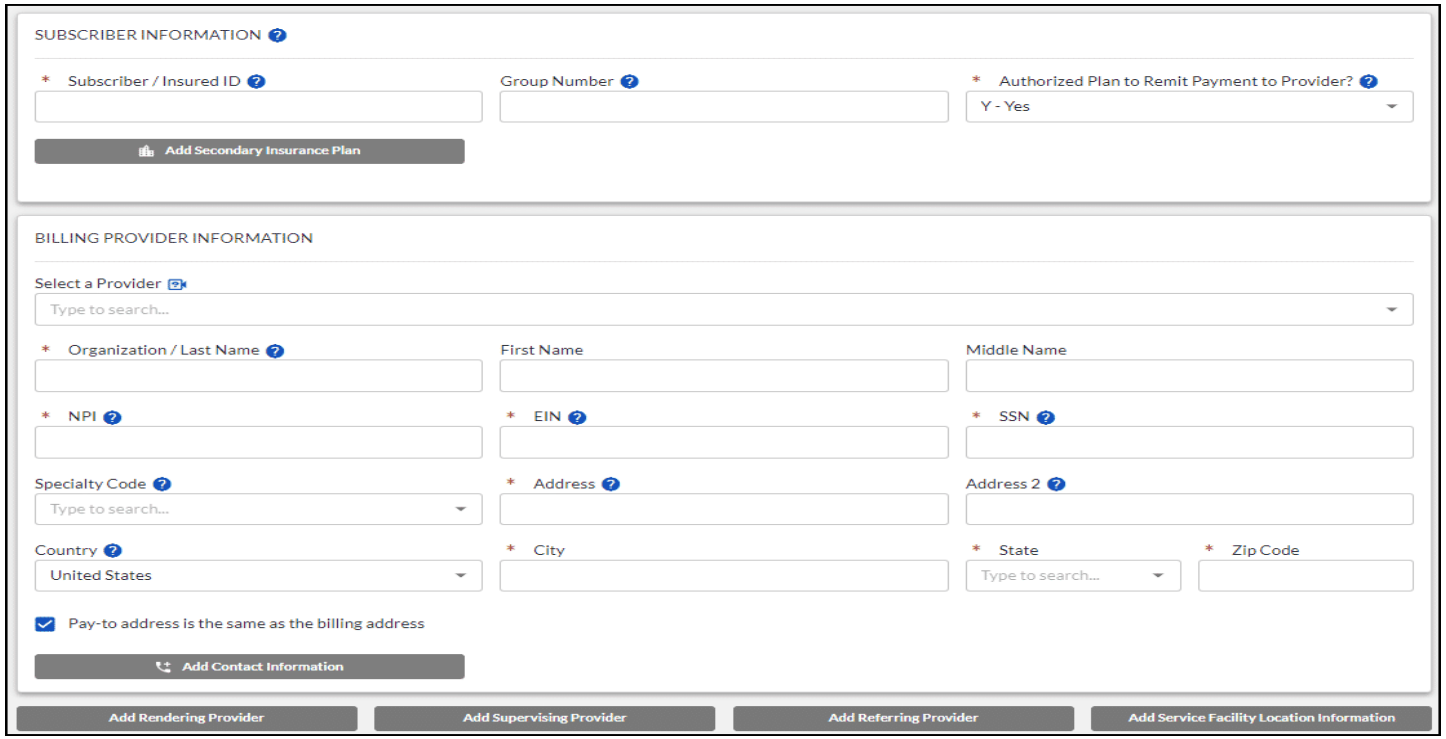
Availity Claims Submission – Select Claims & Encounters



Payer ID: WLPT

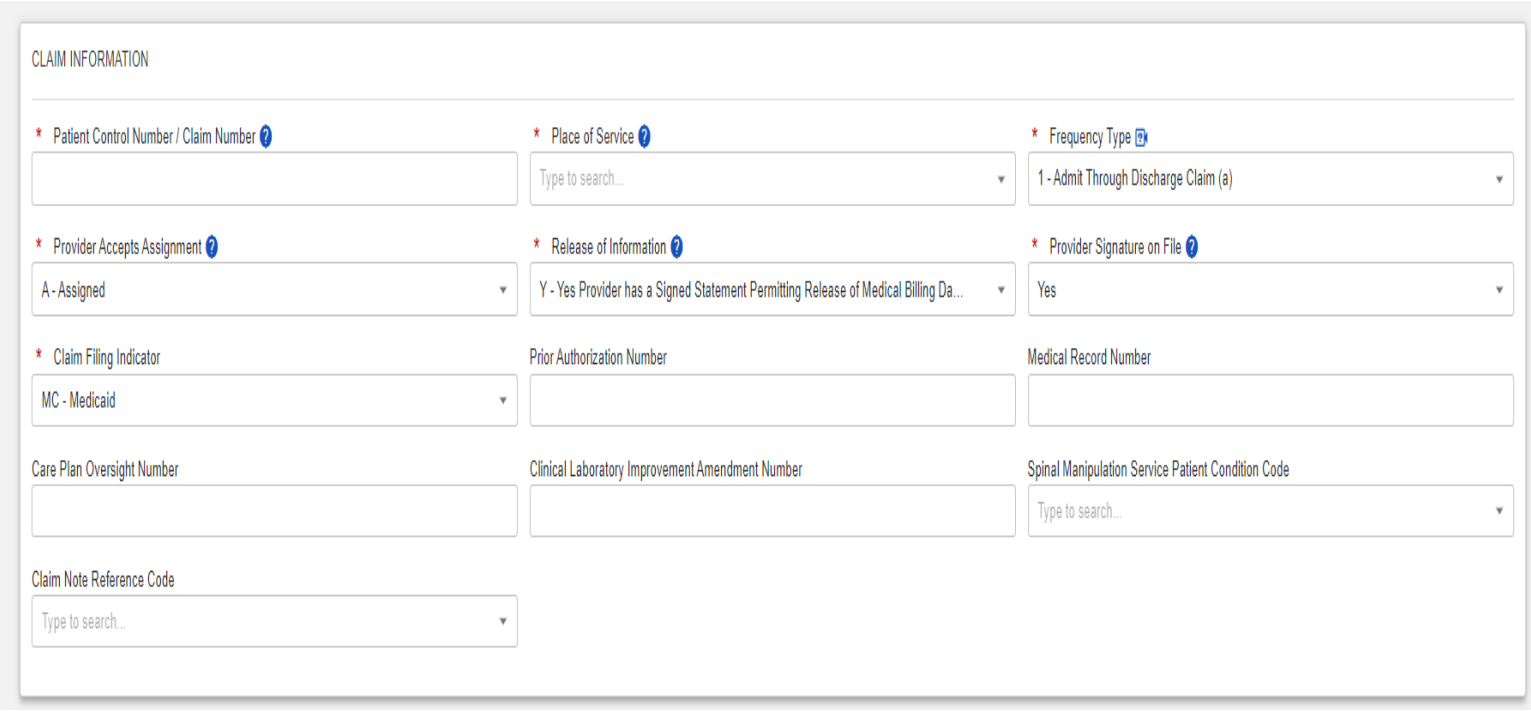
Availity Claims Submission - Input subscriber and provider information

Add 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.



Availity Claims Submission – Input Claim and Diagnosis

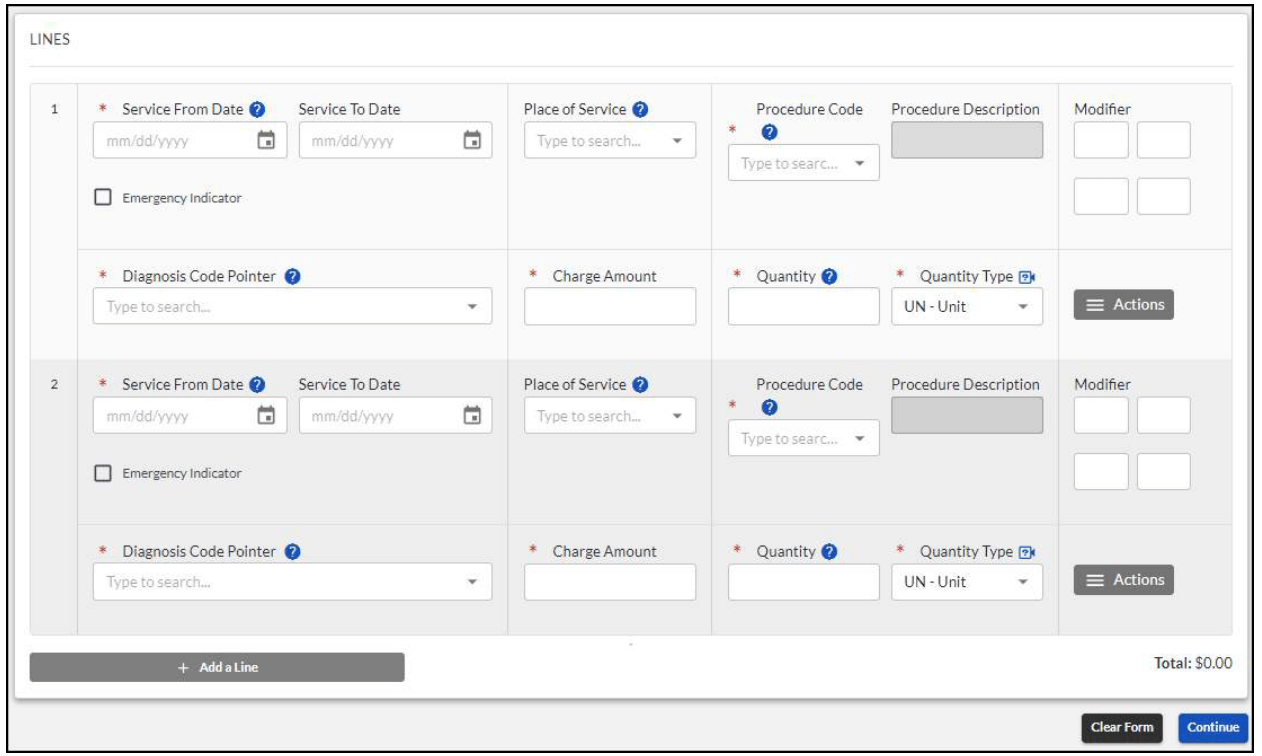
Additional claim information will be entered here. You can see fields for Patient Account Number, Place of Service, Assignment of Benefits, Diagnosis Codes and more.



Availity Claims Submission – Service Line Detail

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.



Availity Tutorials – www.Wellpoint.com (Provider Education and Training)

Claims: How to Submit Claim Disputes with Availity

WEBINAR REPLAY

Learn how to use Availity Essentials Claim Status application to submit a dispute by taking this On- Demand training course. You will be prompted to logon to...

Claims: How to Submit Institutional Claims

COURSE

Learn how to send your organizations UB04 institutional claims using Availity Essentials single claim entry application by taking this On- Demand training.

Claims: How to Submit Professional Claims

COURSE

Learn how to send your organizations CMS-1500 professional claims using Availity Essentials single claim entry application by taking this On- Demand training.

Claims: How to Submit Secondary Claims

COURSE

Learn how to submit secondary medical claims using Availity Essentials. This course covers good basics about (COB) claim entry.

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Availity Tutorials – www.Wellpoint.com (Provider Education and Training)

Administrators: Availity Reference Guide

USER GUIDE

New Availity administrators review this guide to learn how to register your organization and create an account for yourself and users in your organization.

Administrators: How to Manage My Organization

COURSE

Learn how to "Manage My Organization" to update details such as NPI, Tax ID and providers affiliated with your provider organization.

Administrators: Resources and Tips for New Administrators

WEBINAR REPLAY

Listen to this recorded webinar offered on Availity's Learning Center to learn about Admin-specific topics. You will be prompted to log-in to Availity to begin.

Attachments: Dashboard Workflow Options

WEBINAR REPLAY

Learn about the workflows for submitting attachments to participating payers.


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