NEW JERSEY HUMAN SERVICES

In-Person Provider Office Hours

NJ FamilyCare Behavioral Health Integration

JUNE 26, 2025

Agenda

Welcome and introduction Lynda Grajeda, Chief of Managed Care Operations, DMAHS Shanique McGowan Power, BH Program Manager, DMAHS	2:00–2:10
Update on transition period and refresher on key policies Shanique McGowan Power, BH Program Manager, DMAHS Geralyn Molinari, Director, Managed Provider Relations, DMAHS Steve Tunney, Director of Behavioral Health, DMAHS	2:10–2:30
Guided State Q&A and FAQs Geralyn Molinari, Director, Managed Provider Relations, DMAHS Steve Tunney, Director of Behavioral Health, DMAHS	2:30–2:45
Next steps Geralyn Molinari, Director, Managed Provider Relations, DMAHS	2:45–2:50
Open State and MCO tables for Q&A Shanique McGowan Power, BH Program Manager, DMAHS Geralyn Molinari, Director, Managed Provider Relations, DMAHS Steve Tunney, Director of Behavioral Health, DMAHS Aetna, Fidelis Care, Horizon NJ Health, UnitedHealthcare, Wellpoint	2:50–4:00

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Phase 1 of BH Integration went live January 1, 2025 and is taking a phased approach to integrating BH services into managed care

Jan 1, 2025

Phase 1

Outpatient BH Services
(for both 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
  - Ambulatory withdrawal management
  - Peer support services
  - SUD care management
- SUD partial care

TBD but no sooner Jan '26[1]

Phase 2

Residential & Opioid
Treatment Programs

- Adult mental health rehab (AMHR) / MH supervised residential
- SUD short-term residential
- SUD — medically monitored inpatient withdrawal management
- SUD long-term residential
- Opioid treatment programs (OTPs)

TBD[1]

Phase 3

Additional BH services
TBD

- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes (BHHs)
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM):
  - Program of Assertive Community Treatment (PACT)
  - Children's System of Care (CSOC)
  - Intensive Case Management Services (ICMS)

1. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live based on additional analysis and stakeholder input

NJ FamilyCare is integrating BH services under managed care

Goals for NJ FamilyCare BH Integration are…

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

The State implemented a Phase 1 transition period to ease the shift

Key priorities for the transition period include…

- Promote continuity of care for members served by providers not yet contracted with the MCOs
- Provide additional time for MCOs to expand and stabilize provider networks
- Give providers time to learn and practice how to submit prior authorization requests in line with MCO and State guidelines and ensure timely processing of these requests
- Minimize barriers to timely and accurate claims submission and MCO payment to providers

DMAHS is extending transition period flexibilities past June 30, 2025 to ease provider burden

In response to potential member disruptions in care and provider concerns regarding ongoing challenges with claims payments and prior authorization processes, DMAHS is **temporarily extending some of the transition period flexibilities**.

Today, we will cover **how policies will change beginning July 1**. These modified transition period policies will be in effect until further notice. In the meantime, the State will continue to assess readiness to determine an end date for the transition period.

There will be some modifications to each of the Phase 1 transition period policies beginning July 1, 2025

Policy	Jan 1, 2025 to June 30, 2025	Beginning July 1, 2025 to TBD
Automatic approval of PA requests	• Providers **should submit PA requests**, which MCOs are required to **auto-approve** (cannot be denied for lack of medical necessity) • Valid claims for **PA-required services** are **paid even if no PA is on file**	• Providers **must submit PA requests**, which MCOs will review but are required to **auto-approve** • Claims for **PA-required services** will be **denied if no PA is on file**
Payments to out-of-network providers	• MCOs must **pay out-of-network providers** using Medicaid FFS rates as the floor for all claims that: - Are valid (i.e., submitted with **no errors**)	• MCOs must **pay out-of-network providers** using Medicaid FFS rates as the floor for all claims that: - Are valid (i.e., submitted with **no errors)** - Have a **PA on file for a PA-required service** (*out-of-network PA requirements vary by MCO;* ***detail to follow****)*

Detail | PA auto-approval policy will be extended until TBD date; however, claims for PA-required services can be denied if no PA is submitted

Adjudication of valid claims for **MH/SUD Outpatient Counseling and Psychotherapy** services based on PA submission

Scenario	Pre-7/1	Post-7/1
In network provider; no PA on file	Paid	Paid
Out-of-network provider; no PA on file	Paid	Varies by MCO *(Detail to follow)*[1]

Adjudication of valid claims for **MH/SUD Partial Care, MH Partial Hospital, SUD IOP, and SUD Ambulatory Withdrawal Management** services based on PA submission

Scenario	Pre-7/1	Post-7/1
In network provider; no PA on file	Paid	Denied[2]
Out-of-network provider; no PA on file	Paid	Denied

Until further notice, all PAs that are submitted must be auto-approved (i.e., cannot be denied for medical necessity)

1. Aetna and Fidelis would deny claims; Horizon, UnitedHealthcare, and Wellpoint would pay claims; 2. Horizon would pay claim for ambulatory withdrawal management as MCO does not require PA for this service

CHANGE

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Four key steps in managed care prior authorization

1. Determine when PA is required
2. Submit PA request
3. MCO processes PA request
4. Dispute and/or appeal PA decision

- For which services is PA required vs. not required?

- Where do I submit my PA request?
- What are the required fields / information I must submit?

- How long will it take to process my PA request? (i.e., turnaround time)
- How long will my PA last, if approved? (i.e., authorization duration)

- My PA got denied. What can I do?
- Who can I contact to help me?

- ***Information covered in live State presentation***
- ***More information in previous training materials***

Prior Auth | Phase 1 PA submission requirements for in-network and out-of-network providers by MCO beginning July 1, 2025

✓ - PA required for service

	Aetna		Fidelis Care		Horizon NJ Health		UnitedHealthcare		Wellpoint	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network[1]	In-network	Out-of-network	In-network	Out-of-network
MH / SUD partial care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MH partial hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD intensive outpatient	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD ambulatory withdrawal management	✓	✓	✓	✓		✓	✓	✓	✓	✓
MH / SUD outpatient counselling and psychotherapy		✓		✓						

Claims will be denied for providers who **do not follow these requirements**

1. For Horizon: Out-of-network providers who use the HF and UC modifiers or are a nurse psychiatry, psychiatry, child psychiatry, or neurology specialty type do not need to submit PAs for evaluation and management (E&M) service codes; all other out-of-network providers (e.g., primary care physicians) must submit a PA for these E&M codes

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Prior Auth | Where to submit MH and SUD PA requests

MH PA requests

Preferred method: Submit to each MCO via their provider portal

- Provider enters the required PA information into the platform and attaches any necessary documentation — *MCO portal demos in Appendix*
- Once submitted, PA requests are sent directly to MCO, who will review and communicate approval decision via portal, fax, phone, or mail

Other ways to submit a request: All MCOs have a phone submission option and 4 of 5 have a fax[1] submission option

- *Contact information and submission instructions in Appendix*

For members with presumptive eligibility and those without an active MCO, MH PA gets submitted to the county Medical Assistance Customer Centers (MACC) offices

SUD PA requests

All SUD PA requests for adult and youth must be submitted to MCOs via **NJSAMS**

- Provider enters the required PA information into NJSAMS
- Provider submits and sends information to MCO electronically in real time
- MCO will receive 3 PDF reports (i.e., admission, LOCI, DSM-5 reports)
- MCO reviews and enters PA information into their PA system
- MCO communicates to provider external to NJSAMS (e.g., via MCO PA portal or call/fax) the authorization decision or if additional information is needed

1. UnitedHealthcare does not have a fax submission option

Prior Auth | Required fields for complete MH PA request

Category	Required fields
General information	• Non-urgent vs. urgent (& clinical reason for urgency) • Type of request (initial vs. extension, renewal, or amendment)
Patient information	• Name, phone #/address, DOB, member ID and Medicaid #
Provider information	• For both requesting provider/facility and servicing provider or facility: - Name, NPI, Specialty, Contact info (phone, address, email), TIN - PAR vs. OON - **Fax number**
Services requested	• Plan of care • CPT or HCPCS code(s) and units • MH treatment requested with frequency / length, start / end date • Diagnosis description (ICD) & code • Checkmark for level of care required
Clinical documentation	• Brief clinical history • Present clinical status (incl. presenting symptoms, medications used/medication plan) • Risk of harm to self or others • Criteria / level of care utilized in past 12 months • Discharge plan (incl. planned discharge level of care, barriers to discharge, expected discharge date)

Field not required but strongly encouraged by MCOs

DMAHS has established a policy requiring MCOs to standardize these fields as the minimum necessary fields for a complete PA request

MCOs may request additional information or fields but a PA request will be deemed complete for turnaround time tracking as long as these required fields are accurately submitted

Prior Auth | Required fields for complete SUD PA request in NJSAMS

Category	Fields required
Patient information	• Name, phone #/address, DOB, member Medicaid #, SSN/citizenship • Admission date and site location
Provider information	• Provider Name • Provider Medicaid #
Clinical information	• **Admission report:** - Agency / Facility Type 2 NPI # - Patient demographic information - Details on living arrangement, household, employment, income, legal status - Details on current substance use - Level of care indicated / recommended, discharge plan, recommendations / clinical justifications, medications planned - Comment section to **include medication history option**
	• **LOCI report** to assess appropriate level of care for patients across: - Provider telephone and / or **fax number** - Acute Intoxication/Withdrawal - Biomedical conditions/complications - Emotional, behavioral, or cognitive conditions and complications - Readiness to change - Relapse, continued use, or continued problem potential - Recovery environment • Level of care indicated / recommended, discharge plan, recommendations / clinical justifications, medications planned
	• **DSM-5 report**, specifying how a member meets criteria for 1+ of 12 SUD DSM diagnoses with special notation section to include **last date of substance use**, includes CIWA and COWS

Field not required in NJSAMS but required by MCOs

Prior Auth | Maximum turnaround time of a PA request for managed care covered services depends on urgency designation

Some services are always urgent, and others depend on admission method or provider / MCO discretion

	Always urgent	Can be urgent *if referred from inpatient, residential, or ER screening*
MH	• Acute partial hospital (APH) • Inpatient psychiatric hospital care	• Partial hospital (PH) • Partial care (PC) • Adult mental health rehabilitation (AMHR)
SUD	• Ambulatory withdrawal management (AWM) • Intensive outpatient (IOP) • Inpatient medical detoxification • Residential detoxification / withdrawal management (ASAM 3.7 WM) • Short term residential	• Partial care (PC) • Long term residential

Previously integrated
Phase 1 service
Phase 2 service

Any service can additionally be classified as urgent by provider / MCO discretion

Maximum turnaround times

Urgent services:

- **24 hours**
- If PA request is incomplete, MCO must request additional information within 24 hours of PA receipt
  - Clock resets upon MCO receipt of updated PA, with decision to be rendered within **24 hours**
  - TAT time from receipt of original PA within **72 hours**

Non-urgent services:

- **7 calendar days**

Prior Auth | Minimum initial authorization duration

DMAHS has worked with MCOs to set **minimum initial authorization durations** for certain BH services to ensure that members receive care for an appropriate amount of time and to give providers sufficient time to develop and implement a treatment plan

Service	**Minimum** Initial Authorization Duration[1]
MH Acute Partial Hospital and Partial Hospital	14 days
MH Partial Care	14 days
SUD Partial Care and IOP	30 days
Ambulatory Withdrawal Management	Automatically approved for 5 days
Short Term Residential *(Phase 2 service)*	14 days
Long Term Residential *(Phase 2 service)*	60 days

After the initial authorization, MCOs may set different durations at their discretion based on member needs

1. These are required minimums. MCOs can grant longer durations based on member needs at MCO's discretion

While transition flexibilities are extended, it is still important for you to join MCO networks...

We encourage you to credential and contract with all 5 MCOs so that post transition period, you ensure that:

1. Your members have adequate **access** and do not experience disruptions in their care
2. You receive the **FFS reimbursement rate**
3. You only have to submit **prior authorization** requests for the BH services that require them

All MCOs are required to process complete credentialing applications within 60 days of submission

Note: If you are an out-of-network (OON) provider, requirements may vary by MCO. You are encouraged to coordinate with each MCO to understand specific expectations

…and learn how to submit high-quality PA requests

MCOs are required to hold **weekly office hours during July** to field PA inquiries and help providers submit correct PAs in line with MCO and State guidelines to ensure readiness for when the transition period auto-approval policy ends

Providers are encouraged to **join these sessions** and **outreach to MCO representatives** with any questions on PA processes and standards

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Credentialing and contracting | Frequently asked questions

Do all individual practitioners need to credential?

- For **independent practitioners and group practices:**
  - All MCOs require each practitioner in a private or group practice to **individually credential** using their Type 1 NPI
  - Some MCOs may require each licensed practitioner in a group practice to be listed on a **group roster** to associate the individual with the practice for billing
- For **licensed facilities and agencies**:
  - **Some MCOs** allow for licensed facilities or agencies to **credential as an entity** using the Type 2 NPI, while others **require each practitioner to credential individually** under their entity
  - Some MCOs may require each practitioner to be listed on a **facility / agency roster**
- **Please refer questions to MCOs to confirm specific requirements**

Where can providers find information on what services (and service codes) are a part of BH Integration Phase 1 and the rates MCOs should pay?

- Providers can find the **BH Integration Phase 1 service codes and rate schedule** on the NJMMIS website. This document displays the service codes of services carved in Phase 1 and the floor rates that MCOs are required to pay providers at a minimum
- To access this document:
  - Go to the NJMMIS website
  - Click on “Rate and Code Information” using the left-hand navigation
  - Find the “Procedure Code Listings” section, and then click “CY 2025” for “Procedure Master Listing - MCO Behavioral Health Integration”
- Providers should **check this document periodically** as Medicaid rates update over time

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Network | If you have questions about contracting, credentialing, or single case agreements issues, please contact the MCO's network representatives

Payer	Network contact information

Aetna	• **Emails (based on county):**
	  - AcamporaD@aetna.com: Atlantic, Monmouth, Ocean
	  - susan.richards3@aetna.com: Bergen, Essex, Hudson
	  - Gregory.Emmanuel@aetna.com: Burlington, Camden, Cape May, Cumberland, Gloucester, Salem
	  - sanchezl7@aetna.com: Hunterdon, Morris, Passaic, Sussex, Warren
	  - Rosanna.Placencia@aetna.com: Mercer, Middlesex, Somerset, Union
	  - Katelyn.Mignone@Aetna.com
	• **Phone:** 1-855-232-3596
	  - Press * for healthcare provider. Follow prompts for customer service needs.

Fidelis Care	• **Email:** evelyn.mora@fideliscarenj.com or Michael.Czajkowski@fideliscarenj.com • **Phone:** 1-908-415-3101
Horizon NJ Health	• **Email:** BHMedicaid_@horizonblue.com
UnitedHealthcare	• **Email:** njnetworkmanagement@optum.com
Wellpoint	• **Email:** provider.relations.NJ@carelon.com • **Phone:** 1-800-397-1630

Prior Auth | Frequently asked questions

For each MCO, what service codes should providers request on MH PAs for acute partial hospital (APH), partial hospital program (PHP), and partial care?

- **Aetna:**
  - **APH:** REV code **913** with **1 hour** for units of service
  - **PHP:** REV code **912** with **1 hour** for units of service
- **Fidelis Care and Wellpoint:**
  - **APH:** REV code **913** with Procedure code **H0035**
  - **PHP:** REV code **912** with Procedure code **H0035**
- **Horizon**
  - **APH:** REV code **913** (can be submitted with Procedure code **H0035**)
  - **PHP:** REV code **912** (can be submitted with Procedure code **H0035**
- **UnitedHealthcare**
  - **APH:** REV code **913**
  - **PHP:** REV code **912** for adults (18+), REV code **913** for youth (under 18)
- For **all MCOs**, providers should request HCPC code **H0035** for **partial care**

Where can providers find the PA decision after submitting a SUD PA request in NJSAMS?

- PA decisions for SUD PA requests will be communicated external to the NJSAMS system within the required turnaround time
- **Aetna, Fidelis Care, and Wellpoint:** Communicate SUD PA decisions via fax or phone call
- **Horizon:** Communicate SUD PA decisions via their provider portal, fax, or phone call
- **UnitedHealthcare:** Communicate SUD PA decisions via their provider portal or phone call

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Claims | Frequently asked questions

We continue to receive questions from providers regarding the **appropriate billing forms** to use for submitting claims and the **correct NPI numbers** to enter in the various fields of these forms.

To answer these inquiries, the State has included **slides in the appendix** of this presentation, which outline **guidance on selecting the correct billing form** and include **MCO-specific instructions on which NPI numbers should be used** in the billing, rendering, attending, and operating provider fields.

Today's presentation, including the appendix slides, will be posted on the **BH Integration Stakeholder Information website**. Providers should also **reach out directly to each MCO to confirm specific guidance**.

Claims | Providers should follow each of the MCO's MH partial care transportation billing instructions to reduce potential claim denials

Payer	Accepted codes	Dependencies
Aetna	• Z0330 • A0090 **UC** • A0120 **UC** • A0425 UC — must be submitted with A0090 UC, A0120 UC, or Z0330	PC Transportation claims must be **billed for the same date of service** as a submitted H0035 UC claim
Fidelis Care	• Z0330 • A0120 UC • A0425 UC — must be submitted with Z0330 or A0120 UC	
Wellpoint	• A0120 UC • A0425 UC — must be submitted with A0120 UC	
Horizon	• A0120 UC — replaced z-code, can be backdated to any date of service since 1/1/25 • A0425 UC	
UnitedHealthcare	• Z0330 • A0120 UC • A0425 UC — must be submitted with Z0330 or A0120 UC	

Providers should **bill for 2 units of MH PC transportation on the same claim** if a member is transported both **to and from** the place of service

*Providers can find this guidance in the **MCO MH Partial Care Transportation Billing 1-pager** on the BHI Stakeholder Information website*

Claims | If you are running into any claims issues, please contact the MCO

Payer	Claims contact information
Aetna	• **Email:** Katelyn.Mignone@Aetna.com • **Phone:** 1-855-232-3596 - Press * for healthcare provider. Follow prompts for customer service needs.
Fidelis Care	• **Email:** FidelisCareNJ_BHClaimInquiry@fideliscarenj.com
Horizon	• **Email:** BHMedicaid_@horizonblue.com • **Phone:** 1-800-682-9091
UnitedHealthcare	• **Email:** njproviderescalation@optum.com - After reaching out, providers will be prompted to submit the *UHC BH New Jersey Provider Claim Template* for claims research to begin
Wellpoint	• **Visit** www.Availity.com to submit claims appeals • **Phone:** 1-800-454-3730 for Provider Services

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[1]

The BHI stakeholder website has the following materials for providers and additional resources:

- Provider guidance packet – updated!
- Prior DMAHS training materials and recordings
- Additional resources with information on program processes

https://www.nj.gov/humanservices/dmhas/information/stakeholder/

Member's Managed Care Organization

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

Aetna **Fidelis Care** **Horizon NJ Health**

UnitedHealthcare **Wellpoint**

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

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder/

Access key BH Integration resources on the stakeholder information website

Behavioral Health Integration Stakeholder Information website

https://www.nj.gov/humanservices/dmhas/information/stakeholder/

- Provider Guidance Packet
- Prior Authorization Refresher Training materials
- Prior Authorization Training materials
- MCO-led Integrated Care Management Training materials
- DMAHS BH Integration Points of Contact Document

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Appendix

Prior Auth | Right to appeal and request continuation of benefits

Step 0: Receive PA decision letter

If an initial or extension authorization is denied, members and providers will receive a letter from MCO

For extensions, MCOs must send notice 10 days before end of service authorization

The letter outlines:

- **MCO decision** to deny or reduce request
- **Steps to appeal** and continue services
- **Representation options**

Step 1: Request continuation of benefits

Members or representatives must request continued benefits:

- On or before the last day of current authorization; or
- Within 10 days of receiving the denial letter.

Example: If the letter arrives 5 days before authorization ends, request continuation within 5 days after receiving it

Step 2: Request Appeal (starting with first level)

Members have **60 days** from the denial date on decision letter to appeal (verbally or in writing).

Members can request appeals on their behalf through providers or authorized representatives

Three levels of appeal

1. **Internal Appeal:** Formal internal review by MCO
2. **External/IURO Appeal:** External appeal conducted by an Independent Utilization Review Organization (IURO)
3. **Medicaid Fair Hearing:** This can take place in parallel with external/IURO appeal or afterwards if decision is not in member's favor

Network | Contracting is different than credentialing

Credentialing

The process by which MCOs **verify and assess** the qualifications, experience, and professional background of healthcare providers who wish to join their network

Contracting

The process of establishing a **formal agreement** between the healthcare provider and the MCO, defining the **terms and conditions** under which the provider will **deliver** healthcare **services** to the MCO's members

Providers must contract with MCOs in addition to credentialing

- Horizon requires contracting before credentialing
- Other MCOs conduct processes simultaneously (Aetna, Fidelis, United[1] , and WellPoint)
- Providers should work with contracting teams at each MCO to confirm and initiate contracting process

1. For United, facilities treated differently, and some require contracting before credentialing

Network | Credentialing process: Four steps to credential

1. **Select MCOs you want to credential with**
   - To continue providing Phase 1 BH services to your Medicaid members, you (or your entity) must be credentialed with each MCO your members are in
   - Joining an MCO is your choice, but providers are encouraged to credential **with all** MCOs to ensure member access
2. **Check if you need to credential with MCO and/or be listed on roster**
   - Credentialing is done separately by each MCO
   - Approach is different for individuals / groups vs. facilities / agencies
   - Depending on the MCO and your license type, you may need to credential as an individual, and/or be listed on a roster
3. **Compile relevant information & documents**
   - Credentialing requires validating multiple types of data about a provider
   - NJ state standards provide minimum requirements, but some MCOs may have additional requirements
   - Make your CAQH profile if you haven't yet
4. **Submit credentialing application(s)**
   - Submit application electronically through individual MCO portals
   - Paper applications may be available upon request from certain MCOs – can also submit via fax or mail

Contract with MCO(s)

! Credentialing does not replace the need to contract with each MCO

Network | We encourage you to participate with all five MCOs to ensure member access

MCOs are required to contract and credential any willing and qualified provider who can deliver BH Phase 1 services for at least 2 years

You can choose to credential with any of the five NJ FamilyCare MCOs, but participation with all five is recommended, as members may change MCOs over time

Following provider types must credential and contract with all 5 MCOs[1] :

- Psychiatrists
- Advanced Practice Nurses (including Psychiatric Nurses)
- Physician Assistants
- Psychologists (including Neuropsychologists)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Clinical Alcohol and Drug Counselors (LCADC)

1. Facilities are credentialed separately to individuals and are not credentialed by specialty

Network | Credentialing is typically different for individuals and group practices vs. facilities / agencies

	Individuals / Groups	Licensed Facility / Agency
Who this applies to	• Independent practitioners and/or multiple providers practicing in a group practice	• A licensed healthcare location, such as a hospital, outpatient clinic or home health agency
Credentialing requirements	• Credential individually using Type 1 NPI	• Credential as an entity using Type 2 NPI – at Facility / Agency level
Rostering requirements	• Groups may be required to list licensed individuals and OBAT navigators on group roster	• May be required to list all licensed practitioners and peers on facility / agency roster
Network Directory	• Listed individually on MCO network directory	• Only Facility / Agency listed on MCO network directory. If individuals want or need to be listed, **must credential individually**

Network | Compile the relevant information and documents

Not exhaustive

A high-level, non-exhaustive summary of information and documentation that must be submitted is below, but providers are encouraged to review the application specific to your provider type and the specific requirements of each MCO

NJ state standards require validation of (at a minimum):

- ❑ **Licensing:** E.g., valid license to practice, data from licensing board
- ❑ **Experience:** E.g., relevant degree, completion of residency/post-grad training as applicable
- ❑ **Liability, sanctions and insurance:** E.g., professional liability claims history, malpractice insurance, past sanctions
- ❑ **Provider health:** E.g., any physical/mental health condition that affects ability to provide care, history of SUD
- ❑ **Attestations:** Completeness and correctness of application

Additional MCO requirements for Individual providers

- ❑ TIN/NPI
- ❑ Servicing location(s)
- ❑ Disclosure of ownership
- ❑ Special needs/Aged Blind or Disabled (ABD) form indicating experience with specialty populations
- ❑ Background check when applicable
- ❑ Americans with Disabilities Act (ADA) survey / attestation

Additional MCO requirements for Facility / Agency

- ❑ Americans with Disabilities Act (ADA) survey/attestation
- ❑ Certificate of facility insurance
- ❑ Copies of state license(s) for each service location
- ❑ Accreditations from an approved accrediting body
- ❑ Facility roster
- ❑ Background check when applicable

Network | All providers, except physicians, must submit separate applications to each MCO

Submit application electronically via each MCO portal

Aetna link | Fidelis link | Horizon link | UHC link | WellPoint link

Paper applications for each MCO can be requested from the MCO website or MCO credentialing representative

Exception: Physicians

Physicians have the option to submit a single application that can be used across all five MCOs.

NJ Universal Physician Credentialing Form Link

Note: Physicians can still choose to submit separate applications through each MCO portal

What is a single case agreement (SCA)?

A single case agreement or SCA is a contract between an out-of-network provider and an MCO that allows the provider to deliver care to a specific member[1] on a one-time or limited basis at a negotiated rate

This agreement is between:

1. **Provider** *and…*
1. **MCO** *to serve…*
1. **Member**

Once the transition period ends, a **provider may need a single case agreement** in the following scenarios **to continue receiving Medicaid FFS rates:**

- The provider has started, but not yet **completed the contracting and credentialing process** with the member's MCO
- The provider is **interested in contracting** with the member's MCO but has **not initiated the process**
- The provider is **unwilling to contract and credential with the member's MCO** but needs to provide care to the member

1. Some MCOs may allow an SCA to cover multiple members vs. one member

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CMS 1500 billing form | Providers should follow each of the MCO's NPI billing instructions for the CMS 1500 form to reduce submission errors

CMS 1500 Form

- Submitted by individual practitioners, group practices, and licensed agencies / clinics offering **professional services**

- NPI numbers must be entered for both a **billing and rendering provider**
  - ***Billing NPI:*** Type 1 NPI if individual practitioner[1]; Type 2 NPI if group practice/agency/clinic
  - ***Rendering NPI:*** Varies based on provider type, credentialing, and MCO

NPI required in rendering provider field for each MCO, based on provider type and credentialing decision

	Licensed agency or clinic		Group practice	Independent provider
	Credentials as an entity	Credentials individual practitioners	Credentials individual practitioners	Credentials individually
Aetna	Type 2 NPI, but Type 1 NPI required if rendering provider is OBAT	Type 1 NPI	Type 1 NPI	Type 1 NPI
Fidelis Care	Field should be left blank			
Horizon	Type 2 NPI			
UHC				
Wellpoint	*N/A – Credentialing option not allowed for Wellpoint*			

- Type 1 NPI is for individual providers
- Type 2 NPI is for entities

1. Type 2 NPI can be used if available

CMS 1450 billing form | Providers should follow each of the MCO's NPI billing instructions for the CMS 1450 ("UB-04") form to reduce submission errors

CMS 1450 Form ("UB-04")

- Submitted by institutional providers and outpatient facilities offering **facility-based services** (e.g., hospitals, nursing facilities)[1]

- NPI numbers must be entered for the **facility** and rendering providers (i.e., **attending** and **operating**)
  - ***Facility NPI***: Type 2 NPI
  - ***Attending NPI[2]:*** Most MCOs use Type 1 NPI
  - ***Operating NPI[3]:*** Varies by MCO

NPI required in operating and attending provider fields for each MCO

	Operating provider field	**Attending** provider field
Aetna	Field not required	Type 2 NPI, but Type 1 NPI required if rendering provider is OBAT
Fidelis Care		Type 1 NPI
Horizon	Type 2 NPI	
UHC	Field not required[4]	
Wellpoint	Type 1 NPI	

- Type 1 NPI is for individual providers
- Type 2 NPI is for entities

1. Horizon NJ Health requires all licensed facilities to bill on CMS 1500 unless their contract specifies otherwise 2. Individual with overall responsibility for member's care. 3. Surgeon or specialist that performed the procedure; may or may not be same individual as the attending provider. 4. If applicable, UnitedHealthcare instructs providers to enter the Type 2 NPI

NEW JERSEY HUMAN SERVICES

Aetna | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Additional information guidance:

- For continued Stay reviews, please submit the last 30 days of clinical notes if applicable

Where to submit MH PA requests:

Provider portal (preferred method):

- Availity: Access Availity Here

Call or Fax:

- **Call:** 855.232.3596
  - Follow prompts to BH. Request an authorization with our intake team.
- **Fax:** 844.404.3972
  - Submit with the Prior Authorization Request form on the ABH NJ Website.

How providers will be notified of MH PA decisions:

- Decisions sent back to provider via fax or phone call
- PA decisions will also be available in Availity if provider submitted the original PA via the portal

SUD Prior Authorizations

Additional information guidance:

- Please provide the contact information of the clinician that would need the prior authorization information.
- If able, please include a fax number as this is the most streamline way to communicate.
- For Continued Stay reviews, update all 6 dimensions and provide any necessary information to justify the need for extended treatment. This can include faxing us:
  - Treatment plans, progress notes, etc.

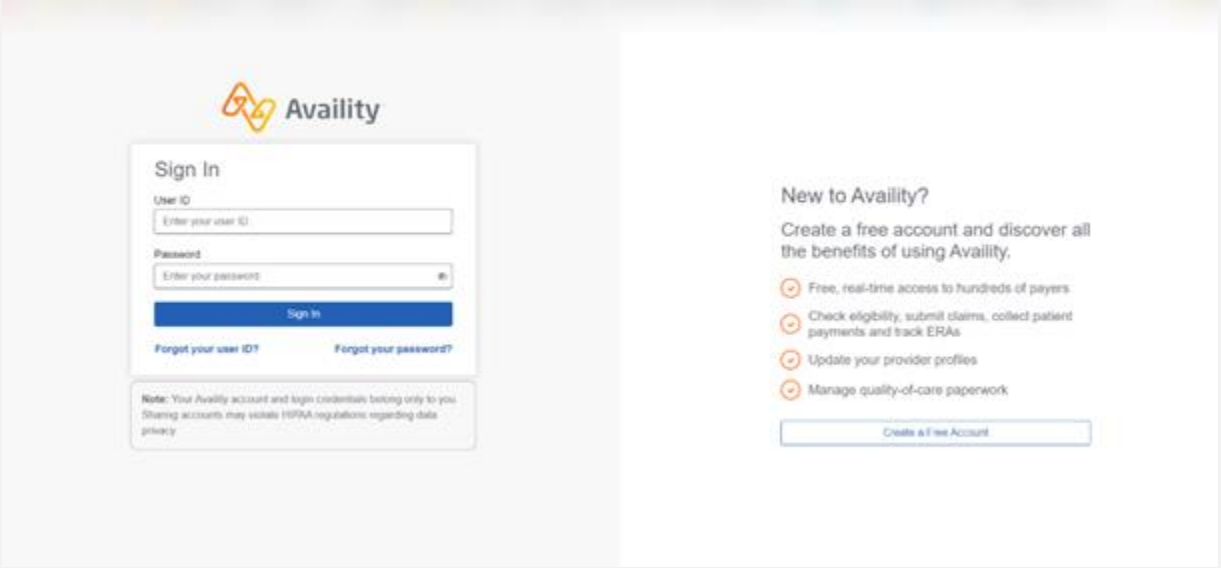
Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions sent back to provider via fax or phone call

Aetna
MH PA requests using our portal

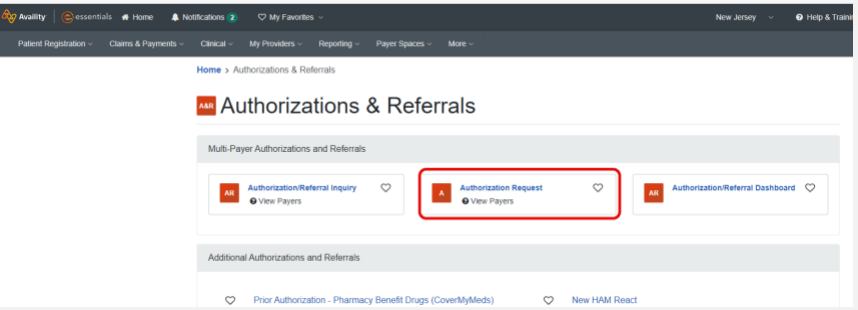


Submit PA using Availity Portal
[Access Availity Here]

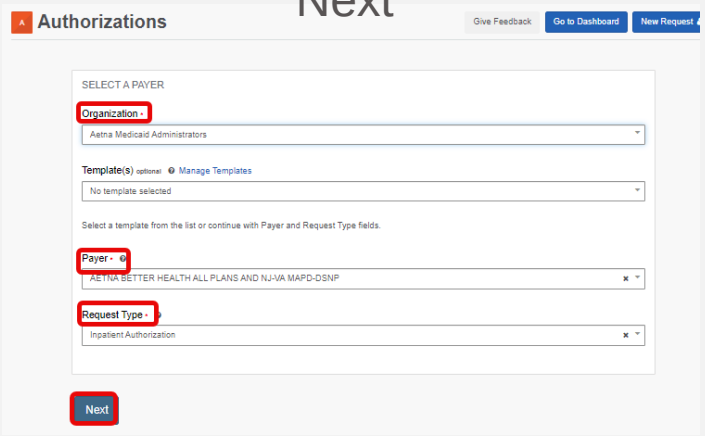
NEW JERSEY HUMAN SERVICES

Submitting Authorizations in Availity

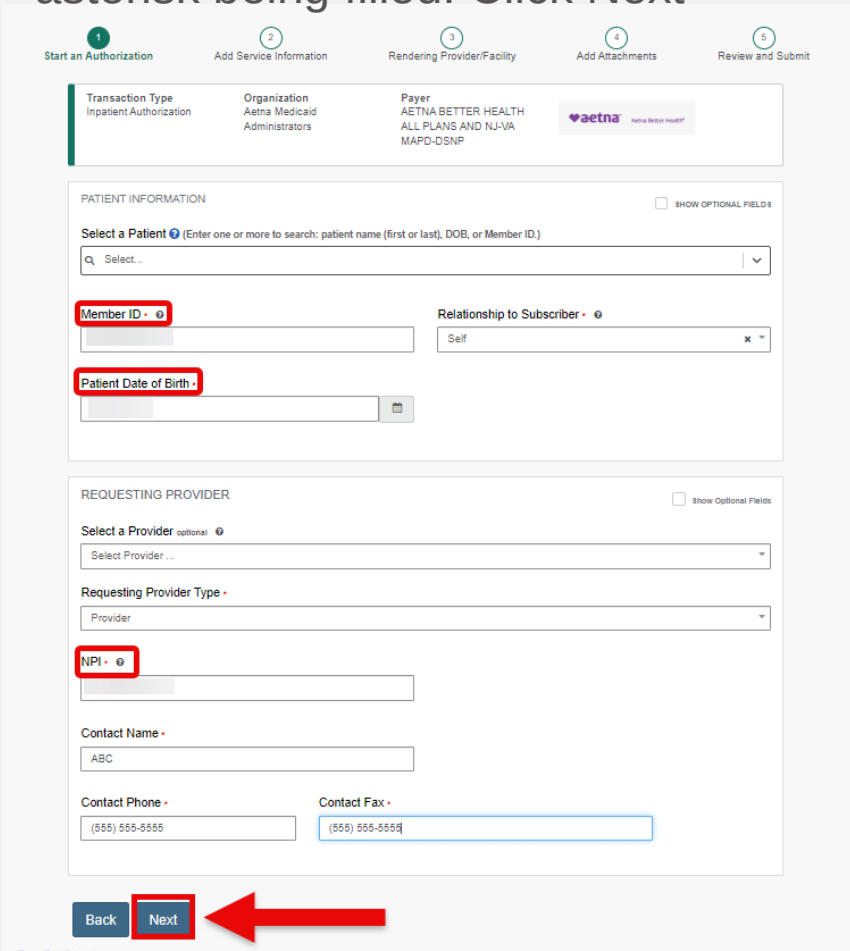
1 Select Authorization Request



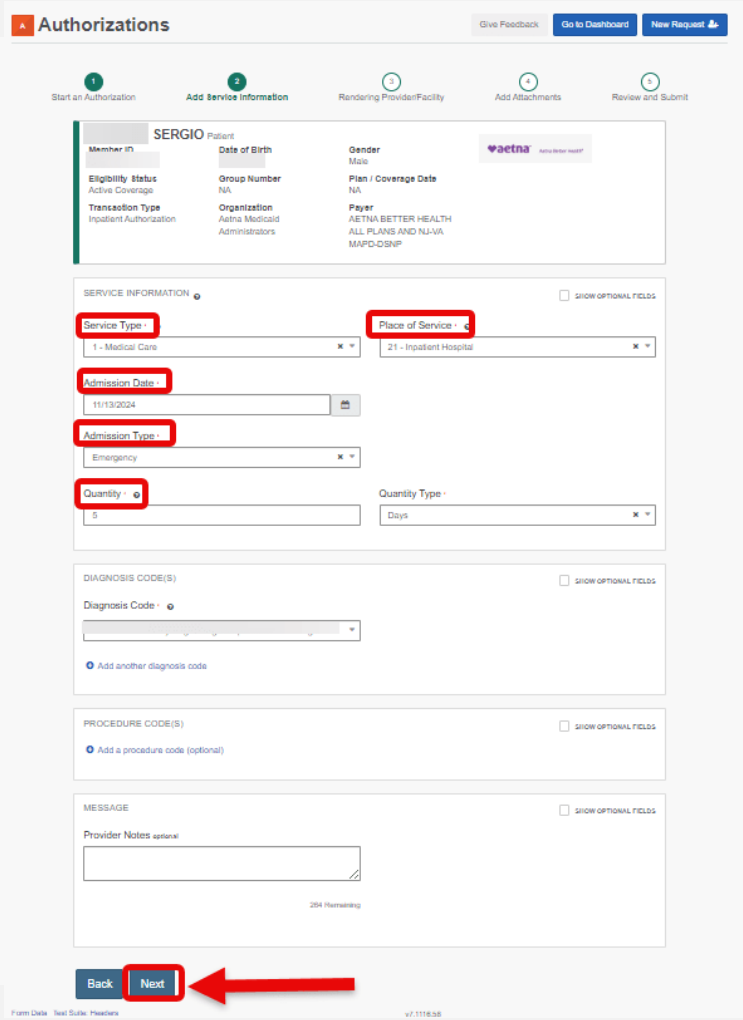
2 Enter applicable info and click Next



3 Enter the information for each asterisk being filled. Click Next

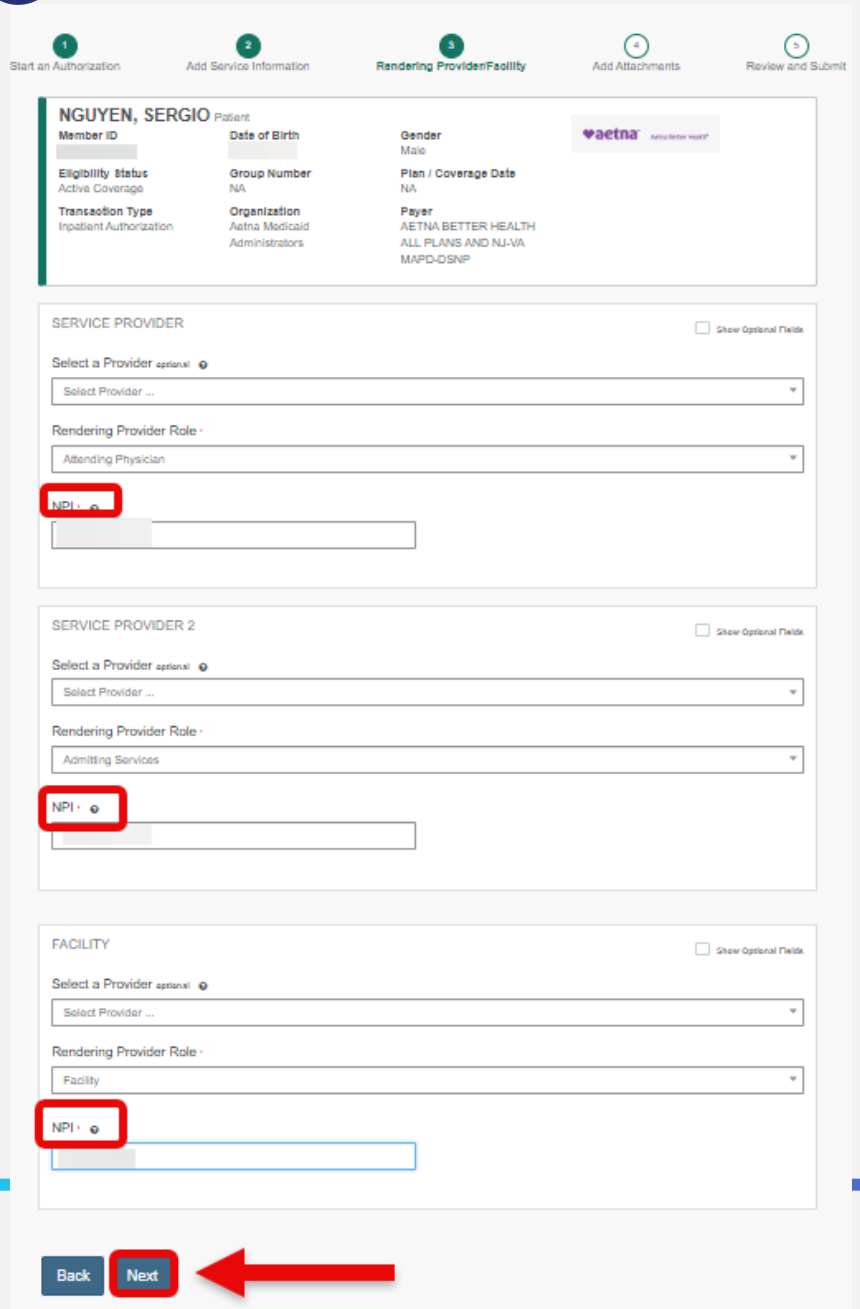


4 Enter the information for the authorization. Click Next

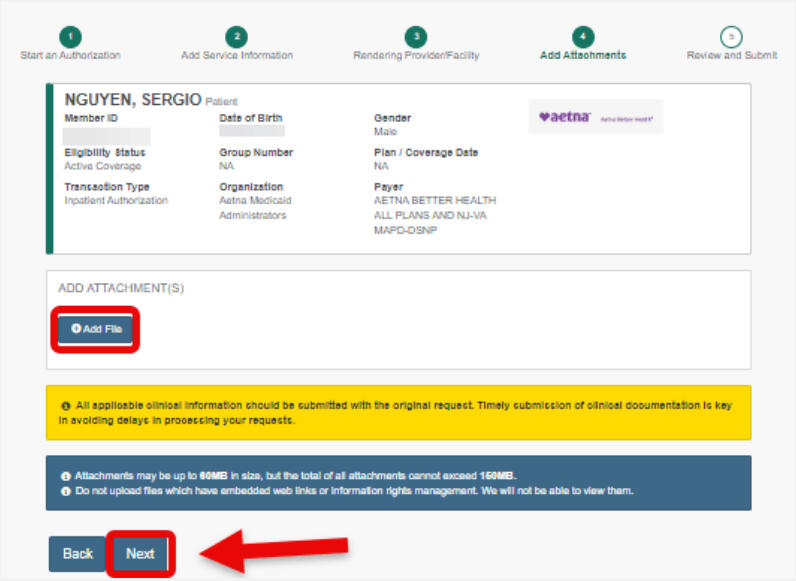


NEW JERSEY HUMAN SERVICES

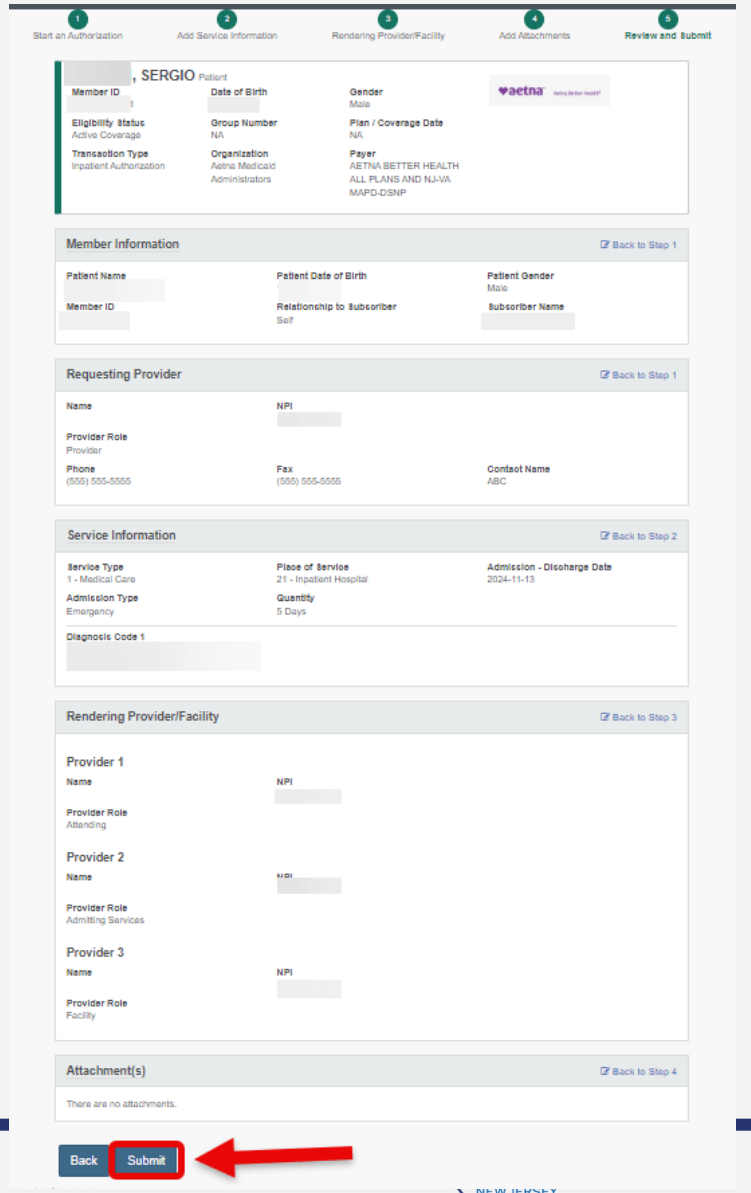
5 Enter the provider info and click Next



6 Add any attachments and click Next



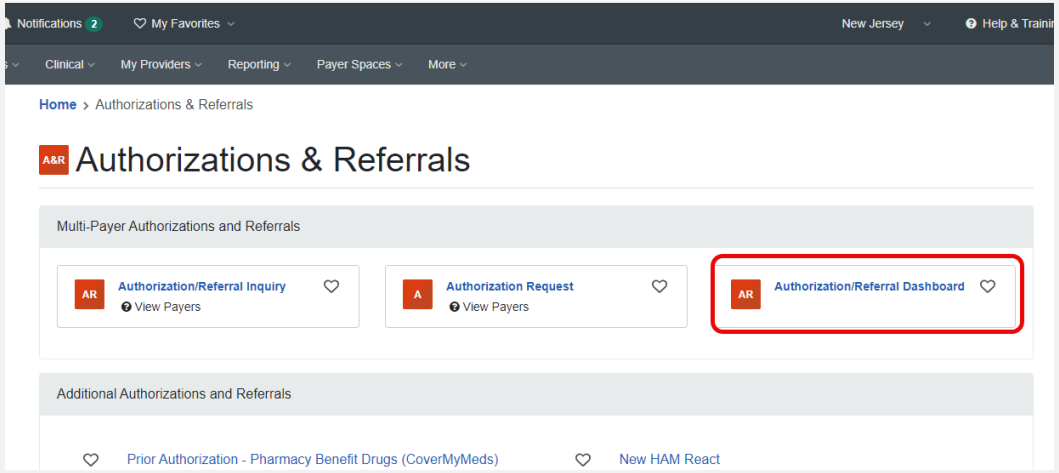
7 Verify all information and hit Submit



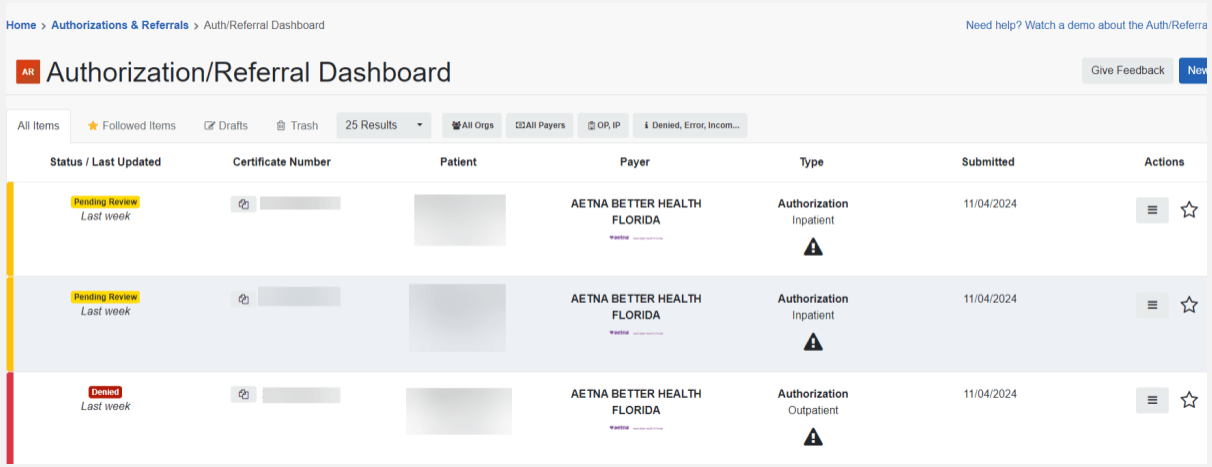
NEW JERSEY HUMAN SERVICES

Checking Status of Authorizations Submitted via Availity

1. Click on Authorization/Referral Dashboard



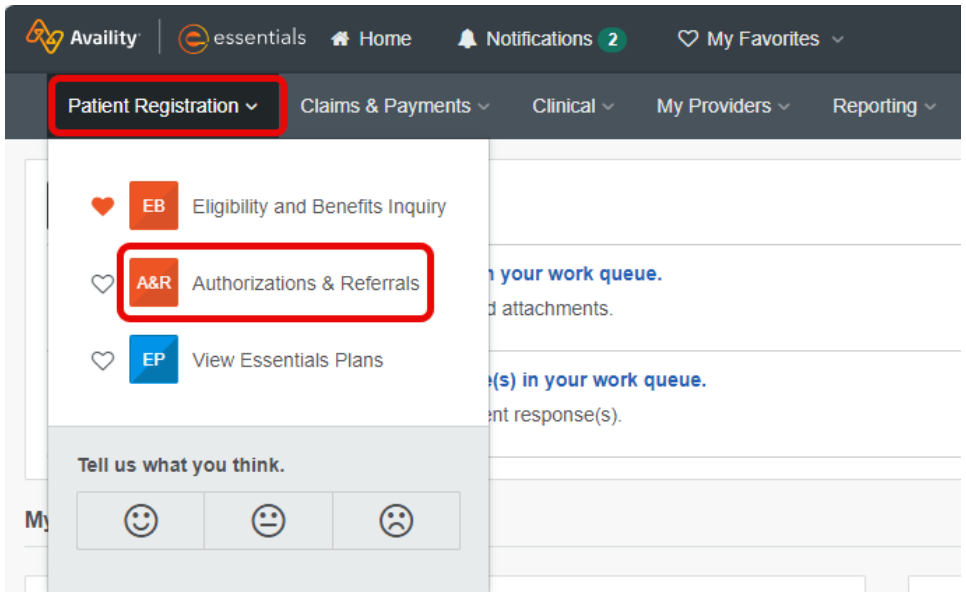
2 This will show status of <u>those submitted in Availity only</u>



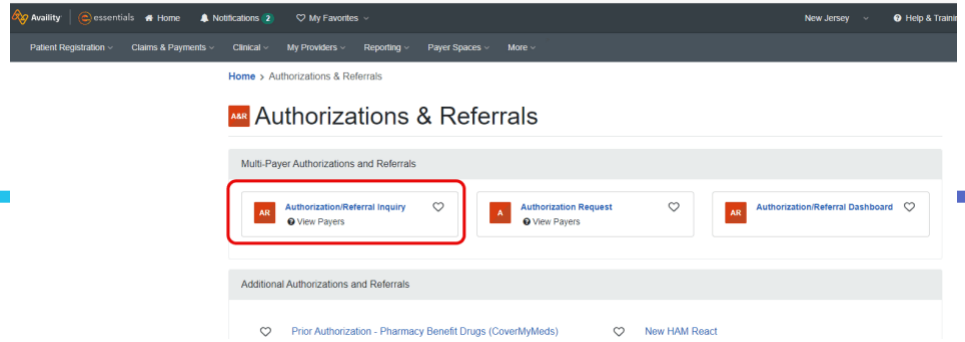
NEW JERSEY HUMAN SERVICES

Authorization Inquiries

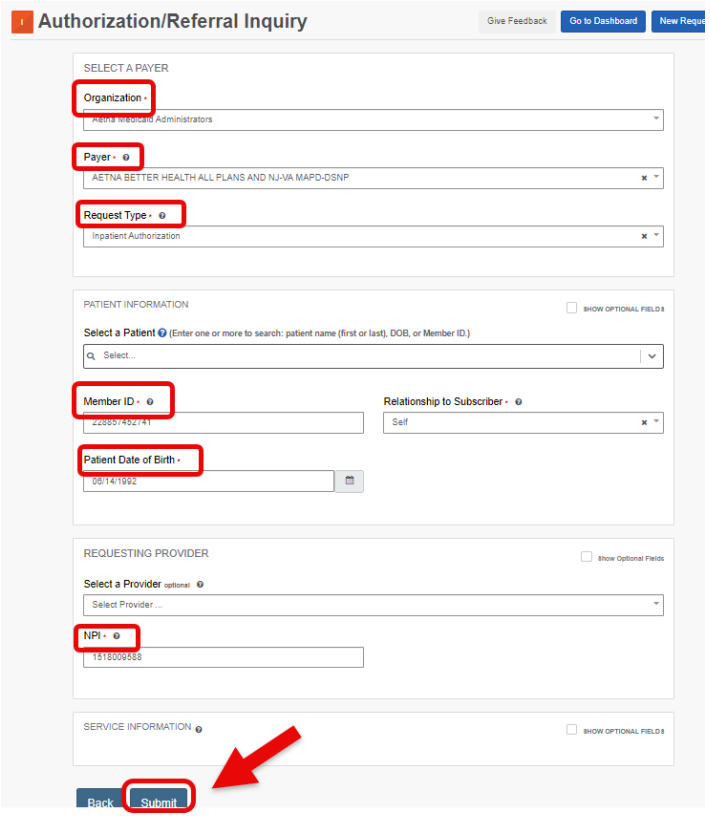
1. Once the provider is logged in, go to patient registration and authorizations & referrals.



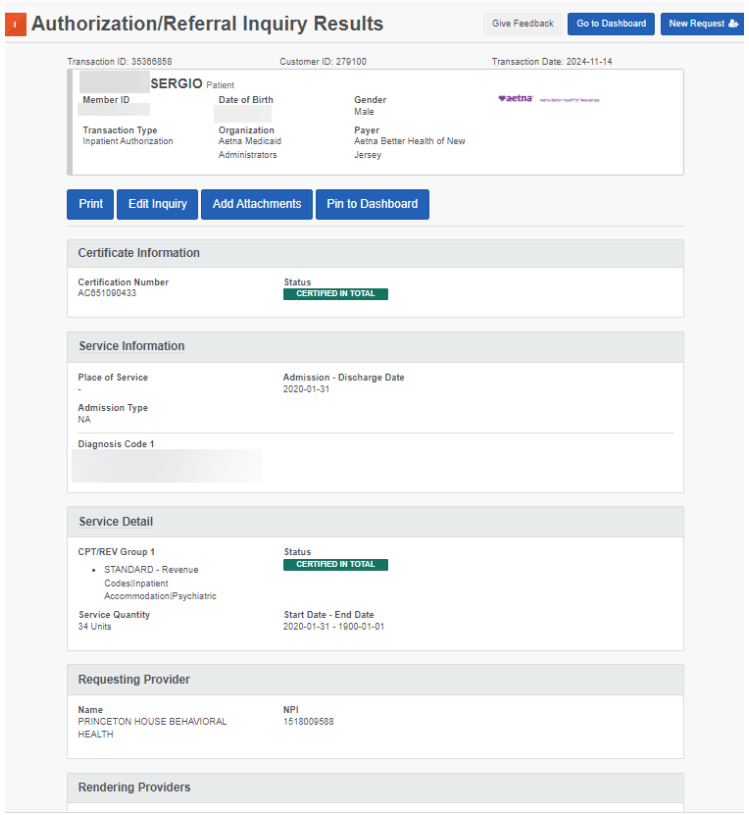
2. For inquiries, select Authorization/Referral Inquiry



3. Enter all applicable data that has an asterisk *. Then click submit



4. Once you click submit, the auth information will populate.



NEW JERSEY HUMAN SERVICES

Fidelis Care | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- Fidelis Care provider portal

Call or Fax:

- **Behavioral Health Phone:** 888-453-2534
- **Outpatient Auth Request Submissions:** 888-339-2677 *(fax)*
- **Inpatient Auth Request Submissions:** 855-703-8082 *(fax)*
- Authorization Forms

How providers will be notified of MH PA decisions:

- Decisions sent back to provider via fax
  - If there is no fax number, there will be telephonic outreach

SUD Prior Authorizations through

Where to submit SUD PA requests:

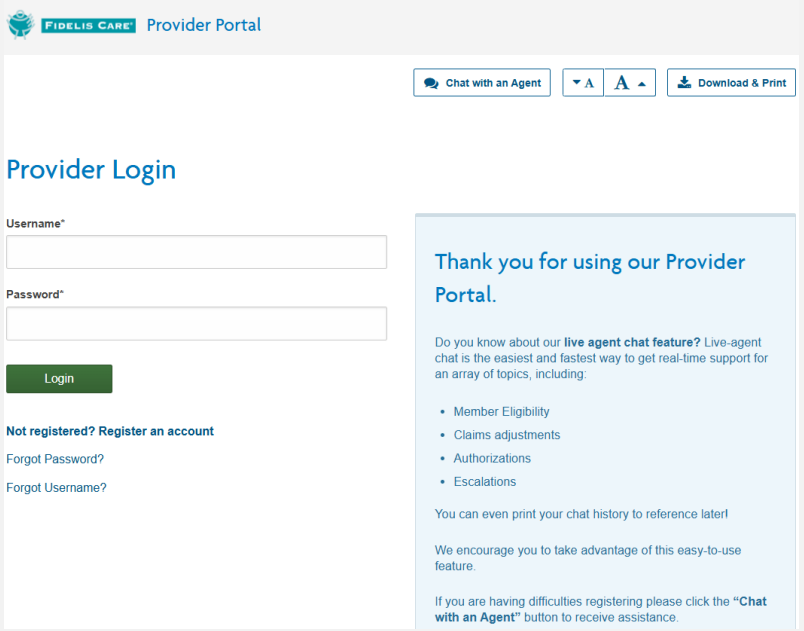
- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions sent back to provider via fax
  - If there is no fax number, there will be telephonic outreach

Criteria to determine medical necessity: InterQual, ASAM
To determine if a service requires authorization see our website: https://www.fideliscarenj.com/en/New-Jersey/Providers/Authorization-Lookup

Fidelis Care
MH PA requests using our portal

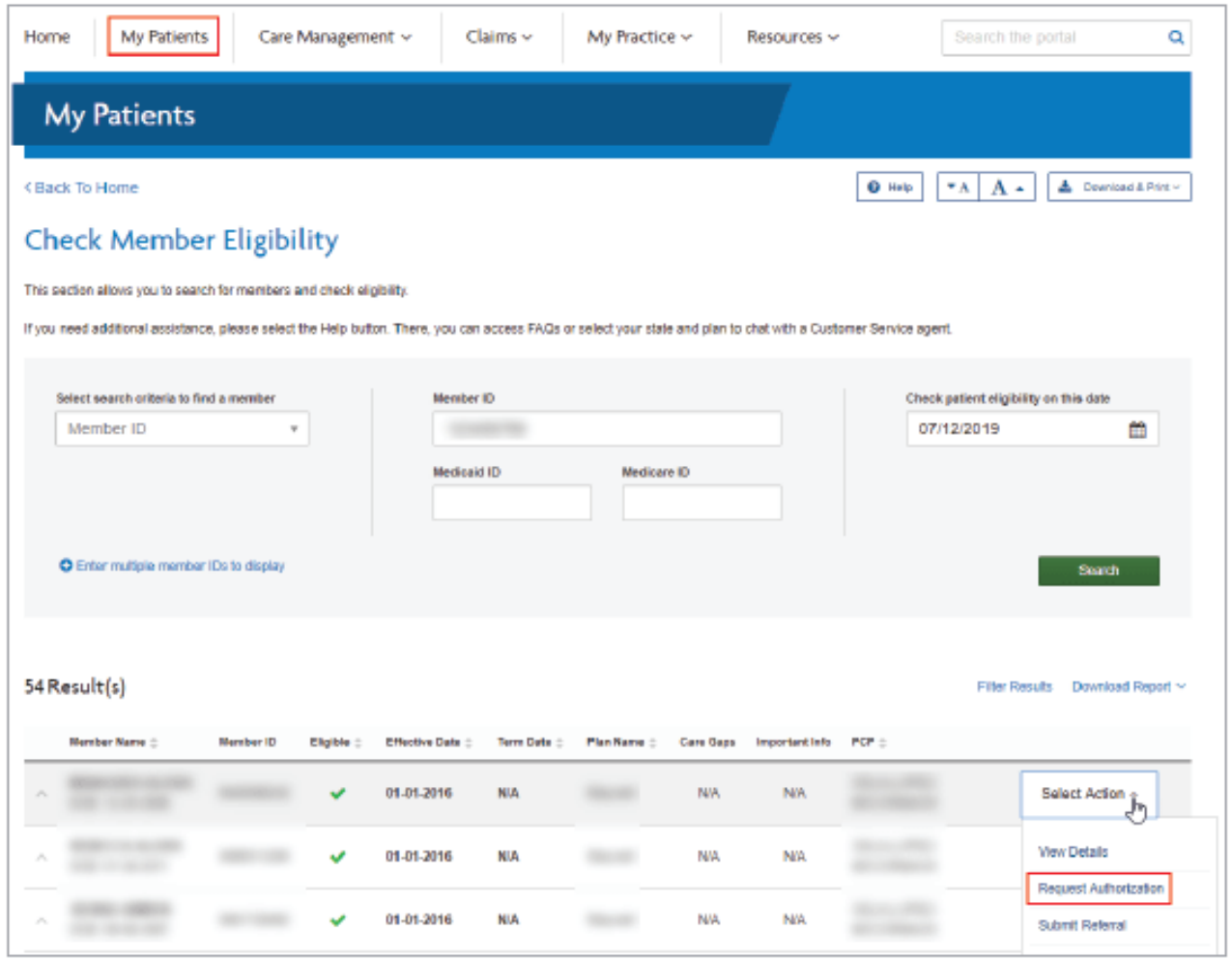


Submit PA using Fidelis Care Portal [secure online provider portal](#).

NEW JERSEY HUMAN SERVICES

Option 1:

Navigate to the "**My Patients**" and search for the desired member. Then open the "**select action**" drop down. Here you will find the "**Request Authorization**" option:

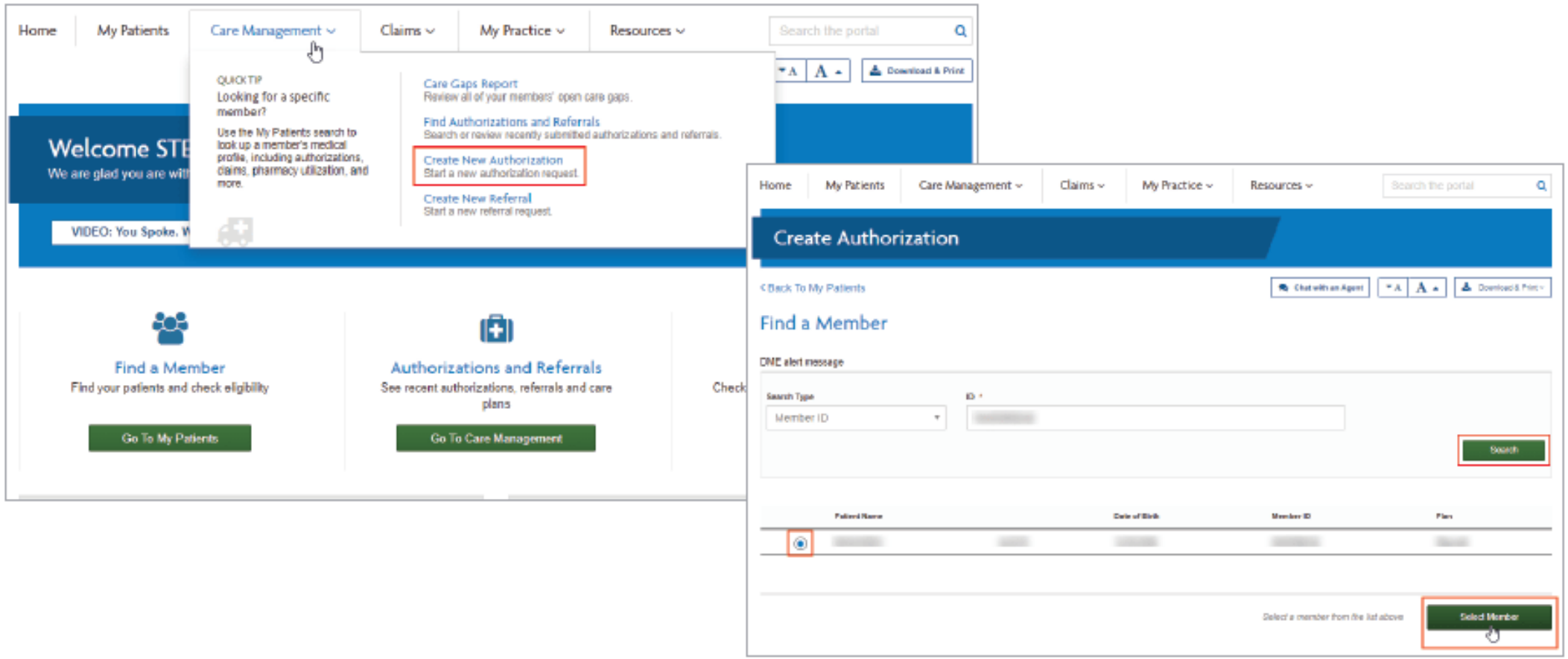


Select "**Request Authorization**" to access the authorization request form.

HUMAN SERVICES

Option 2:

From the "**Care Management**" tab, select "**Create New Authorization.**" You will then be prompted to enter the associated Member ID.



Create Authorization

Chat with an Agent | Help | -A A+

Download & Print

Member Information

COLLAPSE

The following Member is attached to this Authorization

Member Name	Member ID	Date of Birth	Gender	Address	
					Search a Member

Requesting Provider Information

COLLAPSE

The following Provider is attached to this Authorization

Provider ID	Provider Name	Phone Number	Specialty	Address	
					Choose a Provider

County

Requesting Provider Fax *

Is this a prescheduled service or an inpatient notification?

COLLAPSE

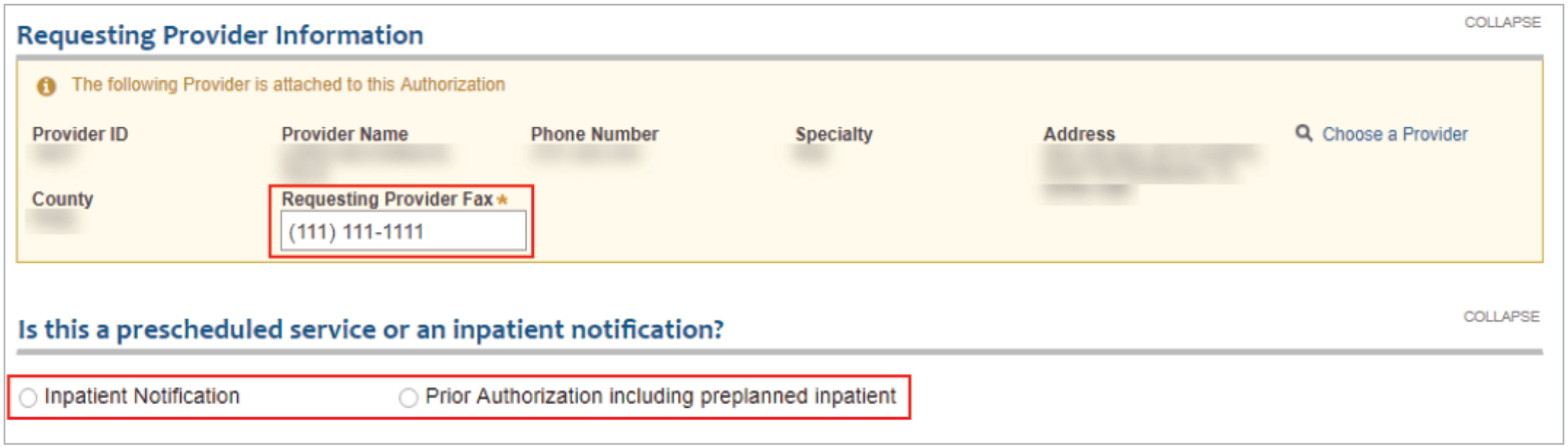
Inpatient Notification

Prior Authorization including preplanned inpatient

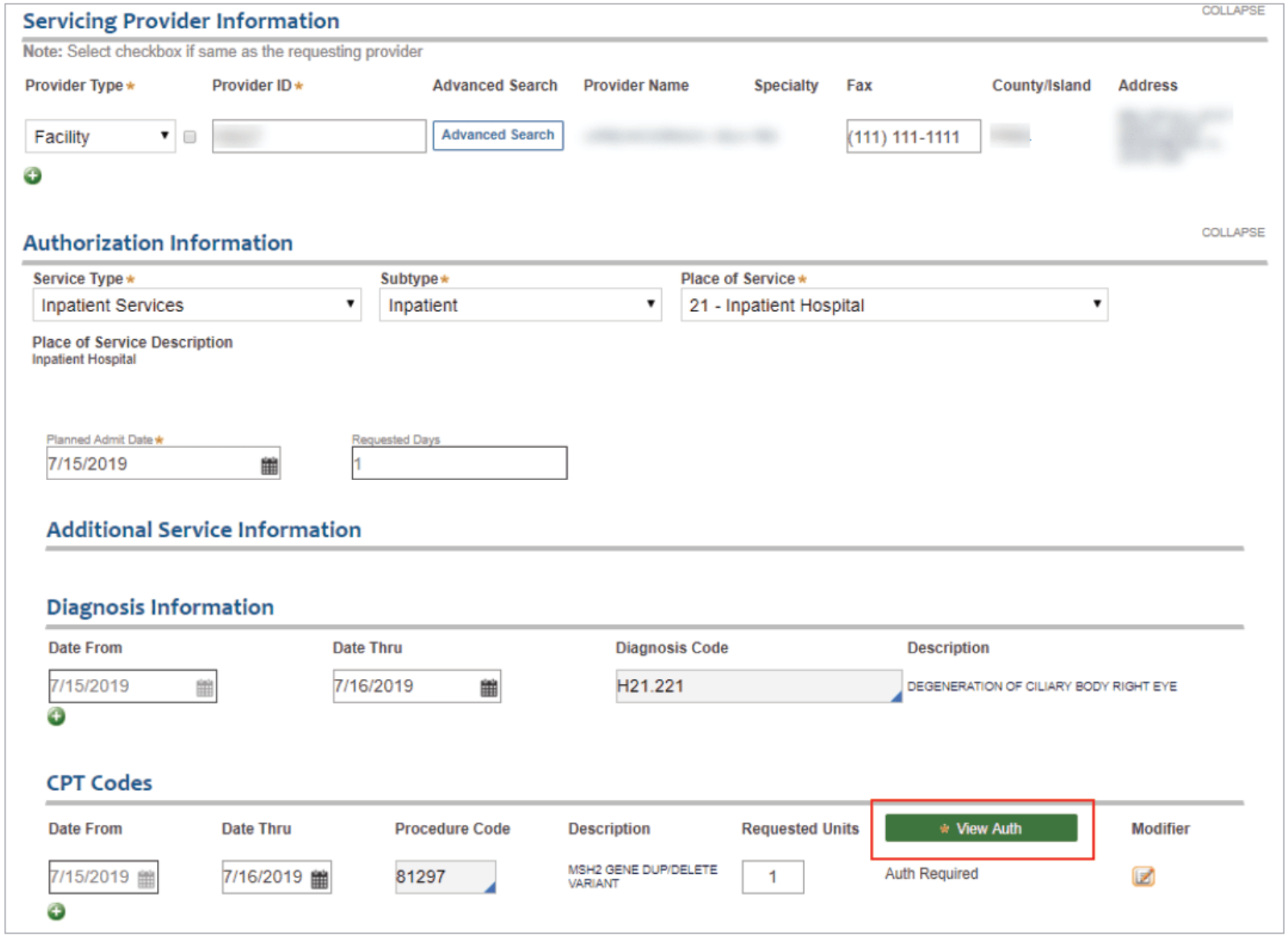
Next, insert a valid fax number using the following format: (111) 111-1111. Then make a selection to determine "**Inpatient**" or "**Outpatient**" for the request. Fields within the form will update, based on whether the authorization is identified as inpatient or outpatient.

Select "**Inpatient Notification**" or "**Prior Authorization including preplanned inpatient**" in the "**Is this a prescheduled service or an inpatient notification?**" field.

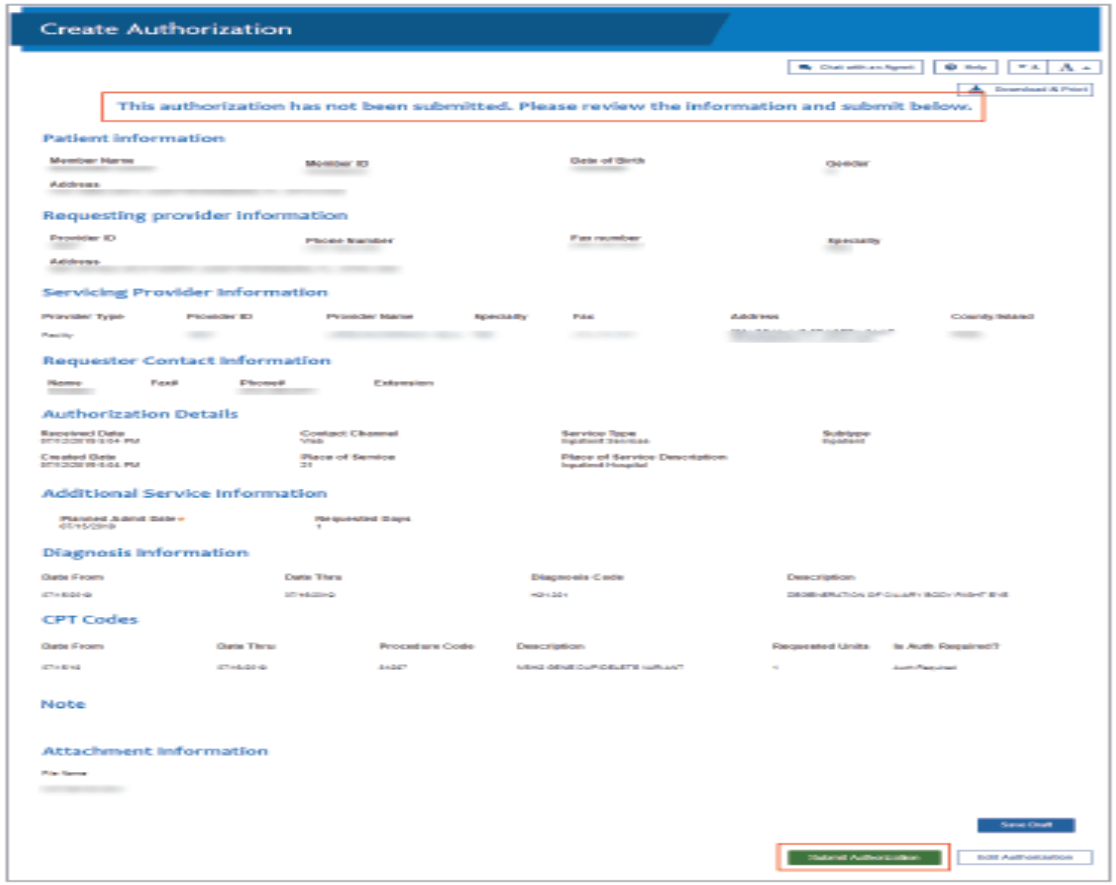
- Inpatient Notification – **Use for an inpatient/observation request**
- Prior Authorization including preplanned inpatient – **Use for an outpatient request or preplanned inpatient request for a future date of service**



Complete the fields in the following sections. For an outpatient authorization, you **must** check the "**View Auth Requirements**" button. (This is not necessary for inpatient authorizations.)



Prior to submission, you will be prompted to review your selections, and given the options to "**Edit**" or "**Submit**":



A reference number will be provided once you submit the request. An authorization number will be sent to you via fax within state-regulated turn around times. You must use the authorization number to search for this authorization in the Provider Portal.

NOTE: An authorization cannot be viewed via the portal until it has moved to an in-progress state and the fax containing the authorization number has been sent.

There are several types of reference numbers:

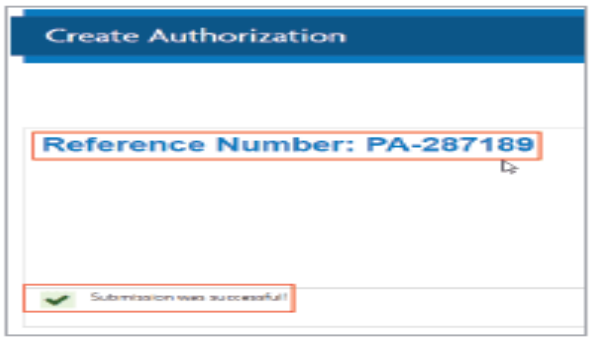
ADMNT: This is a notice of admission

CR: This is a concurrent review. After the notice of admission, this is the clinical review that takes place. There can be multiple concurrent reviews for a single stay. Ex. If a member is admitted to the hospital, there will be an initial review and then one or more additional reviews confirming whether the member is ready for discharge.

PA: Prior authorization. This is an advance notice for outpatient services or for pre-planned inpatient services.

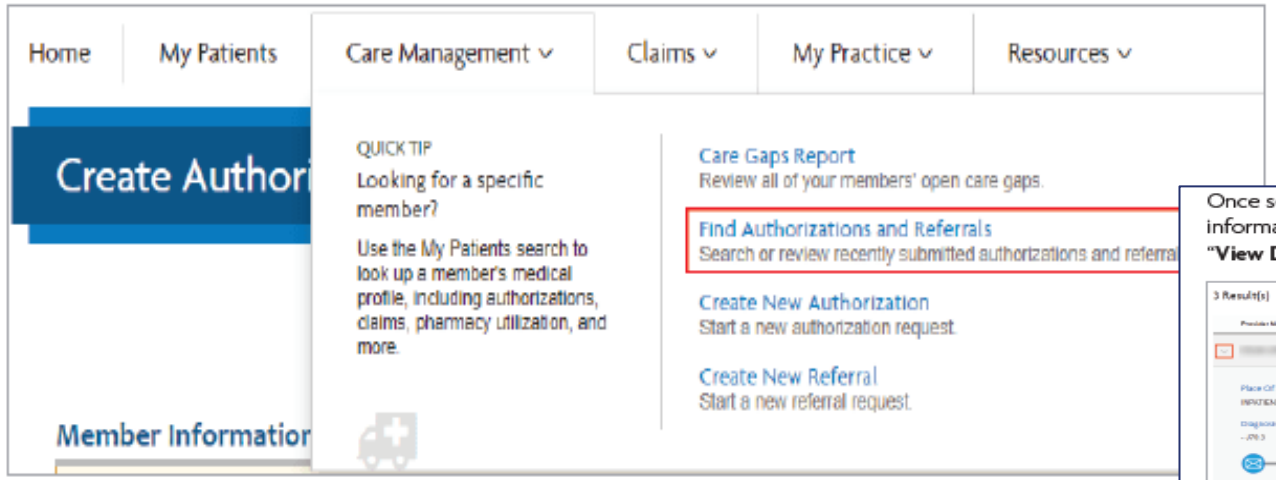
Authorization number: This number is required when submitting your claim(s) for payment.

Example of an ADMNT reference number:

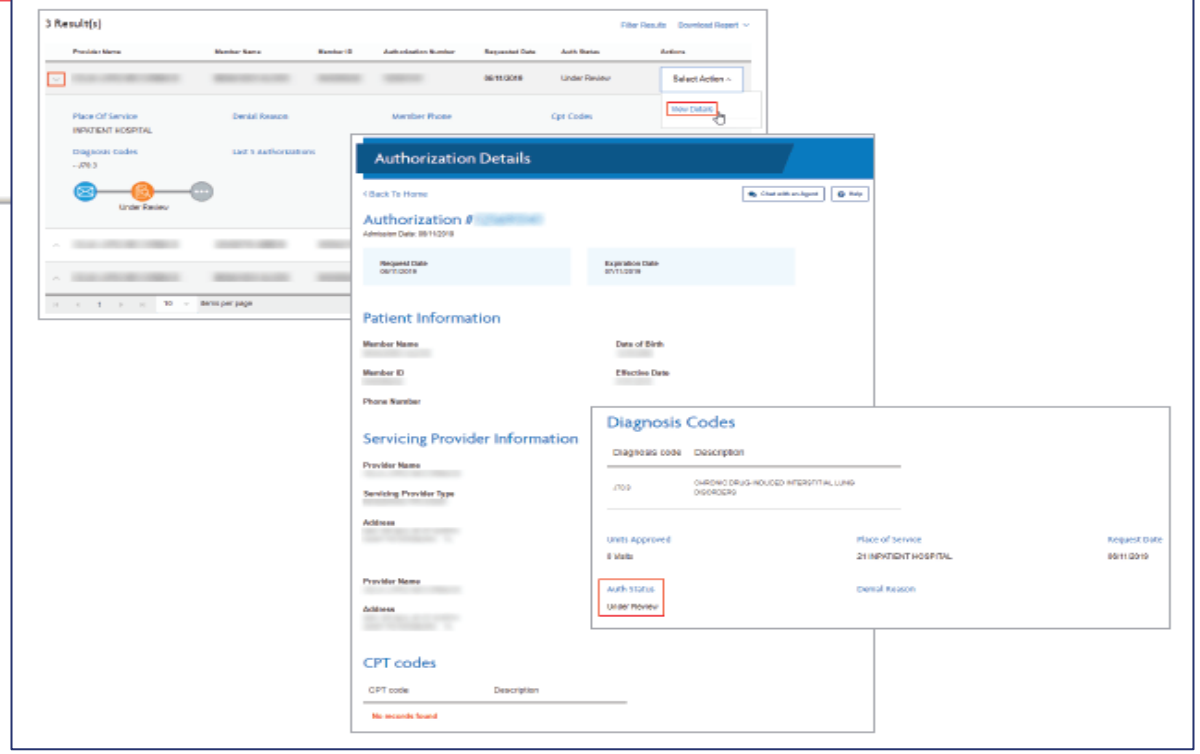


Check Authorization Status

Navigate to the "**Care Management**" tab and select "**Find Authorizations and Referrals**" to view the authorization status.



Once search results are returned, each authorization has an expandable section that provides more detailed information about that authorization. You may also view the full authorization details by selecting the "**View Details**" from the "**Select Action**" drop down.



Horizon NJ Health | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- Availity

Call or Fax:

- **Phone:** 1-800-682-9094
- **Outpatient Fax (ECT/TMS/Routing OP Services):** 855-241-8895
- **PA Fax (IP/RES/PHP):** 732-938-1375

How providers will be notified of MH PA decisions:

- Providers can check outcomes of submitted PA requests via Horizon's CareAffiliate, which can be accessed through Availity
- In addition, providers will also receive a fax or mailed notice of determination letter for each prior authorization request

SUD Prior Authorizations through

Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- SUD PA requests submitted through NJSAMS are loaded into Availity; therefore, providers can check outcomes of submitted SUD PA requests via the portal
- In addition, providers will also receive a fax or mailed notice of determination letter for each prior authorization request

Horizon NJ Health
MH PA requests using Horizon's portal

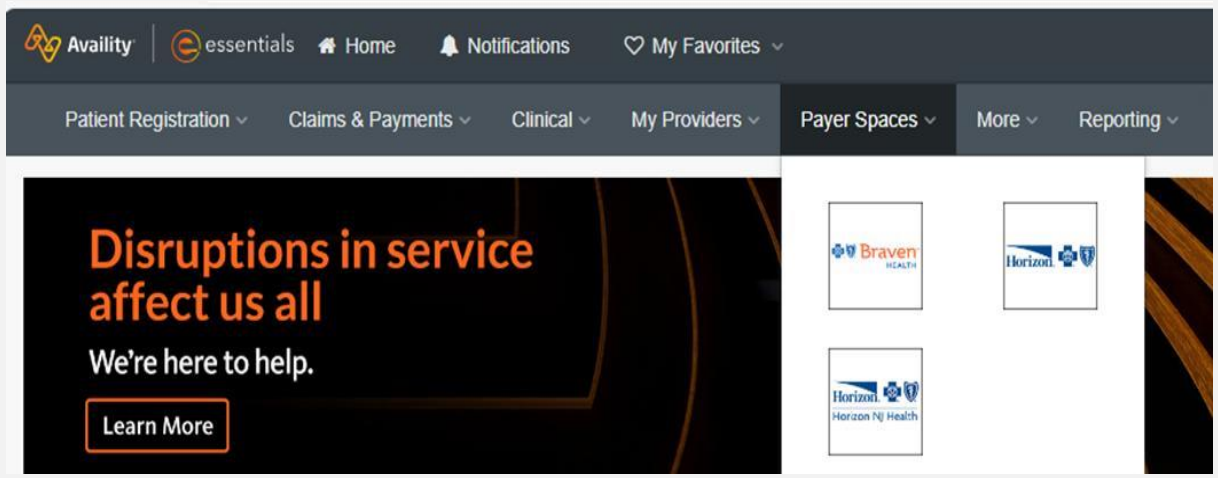
Submit PA using Availity Portal
https://availity.com/

Learn about the Utilization Management Request Tool Enhancements
Self Study Guide

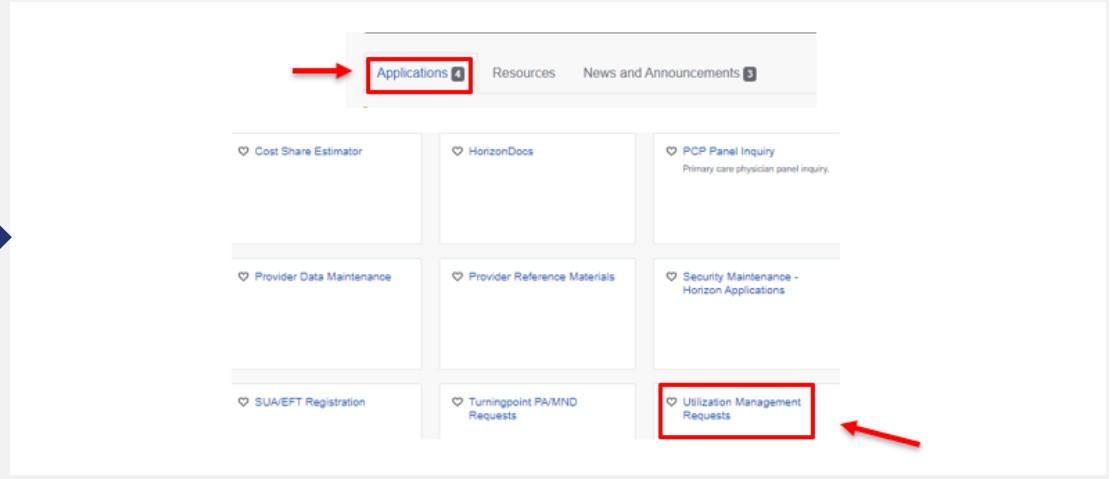
UM Tool Training Module

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



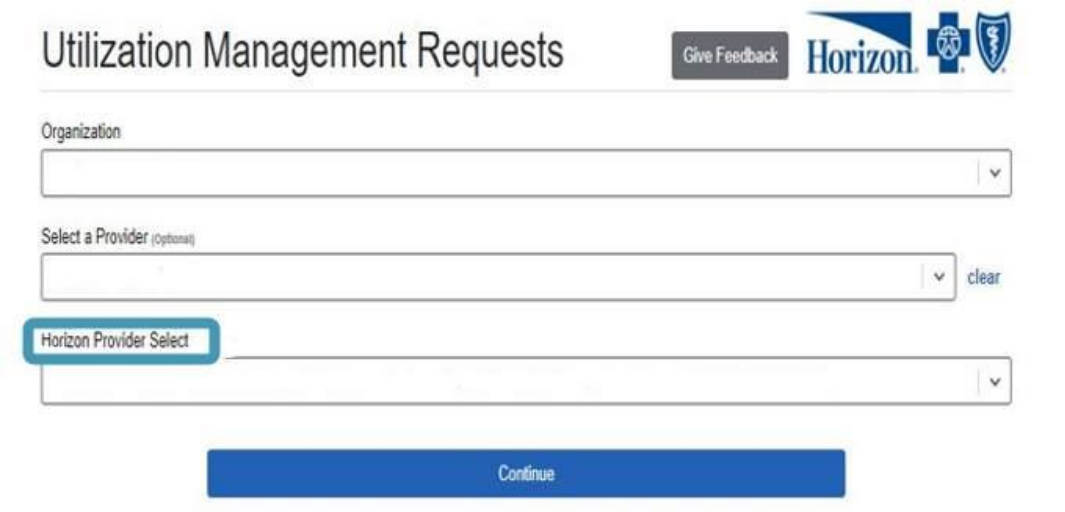
Once logged into Availity, Click Payer Spaces dropdown and select plan type for member you are requesting services for.



Scroll within Applications tab to Utilization Management Requests and click.

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



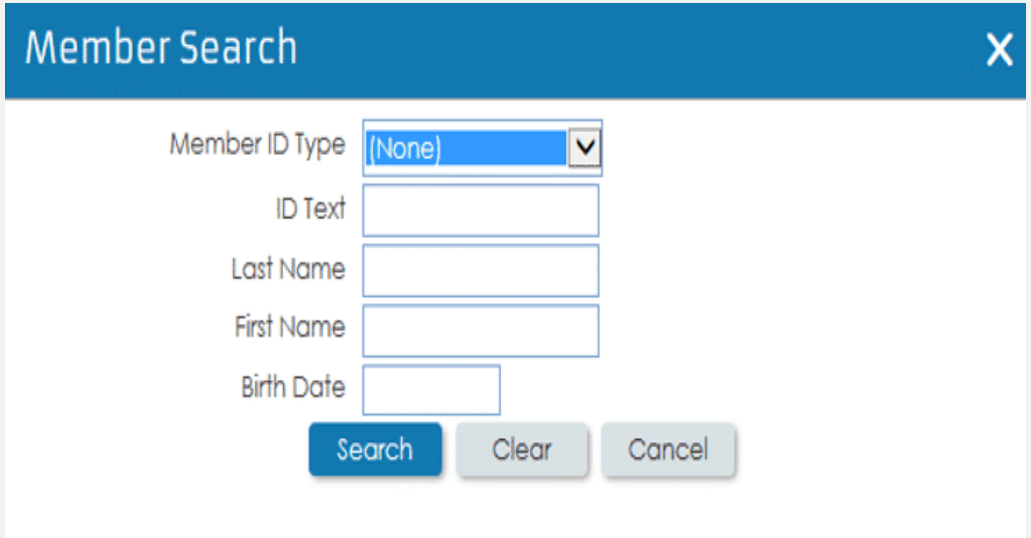
Once you click Utilization Management Requests, you will need to select your organization and complete "Horizon Provider Select" field. Click continue.

This screen advises that you that you will be re-directed to a platform called CareAffiliate. Click Submit to proceed.

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Within CareAffiliate, from the Home tab, click the yellow Look Up button.

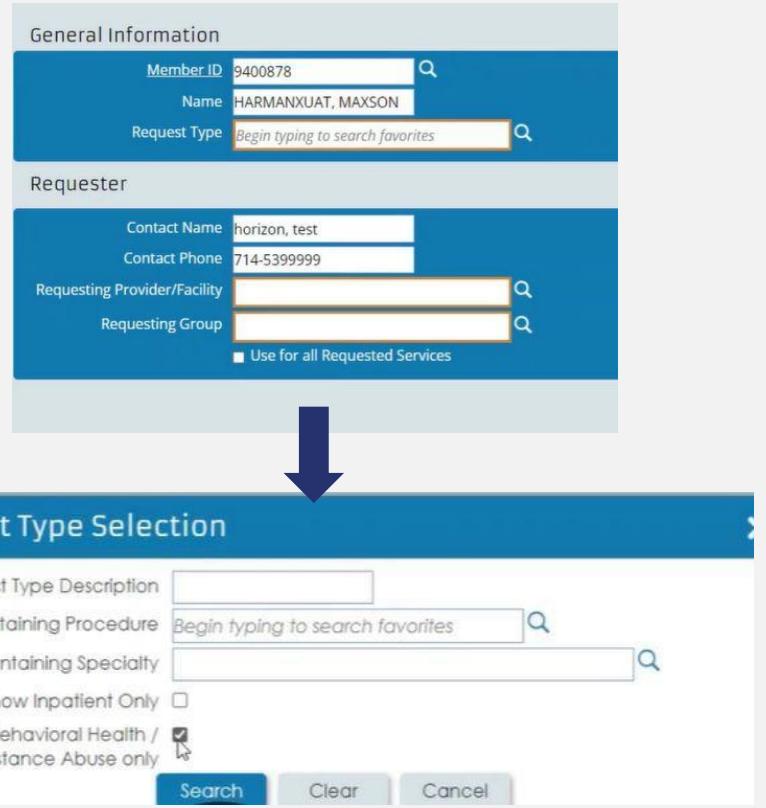


You will then see this screen. You can search by Member Name or Member ID.

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

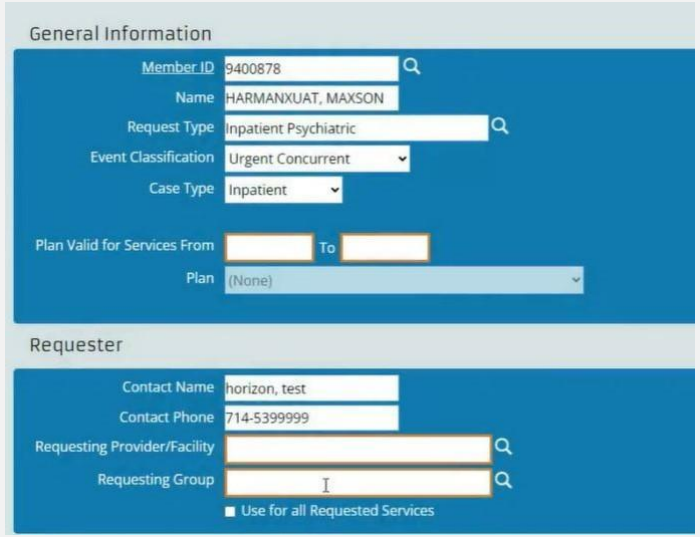
Once member has been found, an authorization can be initiated. Click the New button next to Authorizations option. *Note, if you click the Authorizations link, it will bring up prior submitted requests for selected member.



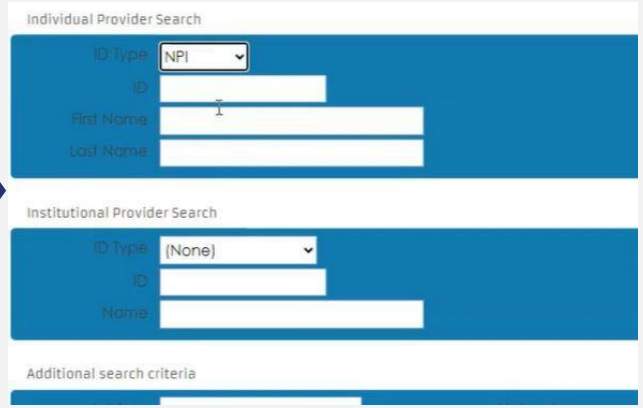
This step allows for entering request type selection. Click magnifying glass next to Request Type. A search box will populate. Click check box next to Show Behavioral Health/Substance Abuse Only, and hit Search. Then scroll through the list of options and select an option.

NEW JERSEY HUMAN SERVICES

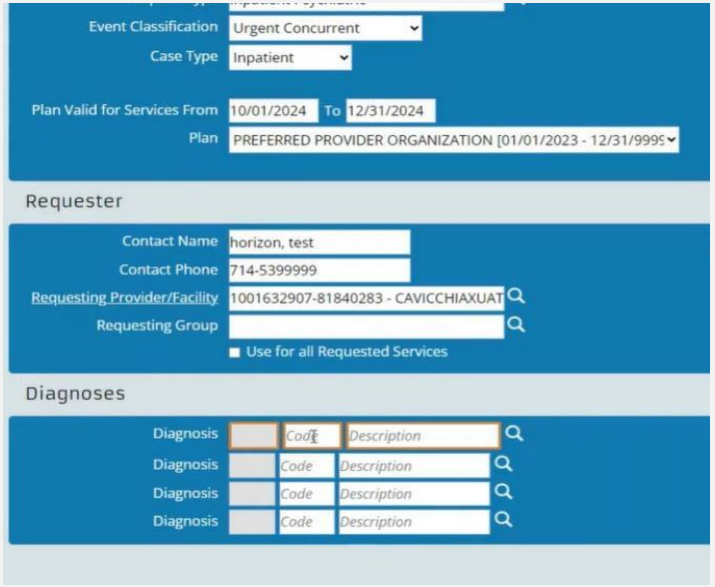
Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



Next, enter 90-day date span under Plan Valid for Services From and To, which will prompt a benefit/eligibility check. Then, click on magnifying glass next to Requesting Provider/Facility or Requesting Group.



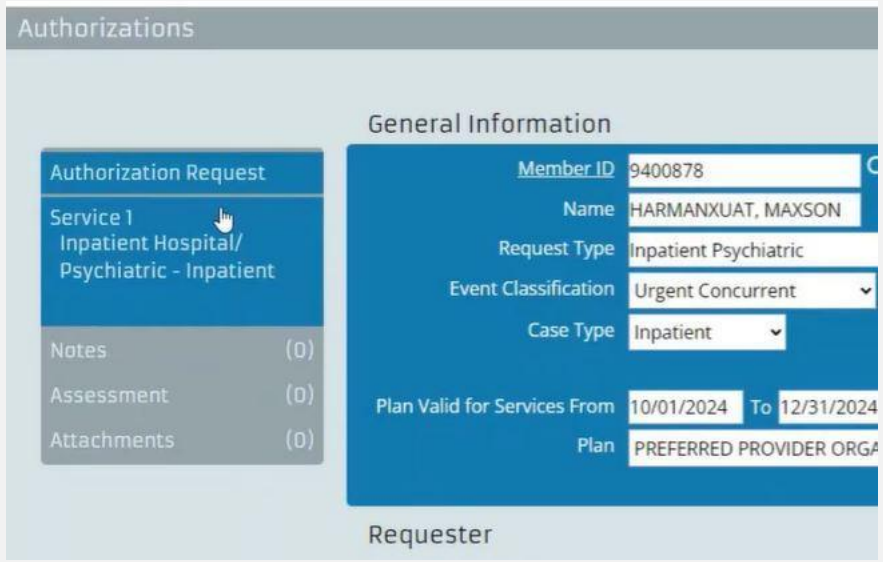
Search box will open. Fill in ID type and ID information, and hit Search. Choose the correct option through the search results.



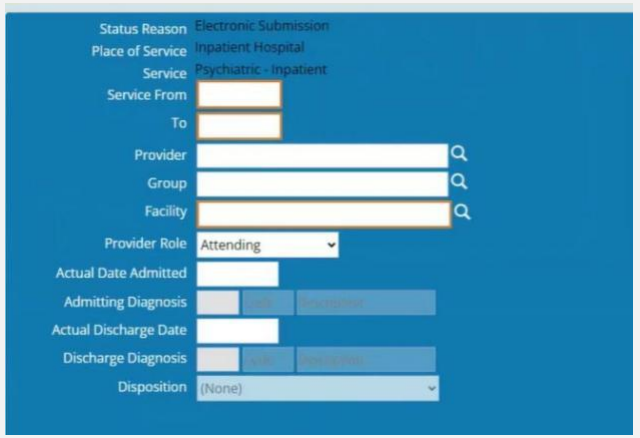
Diagnosis codes can now be added. Click magnifying glass next to description, and search by F code. Up to 4 diagnoses can be entered in this section.

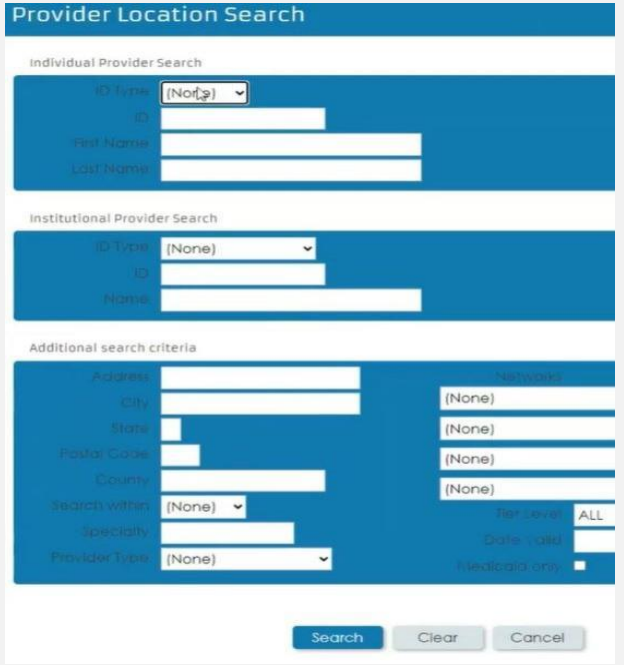
NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



To initiate adding a service, click Service 1 in the Authorization Request box in upper left side of page.

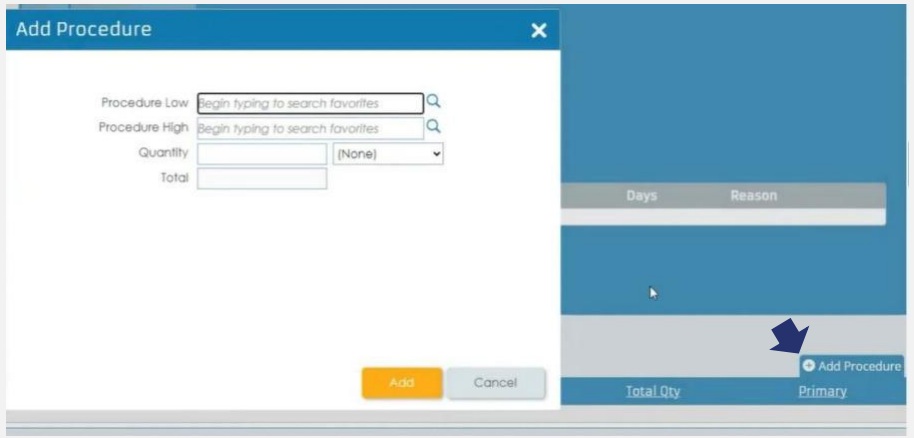


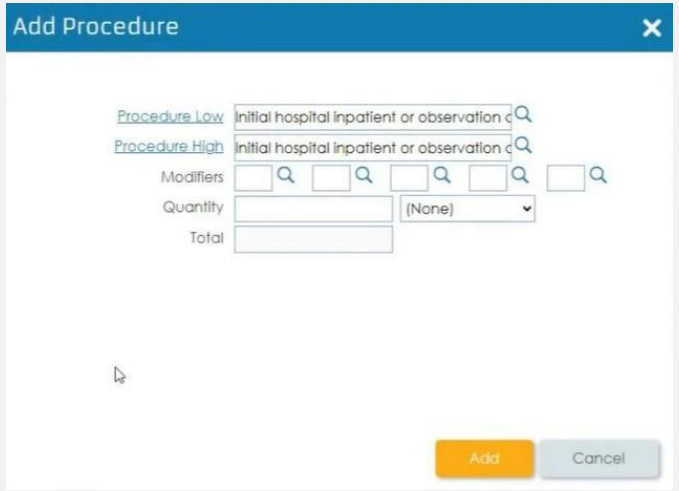


When entering dates of service, they must fall within 90 day date span that was initially entered. Click Magnifying glass for Provider, Group or Facility, and repeat provider search steps previously described by searching individual or institutional provider. This time, you must enter rendering provider's information.

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal





Next, procedure information should be added only for outpatient levels of care. Click add procedure tab toward bottom right of screen. A new window will open. Click magnifying glass next to Procedure Low to open search window.

Open drop down menu next to Procedure type. Make your selection and enter code. Click Search. You will be back at Add Procedure page. Procedure Low and High will be populated. Next, enter number of units requesting in Quantity field. Click drop down to right to select units. Then Click Add. *Note, if needing to add additional procedures, scroll up and click orange Copy Service Line.

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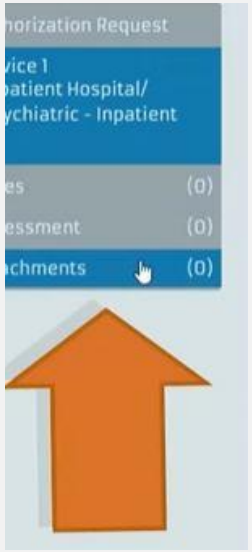
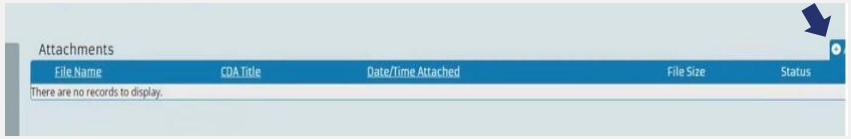
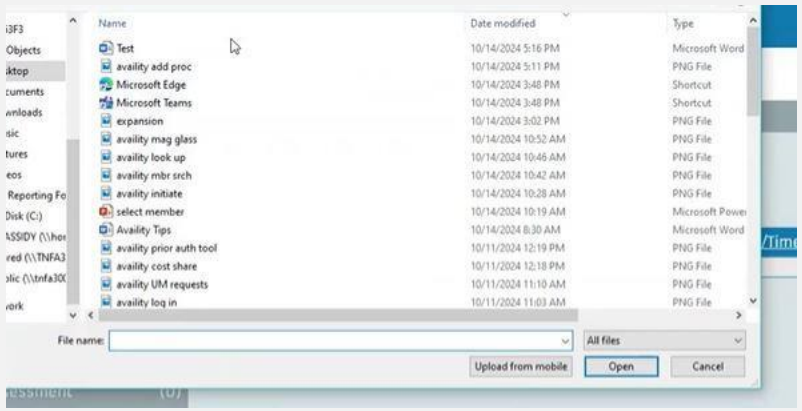
Horizon NJ Health | How to submit MH PA requests using Horizon's Portal







To add clinical information, attachments of clinical records can be added. Click add attachments in top left and then add file in the top right.

Double click on the file to be attached and then click upload file. A status of Attached appears when files are uploaded successfully.

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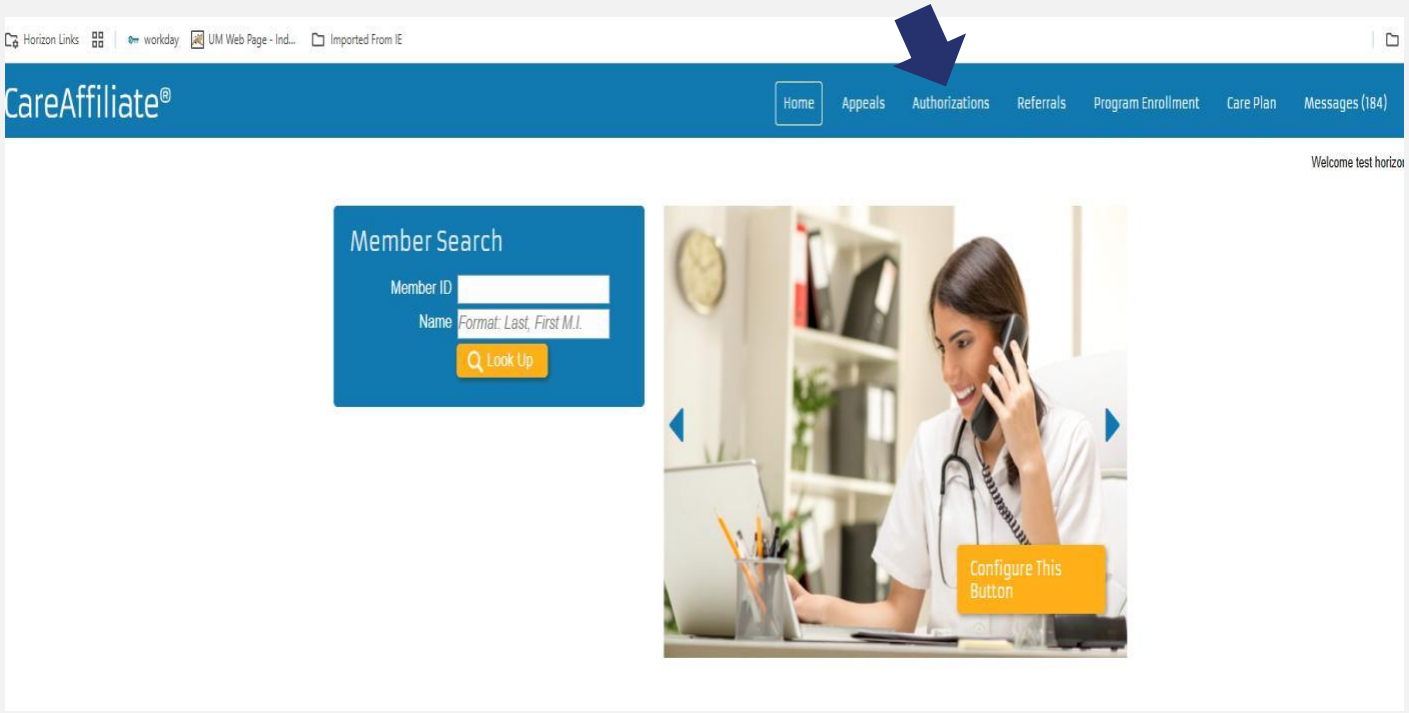
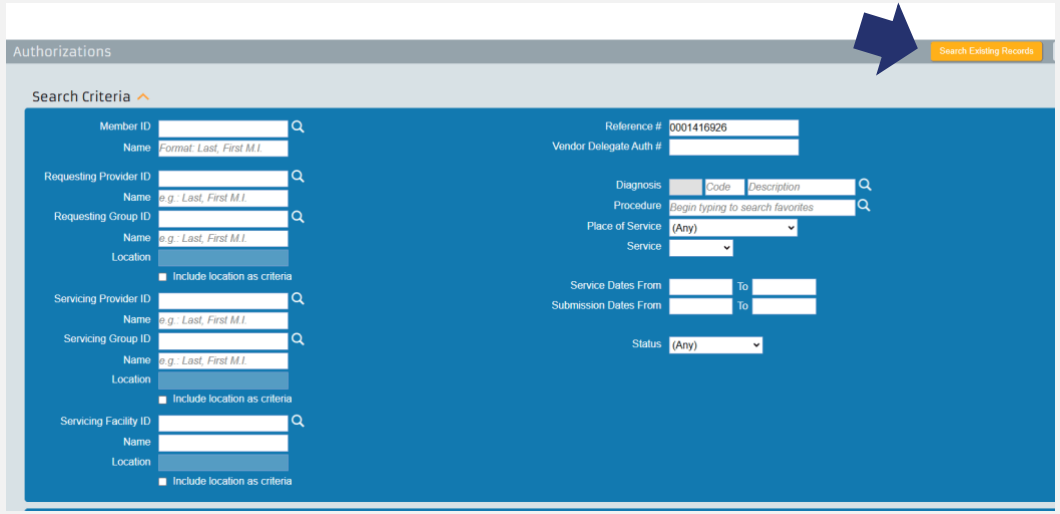
Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal



On the Home Screen, go to Authorizations section for Mental Health and Substance Use Disorders.

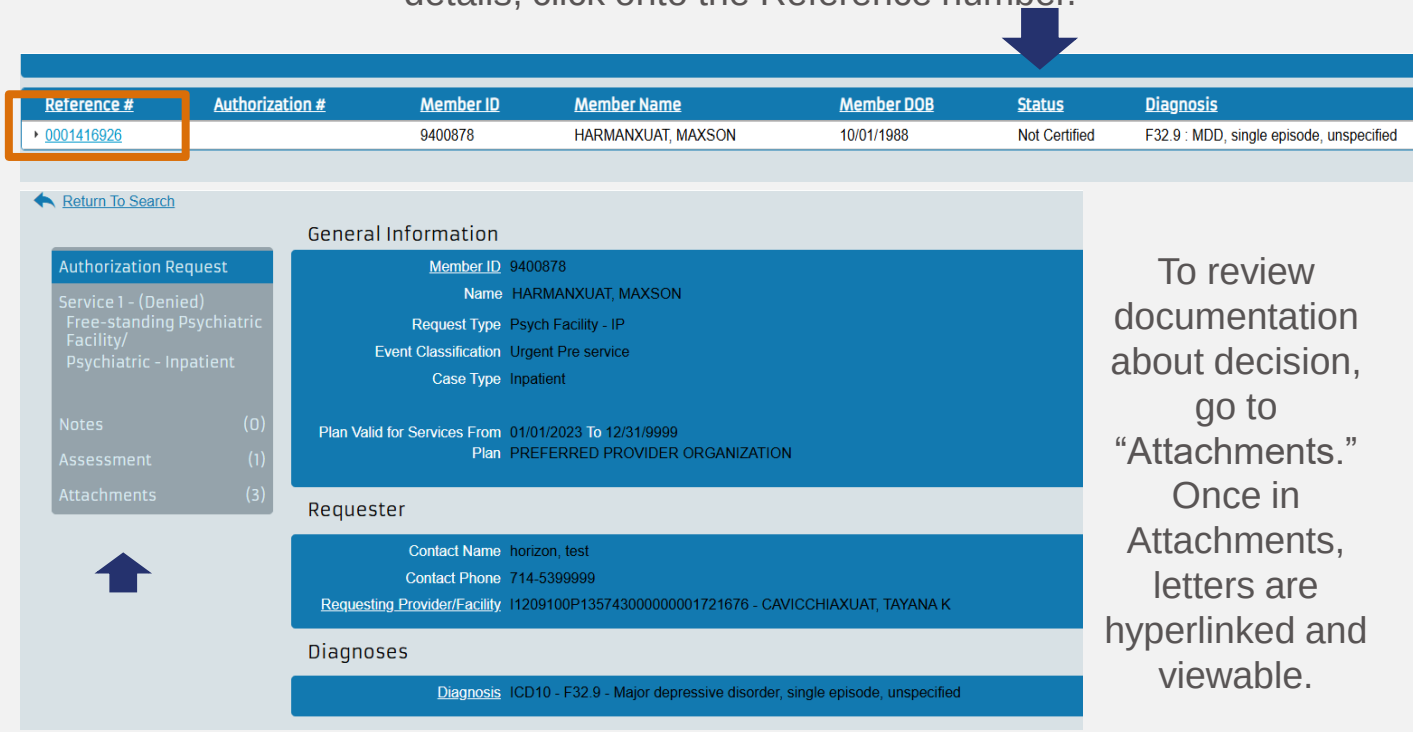
NEW JERSEY HUMAN SERVICES

Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal



Input the Reference number given on initial submission and click on "Search Existing Records."

Immediately you can review the Status. To get additional details, click onto the Reference number.



To review documentation about decision, go to "Attachments." Once in Attachments, letters are hyperlinked and viewable.

*Note: In order to get a print-out of the request and status, you can print screen.

UnitedHealthcare | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- Provider Express: Optum - Provider Express Home

Call:

- 1-888-362-3368 (found on back of member's ID card)
- Follow the below system prompts:
  - Enter TIN #
  - Select option 3 (intake)
  - Enter member ID/DOB
  - Select option for "Mental Health"

How providers will be notified of MH PA decisions:

- PA decisions will be available in Provider Express if provider submitted the original PA via the portal
- PA requests submitted telephonically will be communicated via phone in real time
- In addition, providers will also receive a letter with a decision

SUD Prior Authorizations through

Additional information guidance:

- UHCCPNJ receives authorization requests via NJSAMS, which is a one-way communication system. We cannot send any information back to the provider via this one-way communication system.
- Its important to have a current and updated contact at the facility/org.
- Once authorization is given by UHCCPNJ BH based on an NJSAMS submission, the provider can view that authorization in Provider Express.com.

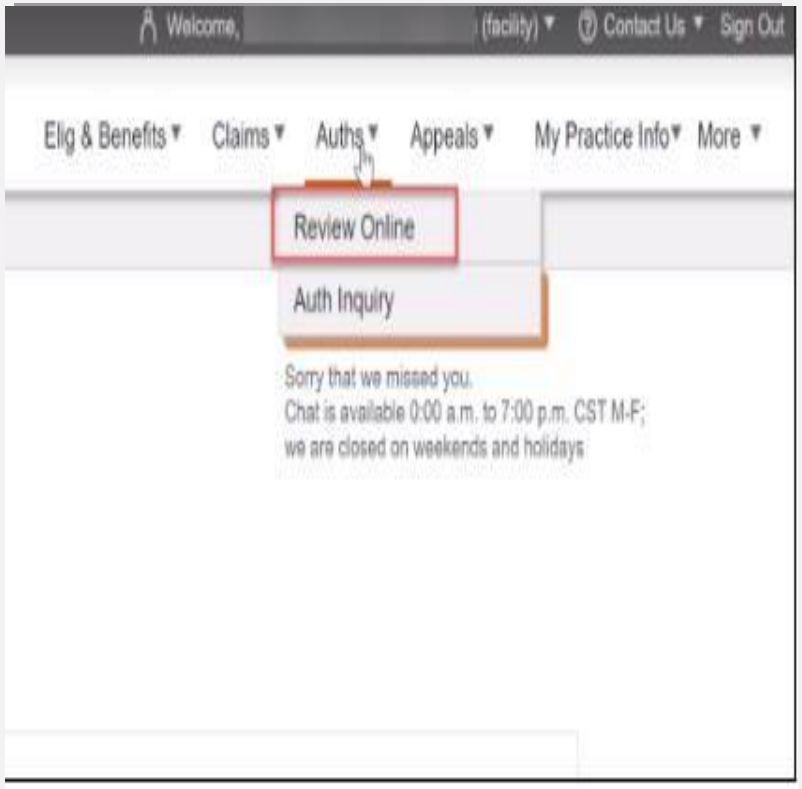
Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions sent back to provider via phone call
- SUD PA requests submitted through NJSAMS are also loaded into Provider Express; therefore, providers can check outcomes of submitted SUD PA requests via the portal

UnitedHealthcare
MH PA requests using our portal



Submit PA using Providerexpress.com
[Optum - Provider Express Home]

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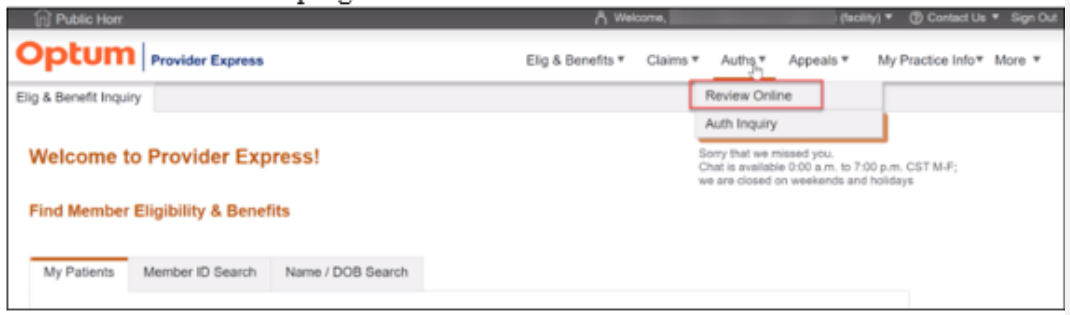
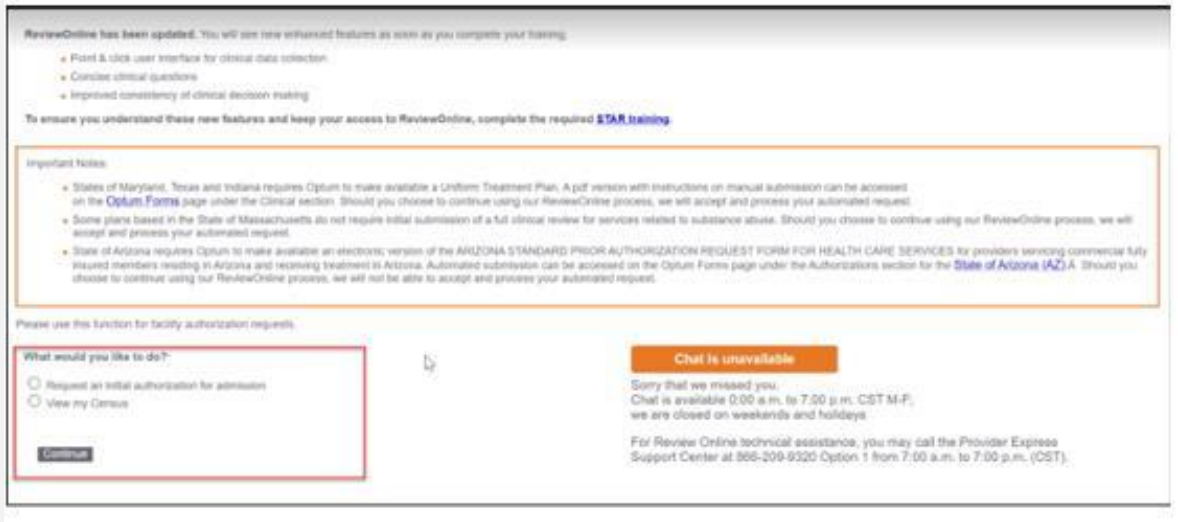
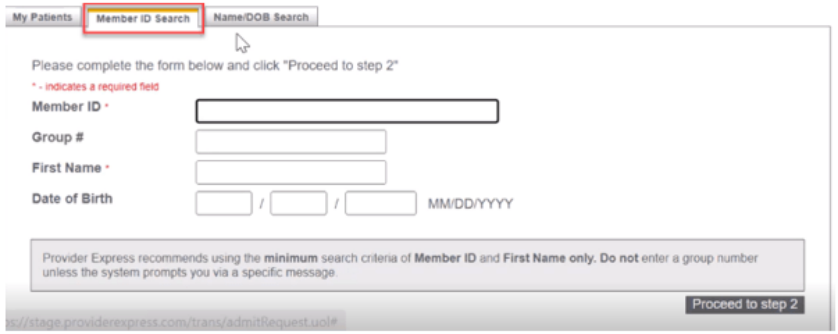
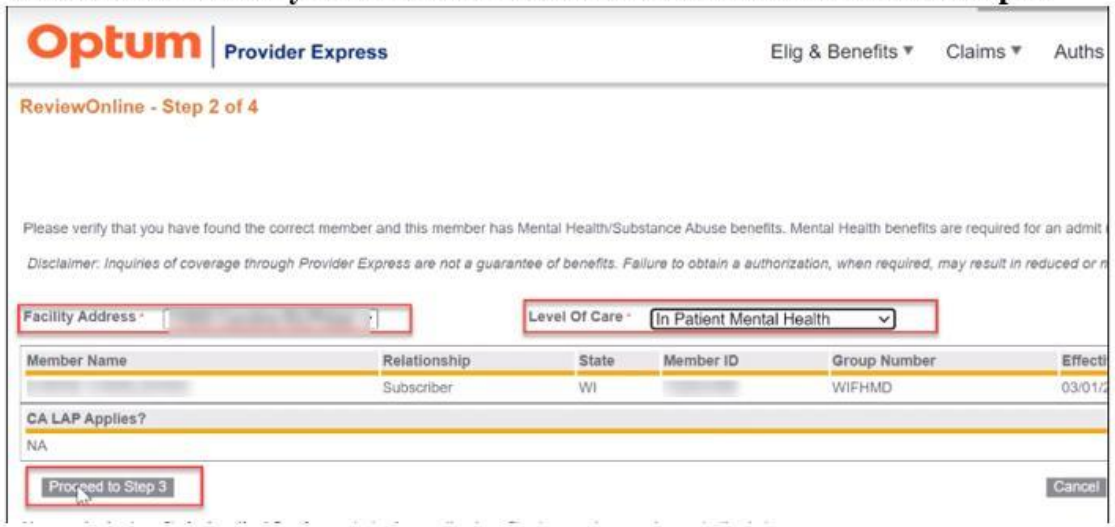
Step	Action
1	Providers will sign into Provider Express. https://public.providerexpress.com/content/ope-provexpr/us/en.html
2	Click on **Auths** in the top right-hand corner and select **Review Online**. 
3	Now, there are two options for the provider at this point. Providers can • **Request an initial authorization for admission** • **View their Census** - This takes you to a list of all of the facilities, patients and admit status. The Census page will show if an action is required or just the status of where the authorization is. Providers can also click on the Census option for Concurrent Review. 

UnitedHealthcare

Step	Action
1	The provider will land on the **ReviewOnline**- On this page providers can locate a member 3 different ways. a. **Member ID Search** – search by Member ID. 
2	Select **Proceed to step 2** at the bottom of the page.

3	This takes the provider to the **ReviewOnline-Step 2 of 4**. On this page the provider will select the **Facility Address** and **Level of Care**. Select **Proceed to Step 3**. 

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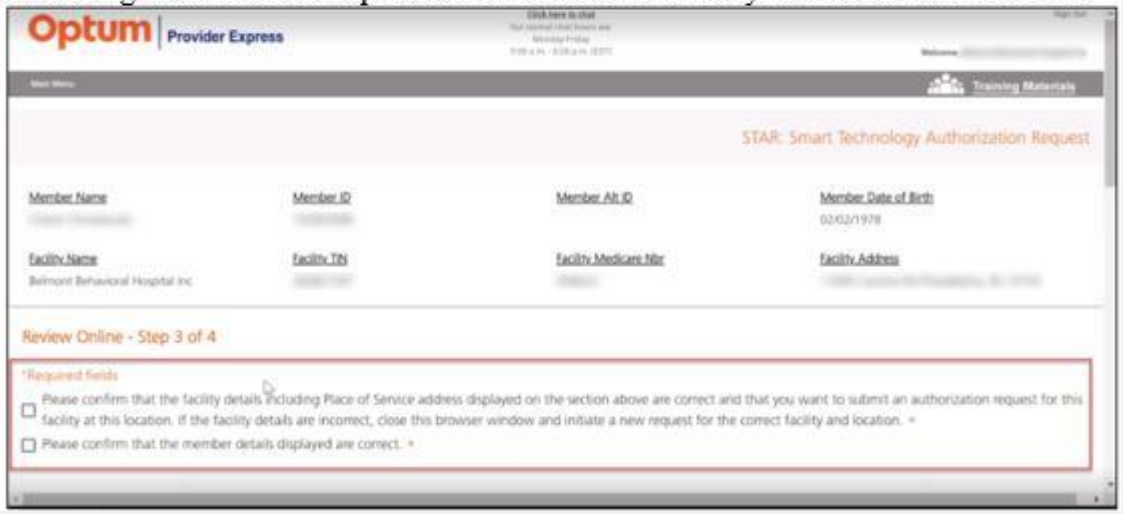
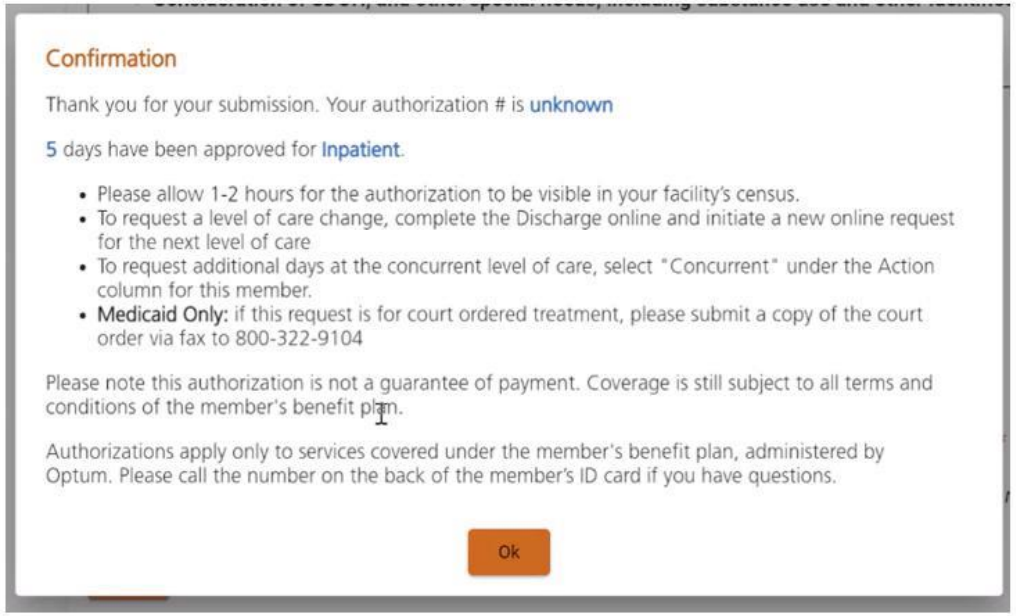
Step	Action
4	This takes the provider to the **ReviewOnline-Step 3 of 4**. On this page begin answering the initial set of questions to confirm the facility and member information. 

	• Enter the diagnosis
	• Pick the Level of Care
	• Answer the following questions
	  ○ **Involuntary admission?**
	  ○ **Is this request from an ER?**
	  ○ **Member admitted?**
	  ○ **Admit date**
	  ○ **Has the member been discharged from the current episode of care?**
	Select **Next**.

5	On the next page the provider will see a popup reminder letting the provider know that *The Draft is Saved. Incomplete drafts will be removed in 72 hours and no authorization will be created.* Select **OK**.

UnitedHealthcare

Step	Action
6	On the next page the Provider will complete all of the required information in the following sections • **Member Information** • **Admission Information** • **Attending MD** • **Utilization Reviewer** • **Current Symptoms and Severity.** • **Risks** • **Proposed Treatment** • **Discharge Planning** • **Attestation** **Note**: Fields with a red asterisk are required. Click **Next**.
7	On the next page the provider will see the Confirmation pop-up. The pop-up will provide the following • Authorization number • Number of days the level of care has been approved for 

UnitedHealthcare MH Partial Care PA

Electronic Submission – MH Partial Care	• Electronic Prior Authorization for partial care mental health can be submitted through Provider Express. To access the request form, go to: Providerexpress.com > Our Network > State-Specific Provider Information > New Jersey > Authorization Template • Complete the online request form. • Use the “Attesting Individual’s Email Address” to track where the request is in the authorization process.

Wellpoint | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):
- Availity Portal (access here)

Call or Fax:
- **Inpatient Medicaid, PHP, IOP, and all Urgent Services:** 844-451-2794 *(fax)*
- **Inpatient Medicare, PHP, IOP, and and Urgent Services:** 844-430-1702 *(fax)*
- **Access Fax Forms Here:**
  - Forms | Wellpoint New Jersey, Inc.
- **Call:** 833-731-2149

How providers will be notified of MH PA decisions:
- PA decisions will be available in Availity if provider submitted the original PA via the portal
- PA requests submitted telephonically or by fax will be communicated via phone call or fax

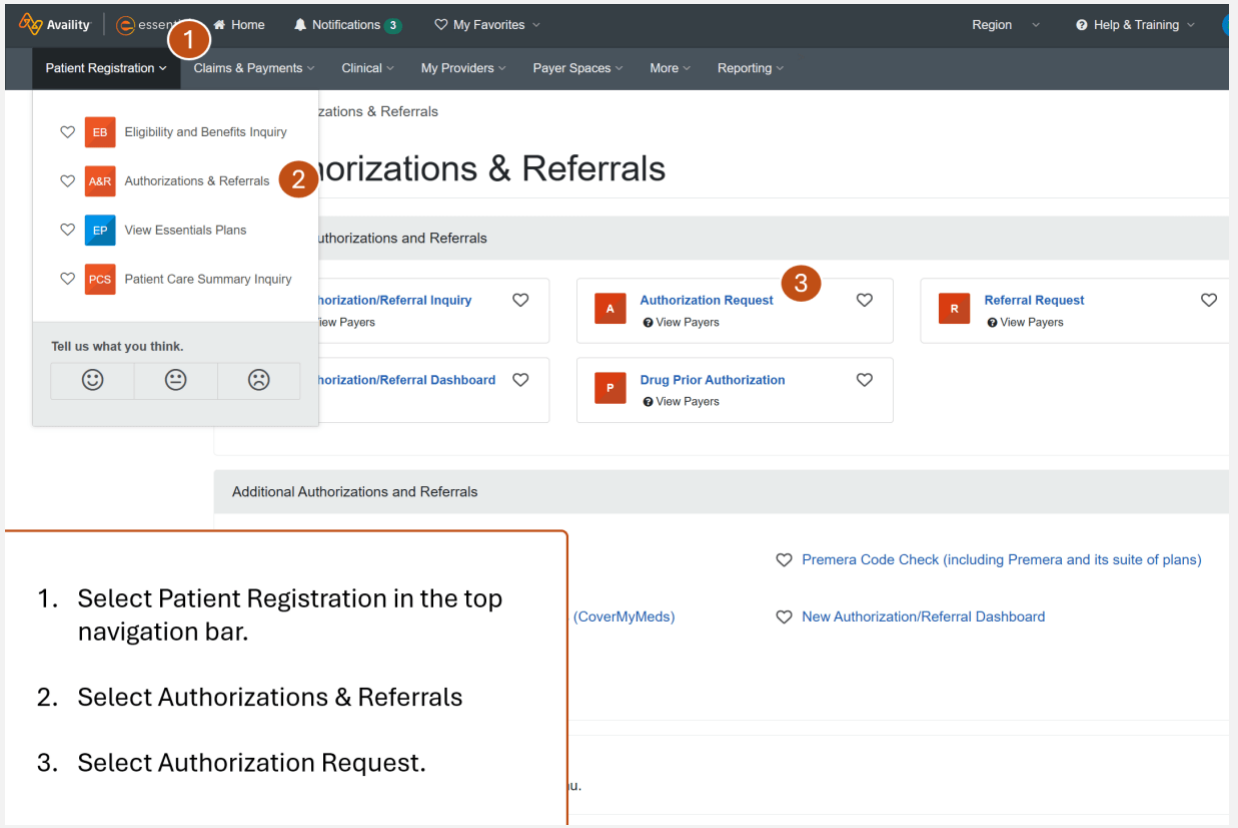
SUD Prior Authorizations through

Additional information guidance:
- Its important to have a current and updated contact at the facility – both phone and fax numbers are important.

Where to submit SUD PA requests:
- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:
- Decisions communicated to provider via fax or phone call

Wellpoint
MH PA requests using our portal



Submit PA using Availity Portal
(access here)

Note – recent issue submitting PA via portal will be fixed by March 17th.
Please use fax until that date

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