



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
Geraldyn Molinari, Director, Managed Provider Relations, DMAHS
Steve Tunney, Director of Behavioral Health, DMAHS

2:10–2:30

Guided State Q&A and FAQs

Geraldyn Molinari, Director, Managed Provider Relations, DMAHS
Steve Tunney, Director of Behavioral Health, DMAHS

2:30–2:45

Next steps

Geraldyn Molinari, Director, Managed Provider Relations, DMAHS

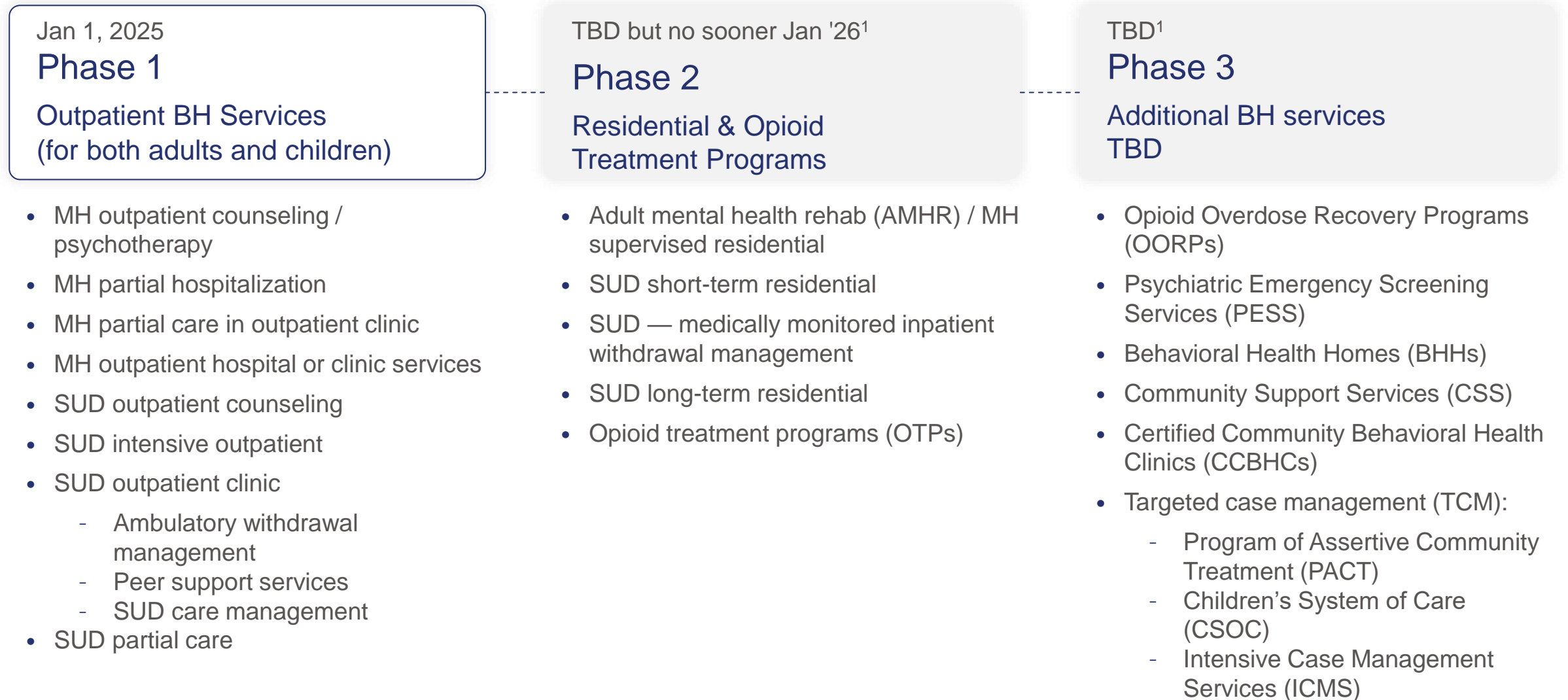
2:45–2:50

Open State and MCO tables for Q&A

Shanique McGowan Power, BH Program Manager, DMAHS
Geraldyn 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

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



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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> MCOs must pay out-of-network providers using Medicaid FFS rates as the floor for all claims that: <ul style="list-style-type: none"> - Are valid (i.e., submitted with no errors) 	<ul style="list-style-type: none"> MCOs must pay out-of-network providers using Medicaid FFS rates as the floor for all claims that: <ul style="list-style-type: none"> - Are valid (i.e., submitted with no errors) - Have a PA on file for a PA-required service (<i>out-of-network PA requirements vary by MCO; detail to follow</i>)

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

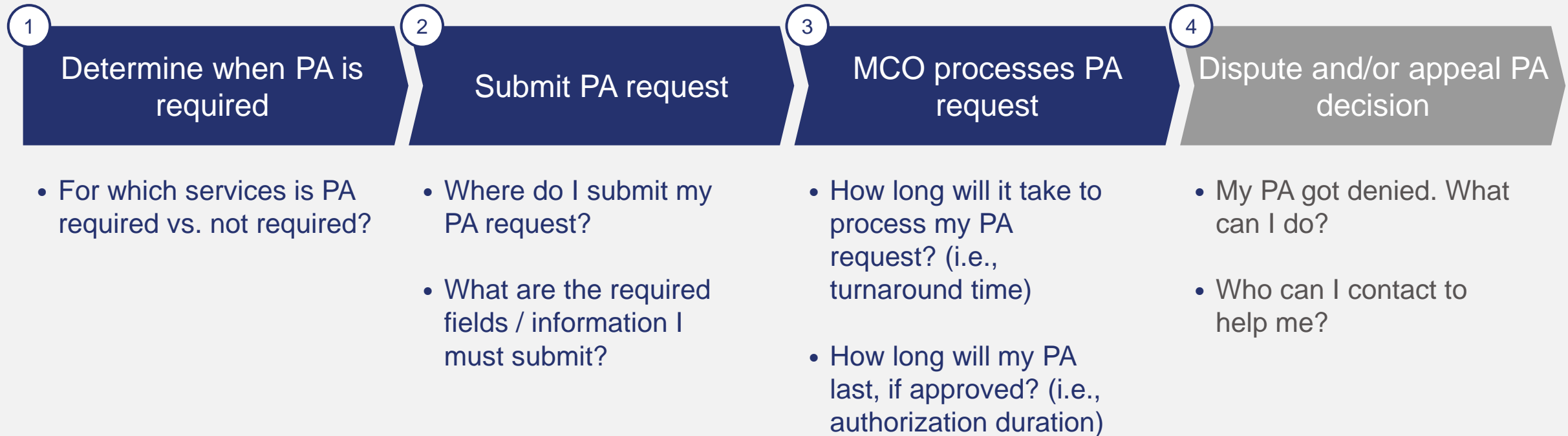
Adjudication of valid claims for **MH/SUD Partial Care, MH Partial Hospital, SUD IOP, and SUD Ambulatory Withdrawal Management** services based on PA submission

Scenario	Pre-7/1	Post-7/1
In network provider; no PA on file	Paid	Denied²
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

Four key steps in managed care prior authorization



- ***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

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 fax¹ 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	<ul style="list-style-type: none"> • Non-urgent vs. urgent (& clinical reason for urgency) • Type of request (initial vs. extension, renewal, or amendment)
Patient information	<ul style="list-style-type: none"> • Name, phone #/address, DOB, member ID and Medicaid #
Provider information	<ul style="list-style-type: none"> • For both requesting provider/facility and servicing provider or facility: <ul style="list-style-type: none"> - Name, NPI, Specialty, Contact info (phone, address, email), TIN - PAR vs. OON - Fax number
Services requested	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> Name, phone #/address, DOB, member Medicaid #, SSN/citizenship Admission date and site location
Provider information	<ul style="list-style-type: none"> Provider Name Provider Medicaid #
Clinical information	<ul style="list-style-type: none"> Admission report: <ul style="list-style-type: none"> 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
	<ul style="list-style-type: none"> LOCI report to assess appropriate level of care for patients across: <ul style="list-style-type: none"> 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
	<ul style="list-style-type: none"> 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 <i>if referred from inpatient, residential, or ER screening</i>
MH	<ul style="list-style-type: none"> Acute partial hospital (APH) Inpatient psychiatric hospital care 	<ul style="list-style-type: none"> Partial hospital (PH) Partial care (PC) Adult mental health rehabilitation (AMHR)
SUD	<ul style="list-style-type: none"> Ambulatory withdrawal management (AWM) Intensive outpatient (IOP) Inpatient medical detoxification Residential detoxification / withdrawal management (ASAM 3.7 WM) Short term residential 	<ul style="list-style-type: none"> 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	<u>Minimum</u> 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 (<i>Phase 2 service</i>)	14 days
Long Term Residential (<i>Phase 2 service</i>)	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

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

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	<ul style="list-style-type: none">• Emails (based on county):<ul style="list-style-type: none">- 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<ul style="list-style-type: none">- Press * for healthcare provider. Follow prompts for customer service needs.
Fidelis Care	<ul style="list-style-type: none">• Email: evelyn.mora@fideliscarenj.com or Michael.Czajkowski@fideliscarenj.com• Phone: 1-908-415-3101
Horizon NJ Health	<ul style="list-style-type: none">• Email: BHMedicaid_@horizonblue.com
UnitedHealthcare	<ul style="list-style-type: none">• Email: njnetworkmanagement@optum.com
Wellpoint	<ul style="list-style-type: none">• 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

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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Z0330• A0120 UC• A0425 UC — must be submitted with Z0330 or A0120 UC	
Wellpoint	<ul style="list-style-type: none">• A0120 UC• A0425 UC — must be submitted with A0120 UC	
Horizon	<ul style="list-style-type: none">• A0120 UC — replaced z-code, can be backdated to any date of service since 1/1/25• A0425 UC	
UnitedHealthcare	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Email: Katelyn.Mignone@Aetna.com• Phone: 1-855-232-3596<ul style="list-style-type: none">- Press * for healthcare provider. Follow prompts for customer service needs.
Fidelis Care	<ul style="list-style-type: none">• Email: FidelisCareNJ_BHClaimInquiry@fideliscarenj.com
Horizon	<ul style="list-style-type: none">• Email: BHMedicaid@horizonblue.com• Phone: 1-800-682-9091
UnitedHealthcare	<ul style="list-style-type: none">• Email: njproviderescalation@optum.com<ul style="list-style-type: none">- After reaching out, providers will be prompted to submit the <i>UHC BH New Jersey Provider Claim Template</i> for claims research to begin
Wellpoint	<ul style="list-style-type: none">• 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 website¹

The [BHI stakeholder website](https://www.nj.gov/humanservices/dmhas/information/stakeholder/) 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:



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/human-services/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](#)

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

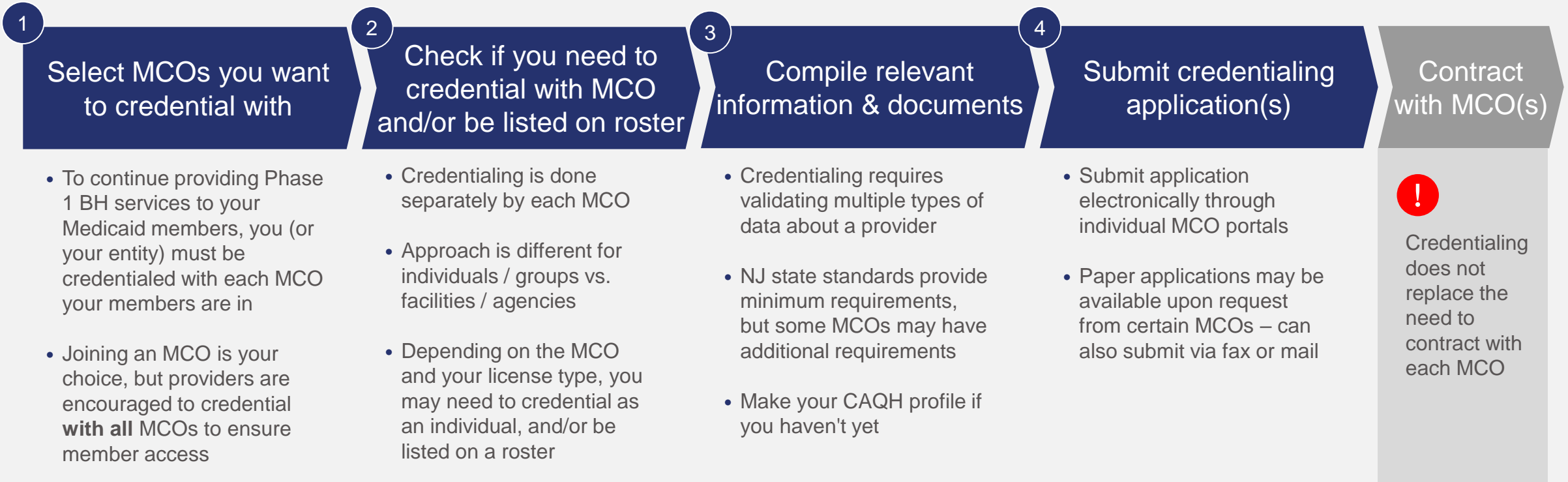
The process of establishing a **formal agreement** between the healthcare provider and the MCO, defining the **terms and conditions** under which the provider will **deliver** healthcare **services** to the MCO's members

Providers must contract with MCOs in addition to credentialing

- ☆ Horizon requires contracting before credentialing
- ☆ Other MCOs conduct processes simultaneously (Aetna, Fidelis, United¹, 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



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 MCOs¹:

- 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	<ul style="list-style-type: none"> Independent practitioners and/or multiple providers practicing in a group practice 	<ul style="list-style-type: none"> A licensed healthcare location, such as a hospital, outpatient clinic or home health agency
Credentialing requirements	<ul style="list-style-type: none"> Credential individually using Type 1 NPI 	<ul style="list-style-type: none"> Credential as an entity using Type 2 NPI – at Facility / Agency level
Rostering requirements	<ul style="list-style-type: none"> Groups may be required to list licensed individuals and OBAT navigators on group roster 	<ul style="list-style-type: none"> May be required to list all licensed practitioners and peers on facility / agency roster
Network Directory	<ul style="list-style-type: none"> Listed individually on MCO network directory 	<ul style="list-style-type: none"> 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 member¹ 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

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 practitioner¹; 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 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

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):

- Availability: [Access Availability 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 Availability 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.

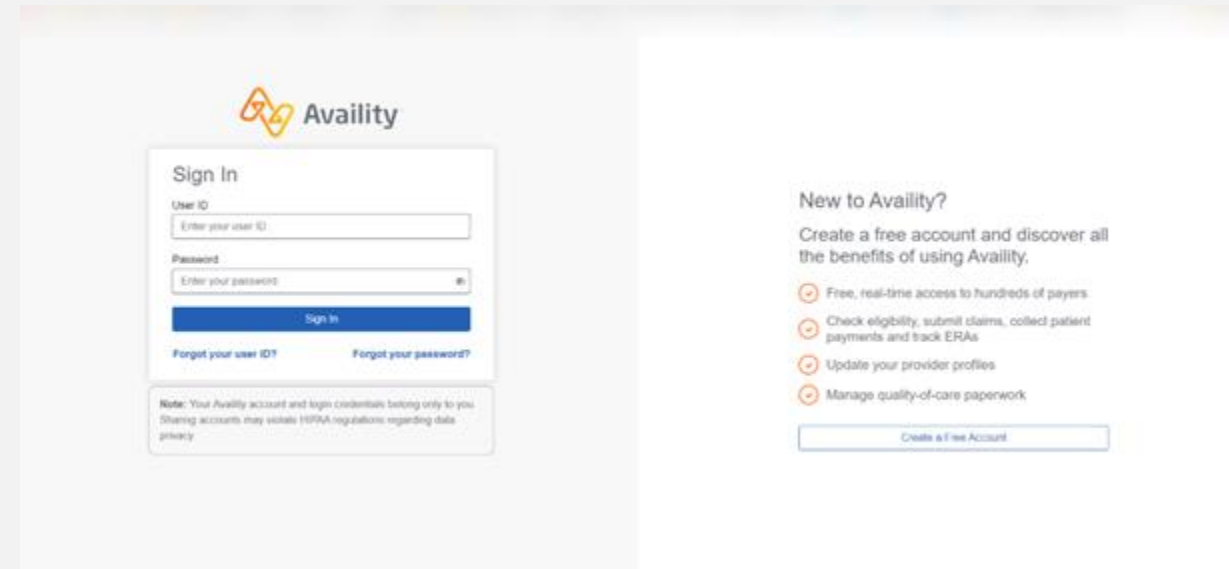
Where to submit SUD PA requests:

- 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



The screenshot shows the Availity portal interface. On the left, there is a 'Sign In' section with fields for 'User ID' and 'Password', a 'Sign In' button, and links for 'Forgot your user ID?' and 'Forgot your password?'. Below this is a note about account security. On the right, there is a 'New to Availity?' section with a list of benefits and a 'Create a Free Account' button.

Sign In

User ID
Enter your user ID

Password
Enter your password

Sign In

[Forgot your user ID?](#) [Forgot your password?](#)

Note: Your Availity account and login credentials belong only to you. Sharing accounts may violate HIPAA regulations regarding data privacy.

New to Availity?

Create a free account and discover all the benefits of using Availity.

- Free, real-time access to hundreds of payers
- Check eligibility, submit claims, collect patient payments and track ERAs
- Update your provider profiles
- Manage quality-of-care paperwork

[Create a Free Account](#)

Submit PA using Availity Portal
[Access Availity Here](#)

Submitting Authorizations in Availity

1 Select Authorization Request

Home > Authorizations & Referrals

Authorizations & Referrals

Multi-Payer Authorizations and Referrals

- Authorization/Referral Inquiry
- Authorization Request**
- Authorization/Referral Dashboard

Additional Authorizations and Referrals

- Prior Authorization - Pharmacy Benefit Drugs (CoverMyMeds)
- New HAM React

2 Enter applicable info and click Next

Authorizations

SELECT A PAYER

Organization

Aetna Medicaid Administrators

Template(s) optional

No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer

AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

Request Type

Inpatient Authorization

Next

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

Start an Authorization Add Service Information Rendering Provider/Facility Add Attachments Review and Submit

Transaction Type: Inpatient Authorization
Organization: Aetna Medicaid Administrators
Payer: AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

PATIENT INFORMATION

Select a Patient (Enter one or more to search: patient name (first or last), DOB, or Member ID.)

Member ID *

Patient Date of Birth *

Relationship to Subscriber *

Self

REQUESTING PROVIDER

Select a Provider optional

Requesting Provider Type *

Provider

NPI *

Contact Name *

ABC

Contact Phone *

(555) 555-5555

Contact Fax *

(555) 555-5555

Next

4 Enter the information for the authorization. Click Next

Authorizations

Start an Authorization Add Service Information Rendering Provider/Facility Add Attachments Review and Submit

Patient: SERGIO

Member ID: [redacted]
Date of Birth: [redacted]
Gender: Male
Eligibility Status: Active Coverage
Transaction Type: Inpatient Authorization
Group Number: NA
Organization: Aetna Medicaid Administrators
Plan / Coverage Date: NA
Payer: AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

SERVICE INFORMATION

Service Type *

Place of Service *

Admission Date *

Admission Type *

Quantity *

Quantity Type: Days

DIAGNOSIS CODE(S)

Diagnosis Code *

PROCEDURE CODE(S)

Procedure Code (optional)

MESSAGE

Provider Notes optional

Next

5 Enter the provider info and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer

Active Coverage
NA
Aetna Medical Administrators
AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

SERVICE PROVIDER ☐ Show Optional Fields

Select a Provider optional

Select Provider ...

Rendering Provider Role

Attending Physician

NPI

SERVICE PROVIDER 2 ☐ Show Optional Fields

Select a Provider optional

Select Provider ...

Rendering Provider Role

Admitting Services

NPI

FACILITY ☐ Show Optional Fields

Select a Provider optional

Select Provider ...

Rendering Provider Role

Facility

NPI

Back Next

6 Add any attachments and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer

Active Coverage
NA
Aetna Medical Administrators
AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

ADD ATTACHMENT(S)

All applicable clinical information should be submitted with the original request. Timely submission of clinical documentation is key in avoiding delays in processing your requests.

Attachments may be up to 80MB in size, but the total of all attachments cannot exceed 150MB.
 Do not upload files which have embedded web links or information rights management. We will not be able to view them.

Back Next

7 Verify all information and hit Submit

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer

Active Coverage
NA
Aetna Medical Administrators
AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

Member Information [Back to Step 1](#)

Patient Name	Patient Date of Birth	Patient Gender
Member ID	Relationship to Subscriber	Subscriber Name

Requesting Provider [Back to Step 1](#)

Name	NPI
Provider Role	Provider
Phone	Fax
(555) 555-5555	(555) 555-5555
Contact Name	
ABC	

Service Information [Back to Step 2](#)

Service Type	Place of Service	Admission - Discharge Date
1 - Medical Care	21 - Inpatient Hospital	2024-11-13
Admission Type	Quantity	
Emergency	5 Days	

Diagnostic Code 1

Rendering Provider/Facility [Back to Step 3](#)

Provider 1	NPI
Name	
Provider Role	Attending
Provider 2	NPI
Name	
Provider Role	Admitting Services
Provider 3	NPI
Name	
Provider Role	Facility

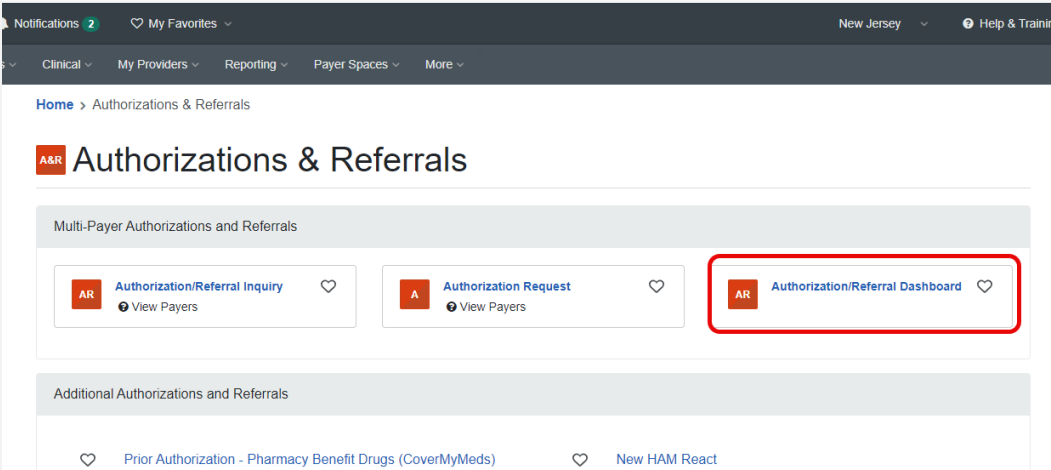
Attachment(s) [Back to Step 4](#)

There are no attachments.

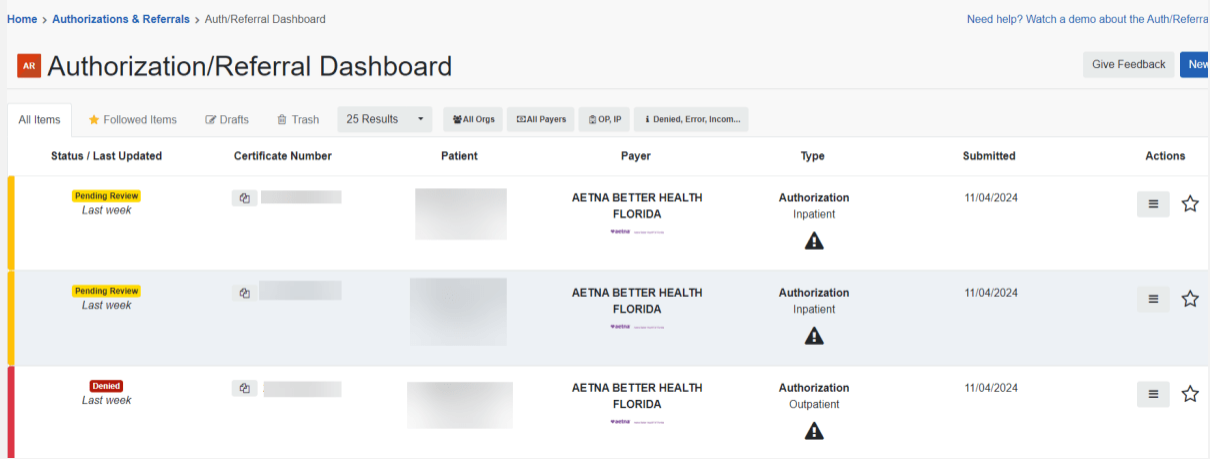
Back Submit

Checking Status of Authorizations Submitted via Availity

1. Click on Authorization/Referral Dashboard

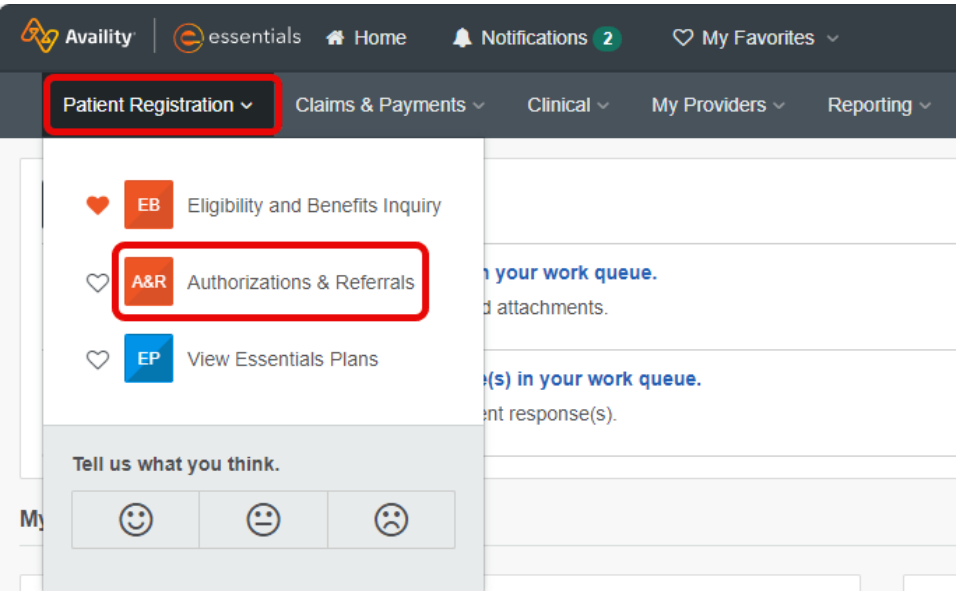


2 This will show status of those submitted in Availity only

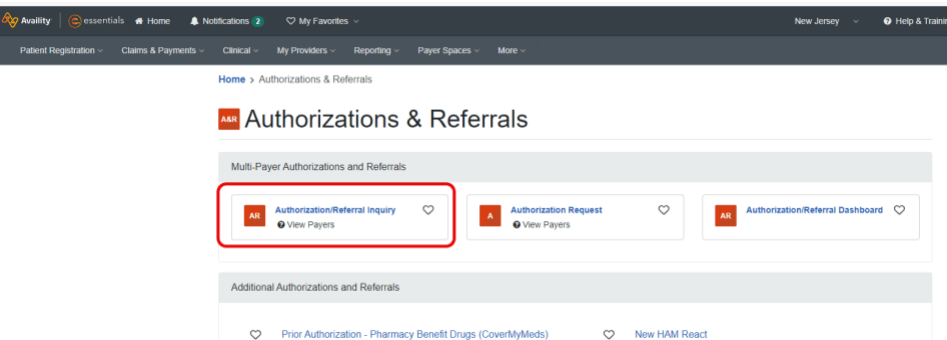


Authorization Inquiries

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.

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**

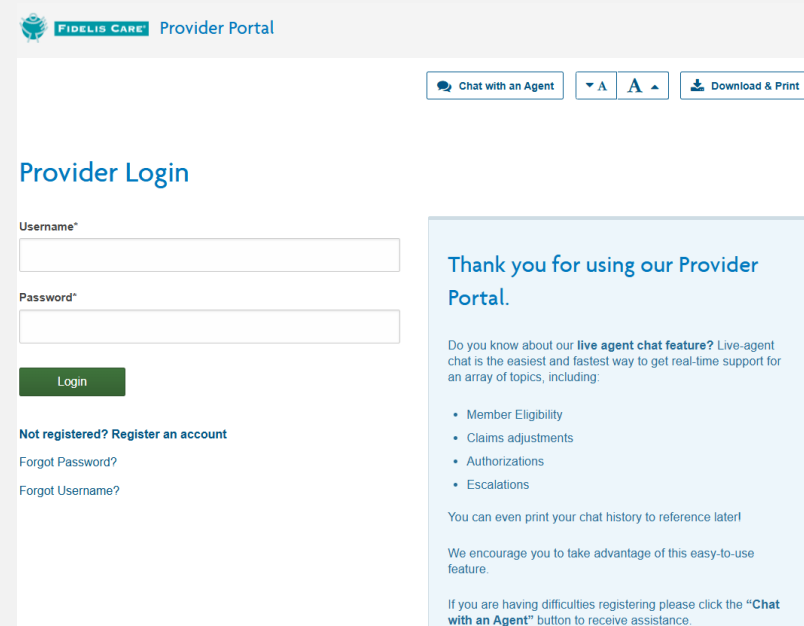
How providers will be notified of SUD PA decisions:

- 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



The screenshot shows the Fidelis Care Provider Portal login interface. At the top, the header includes the Fidelis Care logo and the text "Provider Portal". Below the header, there are three buttons: "Chat with an Agent", a font size selector (A A A), and "Download & Print". The main section is titled "Provider Login" and contains a login form with fields for "Username*" and "Password*", followed by a green "Login" button. Below the login button, there are links for "Not registered? Register an account", "Forgot Password?", and "Forgot Username?". To the right of the login form, there is a light blue informational box. It starts with "Thank you for using our Provider Portal." followed by a paragraph about the live agent chat feature. Below this is a bulleted list of topics: Member Eligibility, Claims adjustments, Authorizations, and Escalations. It also mentions that chat history can be printed and that users are encouraged to use the chat feature. At the bottom of the box, it provides instructions on how to get assistance if registration is difficult.

Fidelis Care Provider Portal

Chat with an Agent A A A Download & Print

Provider Login

Username*

Password*

Login

Not registered? Register an account

[Forgot Password?](#)

[Forgot Username?](#)

Thank you for using our Provider Portal.

Do you know about our **live agent chat feature**? Live-agent chat is the easiest and fastest way to get real-time support for an array of topics, including:

- Member Eligibility
- Claims adjustments
- Authorizations
- Escalations

You can even print your chat history to reference later!

We encourage you to take advantage of this easy-to-use feature.

If you are having difficulties registering please click the "Chat with an Agent" button to receive assistance.

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

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:

The screenshot shows the 'My Patients' section of a web portal. At the top, there is a navigation bar with links: Home, My Patients (highlighted with a red box), Care Management, Claims, My Practice, and Resources. A search bar is also present. Below the navigation bar, the 'My Patients' title is displayed in a blue header. Underneath, there are links for 'Back To Home', 'Help', 'A A A', and 'Download & Print'. The main heading is 'Check Member Eligibility', followed by a brief description: 'This section allows you to search for members and check eligibility. If you need additional assistance, please select the Help button. There, you can access FAQs or select your state and plan to chat with a Customer Service agent.'

The search area includes a dropdown for 'Select search criteria to find a member' (set to 'Member ID'), input fields for 'Member ID', 'Medicaid ID', and 'Medicare ID', and a date picker for 'Check patient eligibility on this date' (set to 07/12/2019). A 'Search' button is at the bottom right of the search area. A link 'Enter multiple member IDs to display' is also present.

Below the search area, it shows '54 Result(s)' and links for 'Filter Results' and 'Download Report'. A table of results is displayed with columns: Member Name, Member ID, Eligible, Effective Date, Term Date, Plan Name, Care Gaps, Important Info, and PCP. The first three rows of the table are visible, all showing 'Eligible' as 'Yes' and 'Effective Date' as '01-01-2016'. A 'Select Action' dropdown menu is open for the first row, showing options: 'View Details', 'Request Authorization' (highlighted with a red box), and 'Submit Referral'.

Select “**Request Authorization**” to access the authorization request form.

Option 2:

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

The image displays two screenshots of a healthcare portal interface.

Left Screenshot: The 'Care Management' tab is selected in the top navigation bar. A dropdown menu is open, showing options: 'QUICK TIP: Looking for a specific member?', 'Care Gaps Report', 'Find Authorizations and Referrals', 'Create New Authorization' (highlighted with a red box), and 'Create New Referral'. Below the navigation bar, there are two main sections: 'Find a Member' and 'Authorizations and Referrals'. The 'Find a Member' section has a 'Go To My Patients' button. The 'Authorizations and Referrals' section has a 'Go To Care Management' button.

Right Screenshot: The 'Create Authorization' page is shown. It features a 'Find a Member' section with a search form. The search form has a 'Search Type' dropdown set to 'Member ID' and an 'ID' input field. A 'Search' button (highlighted with a red box) is to the right of the input field. Below the search form is a table with columns: 'Patient Name', 'Date of Birth', 'Member ID', and 'Plan'. The first row of the table has a blue selection icon in the first column (highlighted with a red box). At the bottom right, there is a 'Select Member' button (highlighted with a red box) and a note: 'Select a member from the list above'.

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 scheduled 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**

Requesting Provider Information

The following Provider is attached to this Authorization

Provider ID	Provider Name	Phone Number	Specialty	Address
County	<div>Requesting Provider Fax * (111) 111-1111</div>			

Choose a Provider

Is this a prescheduled service or an inpatient notification?

☒ Inpatient Notification

☐ Prior Authorization including preplanned inpatient

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.)

Servicing Provider InformationCOLLAPSE

Note: Select checkbox if same as the requesting provider

Provider Type *

Provider ID *

Advanced Search

Provider Name

Specialty

Fax

County/Island

Address

Facility

Advanced Search

(111) 111-1111

Authorization InformationCOLLAPSE

Service Type *

Subtype *

Place of Service *

Inpatient Services

Inpatient

21 - Inpatient Hospital

Place of Service Description

Inpatient Hospital

Planned Admit Date *

Requested Days

7/15/2019

1

Additional Service Information

Diagnosis Information

Date From

Date Thru

Diagnosis Code

Description

7/15/2019

7/16/2019

H21.221

DEGENERATION OF CILIARY BODY RIGHT EYE

CPT Codes

Date From

Date Thru

Procedure Code

Description

Requested Units

✱ View Auth

Modifier

7/15/2019

7/16/2019

81297

MSH2 GENE DUP/DELETE
VARIANT

1

Auth Required

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

Create Authorization

Chat with an Agent

Help

Download & Print

This authorization has not been submitted. Please review the information and submit below.

Patient Information

Member Name

Member ID

Date of Birth

Gender

Address

Requesting provider Information

Provider ID

Phone Number

Fax number

Specialty

Address

Servicing Provider Information

Provider Type

Provider ID

Provider Name

Specialty

Fax

Address

County/State

Facility

Requester Contact Information

Name

Fax#

Phone#

Extension

Authorization Details

Received Date

Contact Channel

Service Type

Subgroup

Created Date

Place of Service

Place of Service Description

Inpatient Hospital

Additional Service Information

Planned Submit Date

Requested Days

Diagnosis Information

Date From

Date Thru

Diagnosis Code

Description

CPT Codes

Date From

Date Thru

Procedure Code

Description

Requested Units

Is Auth. Required?

Note

Attachment Information

File Name

Save Draft

Submit Authorization

Edit Authorization

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:

Create Authorization

Reference Number: PA-287189

Submission was successful



Check Authorization Status

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

[Home](#) | [My Patients](#) | **Care Management** ▾ | [Claims](#) ▾ | [My Practice](#) ▾ | [Resources](#) ▾

Create Authorization

QUICK TIP
Looking for a specific member?
Use the My Patients search to look up a member's medical profile, including authorizations, claims, pharmacy utilization, and more.

[Member Information](#)

Care Gaps Report

Review all of your members' open care gaps.

Find Authorizations and Referrals
Search or review recently submitted authorizations and referrals.

[Create New Authorization](#)
Start a new authorization request.

[Create New Referral](#)
Start a new referral request.

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.

3 Result(s) [Filter Results](#) [Download Report](#)

Provider Name	Member Name	Member ID	Authorization Number	Requested Date	Auth Status	Actions
...	06/11/2019	Under Review	Select Action ▾ View Details

Place of Service: INPATIENT HOSPITAL | Serial Reason: ... | Member Profile: ... | Cpt Codes: ...

Diagnosis codes: ... | Last 5 authorizations: ...

Under Review

Authorization Details

[Back To Home](#) [Clear with no request](#) [Help](#)

Authorization # [\[Link\]](#)
Approval Date: 06/11/2019

Request Date: 06/10/2019 | Expiration Date: 07/11/2019

Patient Information

Member Name: ... | Date of Birth: ...
Member ID: ... | Effective Date: ...
Phone Number: ...

Servicing Provider Information

Provider Name: ...
Servicing Provider Type: ...
Address: ...
Provider Name: ...
Address: ...

Diagnosis Codes

Diagnosis code	Description
J70.9	UNKNOWN DRUG-INDUCED INTERSTITIAL LUNG DYSFUNCTION

Units Approved: 8 Units | Place of Service: INPATIENT HOSPITAL | Request Date: 06/11/2019

Auth Status: **Under Review** | Serial Reason: ...

CPT codes

CPT code	Description
No records found	

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

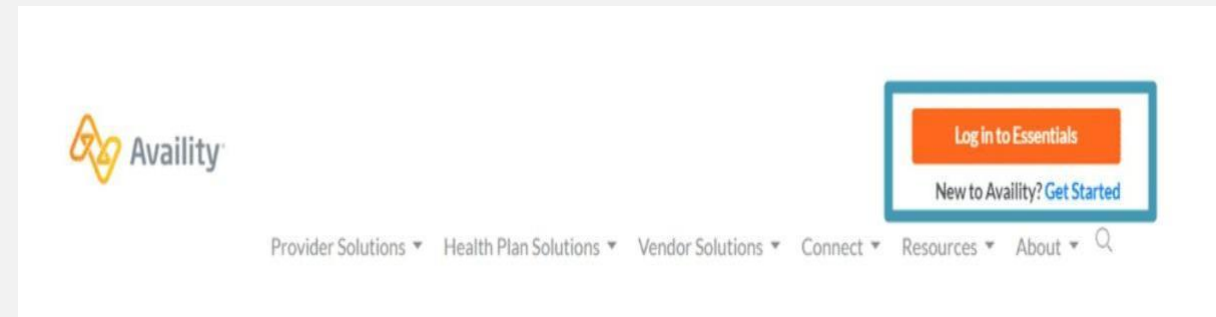
Where to submit SUD PA requests:

- 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

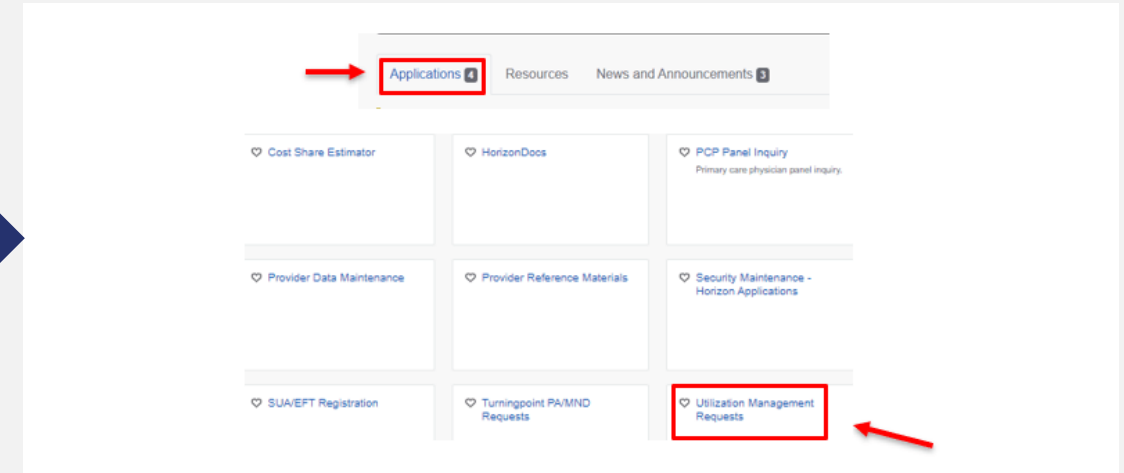
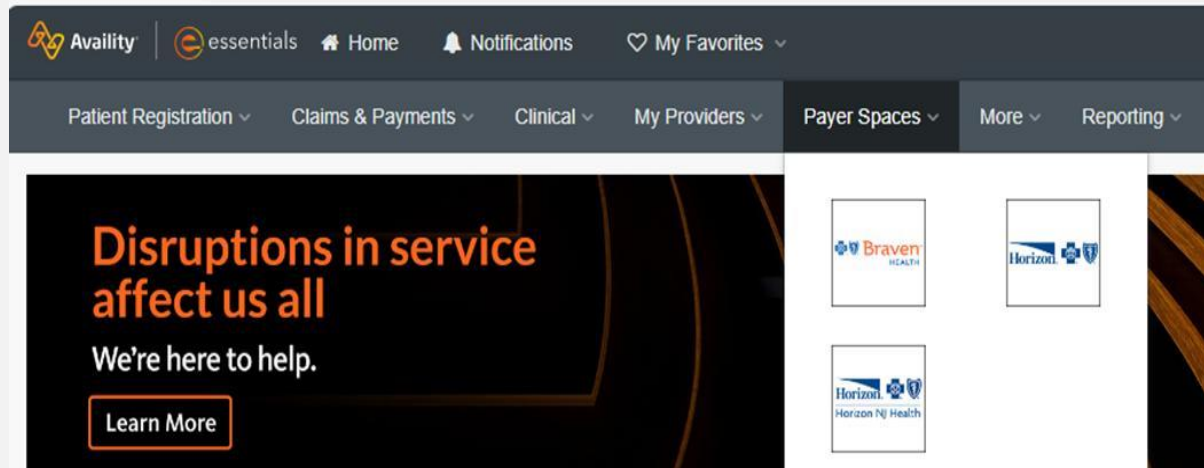
<https://availability.com/>

Learn about the Utilization Management Request
Tool Enhancements

[Self Study Guide](#)

[UM Tool Training Module](#)

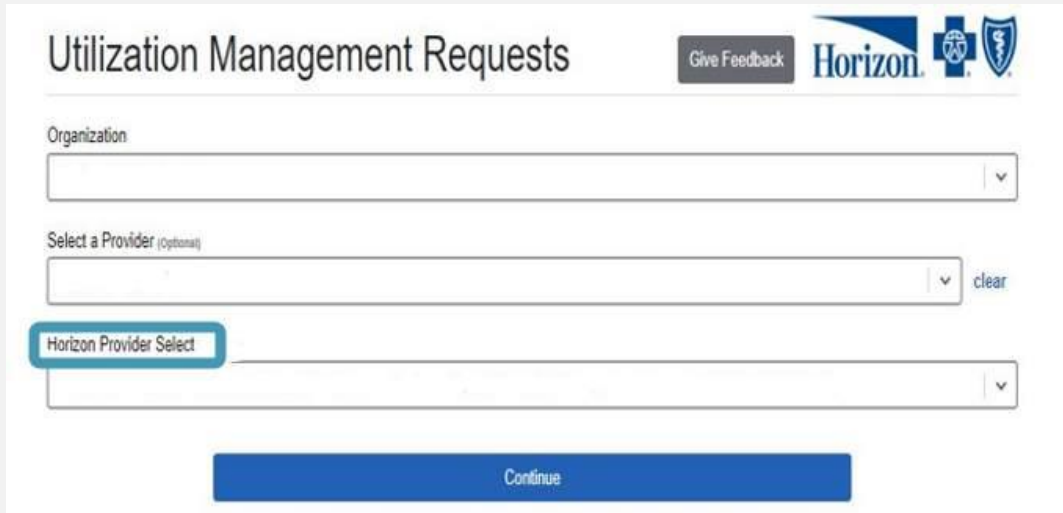
Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



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

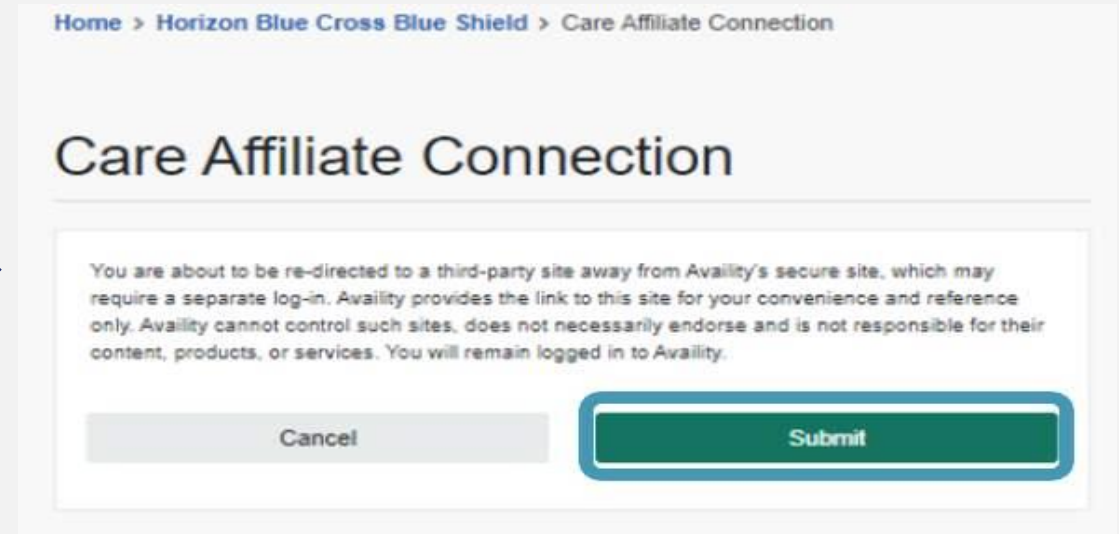
Scroll within Applications tab to Utilization Management Requests and click.

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



The screenshot shows the 'Utilization Management Requests' page. At the top, there is a 'Give Feedback' button and the Horizon logo. Below the title, there are three dropdown menus: 'Organization', 'Select a Provider (Optional)', and 'Horizon Provider Select'. The 'Horizon Provider Select' dropdown is highlighted with a blue border. At the bottom of the form is a blue 'Continue' button.

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



The screenshot shows the 'Care Affiliate Connection' screen. At the top, there is a breadcrumb trail: 'Home > Horizon Blue Cross Blue Shield > Care Affiliate Connection'. Below the title, there is a text box with a disclaimer: 'You are about to be re-directed to a third-party site away from Availity's secure site, which may require a separate log-in. Availity provides the link to this site for your convenience and reference only. Availity cannot control such sites, does not necessarily endorse and is not responsible for their content, products, or services. You will remain logged in to Availity.' At the bottom, there are two buttons: a grey 'Cancel' button and a green 'Submit' button.

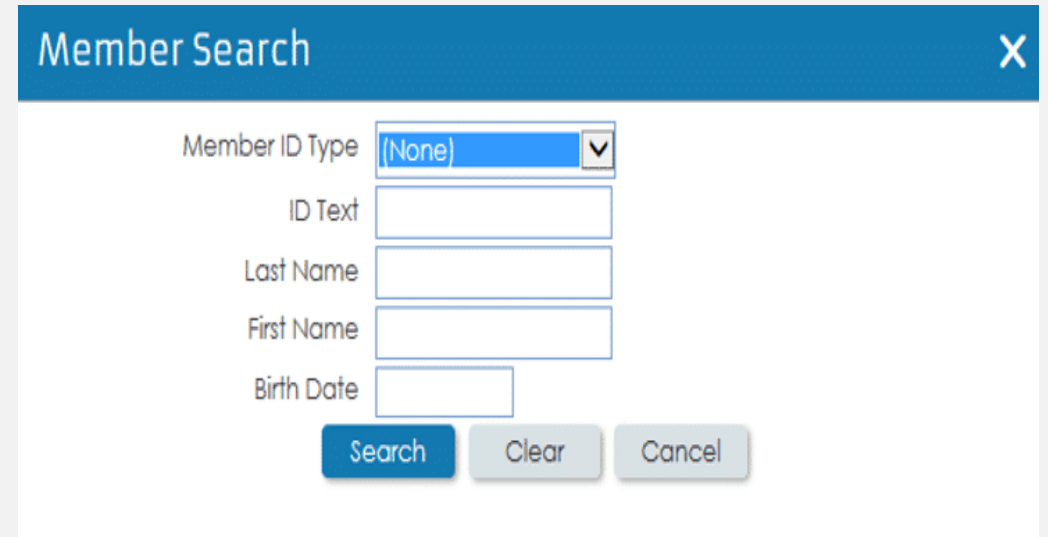
This screen advises that you that you will be re-directed to a platform called CareAffiliate. Click Submit to proceed.

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



The screenshot shows the CareAffiliate portal interface. At the top, there is a blue header with the CareAffiliate logo and navigation links for Home, Appeals, and Authorizations. Below the header, a 'Member Search' widget is displayed. It contains a 'Member ID' text input field, a 'Name' text input field with a placeholder 'Format: Last, First M.I.', and a yellow 'Look Up' button with a magnifying glass icon. A blue arrow points to the 'Look Up' button.

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



The screenshot shows the 'Member Search' screen. It has a blue header with the title 'Member Search' and a close button (X). Below the header, there are several input fields: 'Member ID Type' (a dropdown menu with '(None)' selected), 'ID Text', 'Last Name', 'First Name', and 'Birth Date'. At the bottom, there are three buttons: 'Search' (blue), 'Clear' (grey), and 'Cancel' (grey).

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

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

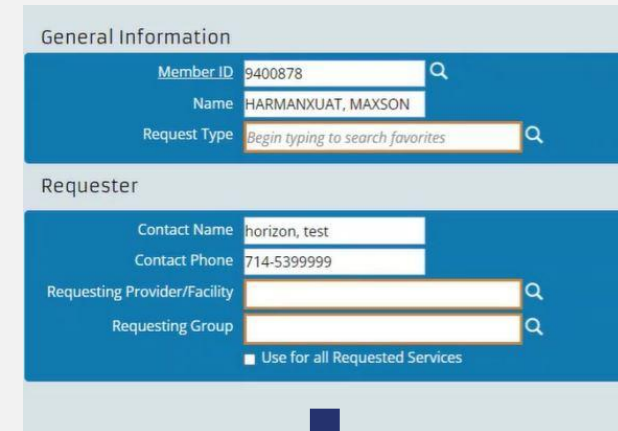


Member Search

Member ID: 2469533
Name: SCHMIDTXUAT, PAYNE
[Look Up](#)

Search Results [Clear](#)

- Appeals (0) [New](#)
- ▶ **Authorizations (4)** [New](#)
- Referrals (0) [New](#)
- Care Plans (0)
- Member Messages (0)
- Last Member Message(s) Received: N/A

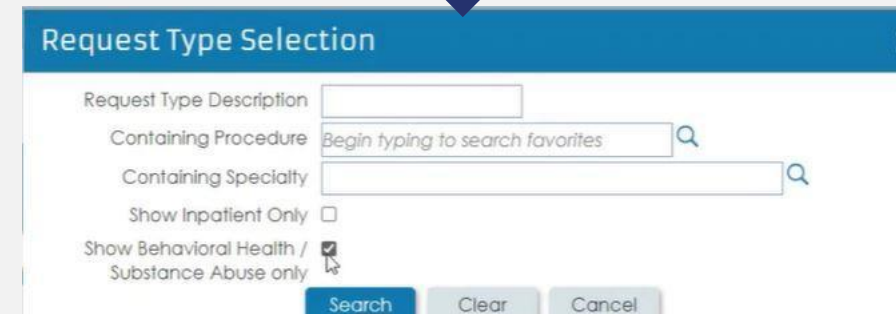


General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: Begin typing to search favorites

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility:
Requesting Group:
☐ Use for all Requested Services



Request Type Selection

Request Type Description:
Containing Procedure: Begin typing to search favorites
Containing Specialty:
☐ Show Inpatient Only
☒ Show Behavioral Health / Substance Abuse only
[Search](#) [Clear](#) [Cancel](#)

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.

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

General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: Inpatient Psychiatric
Event Classification: Urgent Concurrent
Case Type: Inpatient
Plan Valid for Services From: To: Plan: (None)

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility:
Requesting Group:
☐ Use for all Requested Services



Individual Provider Search

ID Type: NPI
ID:
First Name:
Last Name:
Search

Institutional Provider Search

ID Type: (None)
ID:
Name:
Search

Additional search criteria



Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility: 1001632907-81840283 - CAVICCHIAKUAT
Requesting Group:
☐ Use for all Requested Services

Diagnoses

Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description

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.

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

Authorizations

Authorization Request

Service 1
Inpatient Hospital/
Psychiatric - Inpatient

Notes (0)

Assessment (0)

Attachments (0)

General Information

Member ID 9400878

Name HARMANXUAT, MAXSON

Request Type Inpatient Psychiatric

Event Classification Urgent Concurrent

Case Type Inpatient

Plan Valid for Services From 10/01/2024 To 12/31/2024

Plan PREFERRED PROVIDER ORGANIZATION

Requester



Status Reason Electronic Submission

Place of Service Inpatient Hospital

Service Psychiatric - Inpatient

Service From

To

Provider

Group

Facility

Provider Role Attending

Actual Date Admitted

Admitting Diagnosis

Actual Discharge Date

Discharge Diagnosis

Disposition (None)



Provider Location Search

Individual Provider Search

ID Type (None)

ID

First Name

Last Name

Institutional Provider Search

ID Type (None)

ID

Name

Additional search criteria

Address

City

State

Postal Code

County

Search within (None)

Specialty

Provider Type

Ref Level ALL

Date - valid

Medical only

Search Clear Cancel

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.

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

Procedure Low

Procedure High

Quantity

Total

Procedure Type Gender

Code Age

Description

There are no records to display.

Procedure Low

Procedure High

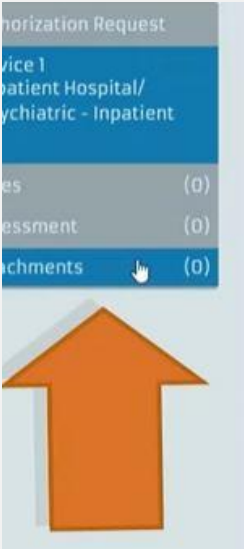
Quantity

Total

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.

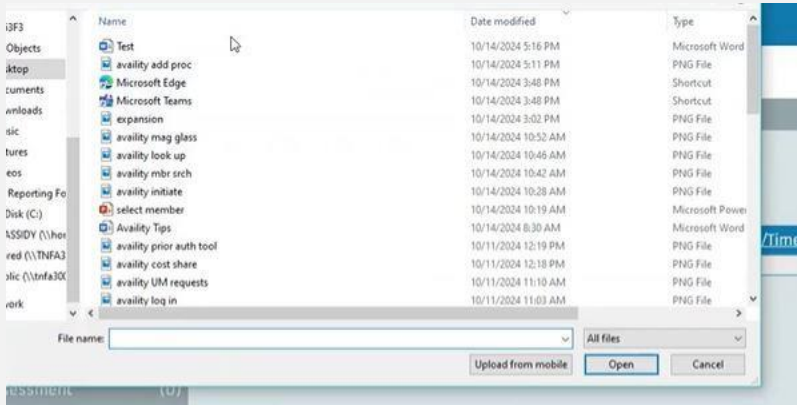
Open drop down menu next to Procedure type. Make your selection and enter code. Click Search. You will be back at Add Procedure page. Procedure Low and High will be populated. Next, enter number of units requesting in Quantity field. Click drop down to right to select units. Then Click Add. *Note, if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

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



Attachments				
File Name	CDA Title	Date/Time Attached	File Size	Status
There are no records to display.				

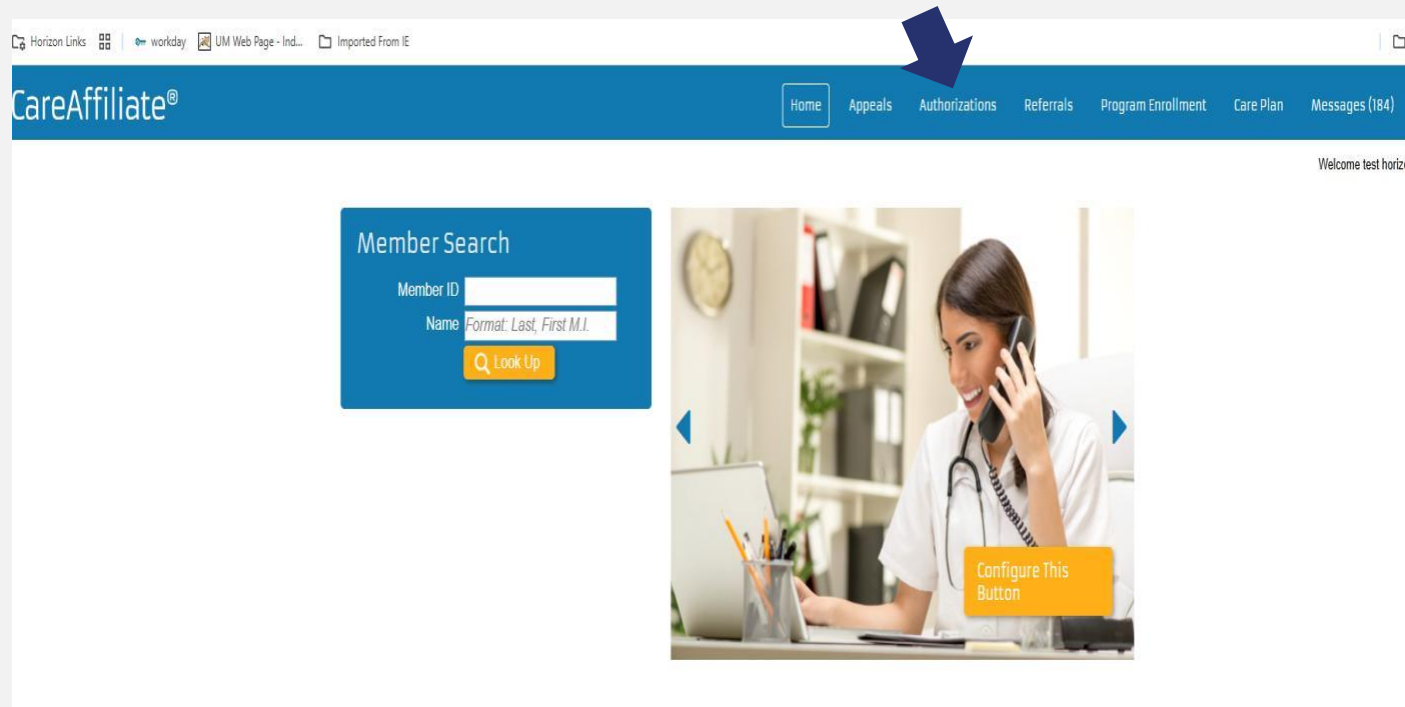
To add clinical information, attachments of clinical records can be added. Click add attachments in top left and then add file in the top right.



CDA Title	Date/Time Attached	File Size	Status
	10/14/2024 5:37 PM	11 KB	Attached

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

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.

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

Authorizations

Search Existing Records

Search Criteria

Member ID

Name Format: Last, First MI

Requesting Provider ID

Name e.g.: Last, First MI

Requesting Group ID

Name e.g.: Last, First MI

Location

Include location as criteria ☐

Servicing Provider ID

Name e.g.: Last, First MI

Servicing Group ID

Name e.g.: Last, First MI

Location

Include location as criteria ☐

Servicing Facility ID

Name

Location

Include location as criteria ☐

Reference # 0001416926

Vendor Delegate Auth #

Diagnosis Code Description

Procedure Begin typing to search favorites

Place of Service (Any)

Service

Service Dates From To

Submission Dates From To

Status (Any)

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.

Reference #	Authorization #	Member ID	Member Name	Member DOB	Status	Diagnosis
0001416926		9400878	HARMANXUAT, MAXSON	10/01/1988	Not Certified	F32.9 : MDD, single episode, unspecified

[Return To Search](#)

Authorization Request

Service 1 - (Denied)
Free-standing Psychiatric Facility/
Psychiatric - Inpatient

Notes (0)

Assessment (1)

Attachments (3)

General Information

Member ID 9400878

Name HARMANXUAT, MAXSON

Request Type Psych Facility - IP

Event Classification Urgent Pre service

Case Type Inpatient

Plan Valid for Services From 01/01/2023 To 12/31/9999

Plan PREFERRED PROVIDER ORGANIZATION

Requester

Contact Name horizon, test

Contact Phone 714-5399999

Requesting Provider/Facility I1209100P135743000000001721676 - CAVICCHIAUAT, TAYANA K

Diagnoses

Diagnosis ICD10 - F32.9 - Major depressive disorder, single episode, unspecified

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.

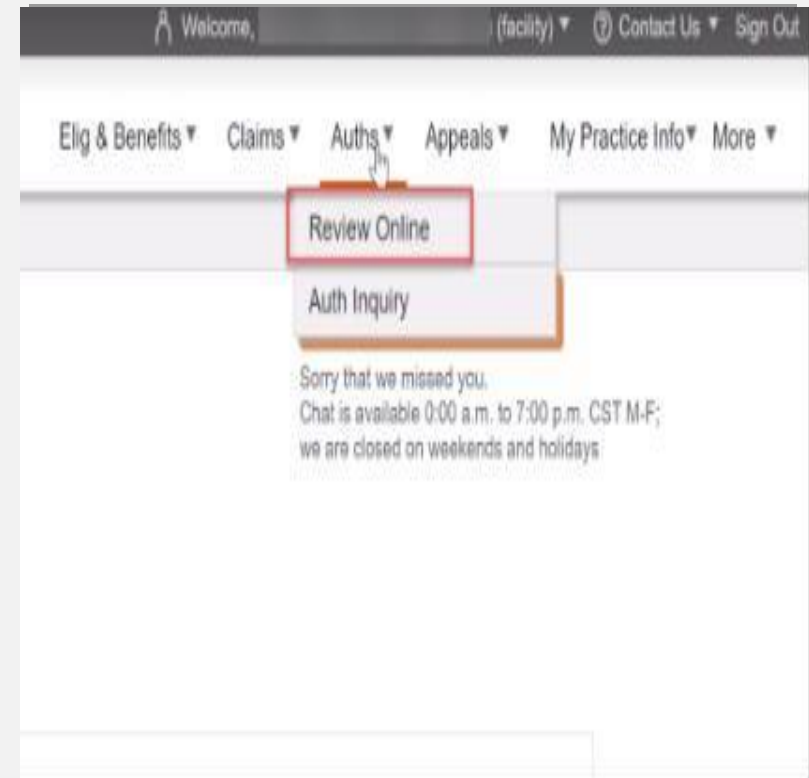
Where to submit SUD PA requests:

- 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](#)

UnitedHealthcare

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.

ReviewOnline has been updated. You will see new enhanced features as soon as you complete your training.

- Point & click user interface for clinical data collection
- Concise clinical questions
- Improved consistency of clinical decision making

To ensure you understand these new features and keep your access to ReviewOnline, complete the required [STAR training](#).

Important Notes:

- States of Maryland, Texas and Indiana requires Optum to make available a Uniform Treatment Plan. A pdf version with instructions on manual submission can be accessed on the [Optum Forms](#) page under the Clinical section. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- Some plans based in the State of Massachusetts do not require initial submission of a full clinical review for services related to substance abuse. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- State of Arizona requires Optum to make available an electronic version of the ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES for providers servicing commercial fully insured members residing in Arizona and receiving treatment in Arizona. Automated submission can be accessed on the Optum Forms page under the Authorizations section for the [State of Arizona \(AZ\)](#). Should you choose to continue using our ReviewOnline process, we will not be able to accept and process your automated request.

Please use this function for facility authorization requests.

What would you like to do?

☐ Request an initial authorization for admission

☐ View my Census

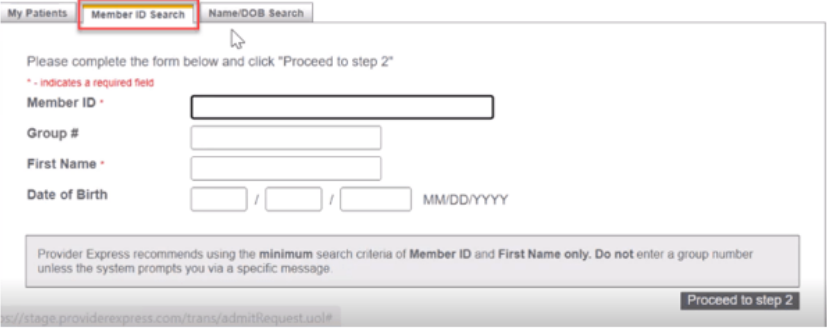
[Continue](#)

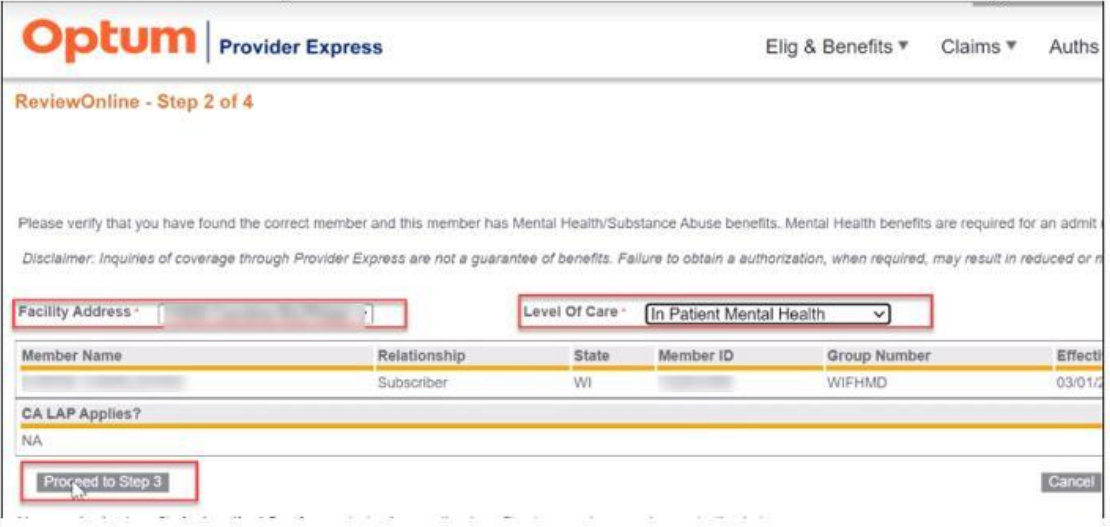
Chat is unavailable

Sorry that we missed you.
Chat is available 0:00 a.m. to 7:00 p.m. CST M-F;
we are closed on weekends and holidays.

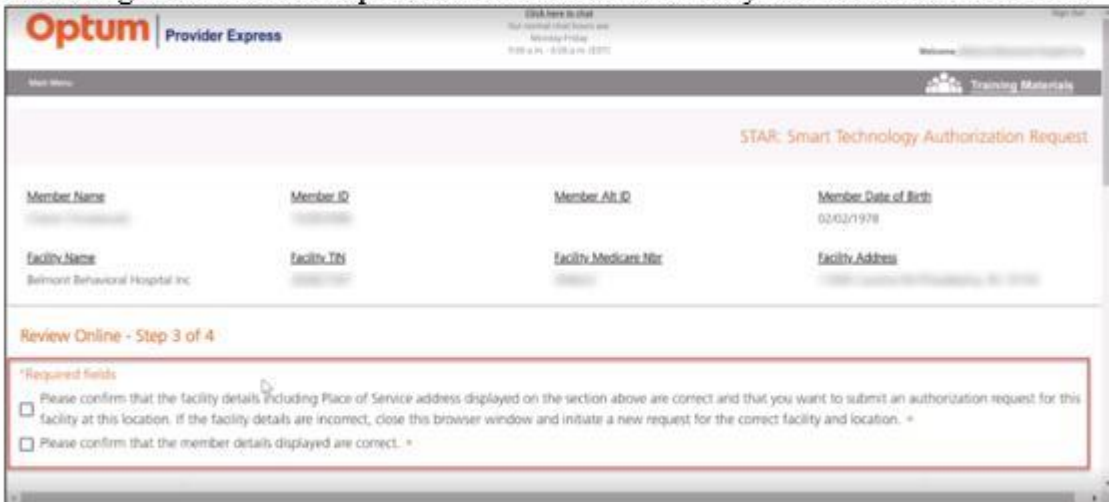
For Review Online technical assistance, you may call the Provider Express Support Center at 866-209-9325 Option 1 from 7:00 a.m. to 7:00 p.m. (CST).

UnitedHealthcare

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

3	<p>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.</p> 
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UnitedHealthcare

Step	Action
4	<p>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.</p>  <p>The screenshot shows the 'Review Online - Step 3 of 4' page. It contains a table with member and facility details. Below the table, there is a section titled '*Required fields' with two checkboxes: 'Please confirm that the facility details including Place of Service address displayed on the section above are correct and that you want to submit an authorization request for this facility at this location. If the facility details are incorrect, close this browser window and initiate a new request for the correct facility and location. =>' and 'Please confirm that the member details displayed are correct. =>'. Both checkboxes are currently unchecked.</p>

- 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	<p>On the next page the Provider will complete all of the required information in the following sections</p> <ul style="list-style-type: none"> • Member Information • Admission Information • Attending MD • Utilization Reviewer • Current Symptoms and Severity. • Risks • Proposed Treatment • Discharge Planning • Attestation <p>Note: Fields with a red asterisk are required.</p> <p>Click Next.</p>

7	<p>On the next page the provider will see the Confirmation pop-up. The pop-up will provide the following</p> <ul style="list-style-type: none"> • Authorization number • Number of days the level of care has been approved for <div data-bbox="1454 618 2453 1222"> <p>Confirmation</p> <p>Thank you for your submission. Your authorization # is unknown</p> <p>5 days have been approved for Inpatient.</p> <ul style="list-style-type: none"> • Please allow 1-2 hours for the authorization to be visible in your facility's census. • To request a level of care change, complete the Discharge online and initiate a new online request for the next level of care • To request additional days at the concurrent level of care, select "Concurrent" under the Action column for this member. • Medicaid Only: if this request is for court ordered treatment, please submit a copy of the court order via fax to 800-322-9104 <p>Please note this authorization is not a guarantee of payment. Coverage is still subject to all terms and conditions of the member's benefit plan.</p> <p>Authorizations apply only to services covered under the member's benefit plan, administered by Optum. Please call the number on the back of the member's ID card if you have questions.</p> <p>Ok</p> </div>
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UnitedHealthcare MH Partial Care PA

Electronic Submission – MH Partial Care	<ul style="list-style-type: none">• 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.
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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

The screenshot shows the Availity portal interface. The top navigation bar includes links for Patient Registration, Claims & Payments, Clinical, My Providers, Payer Spaces, More, and Reporting. A red circle with the number 1 highlights the 'Patient Registration' link. Below the navigation bar, a sidebar menu lists various services: Eligibility and Benefits Inquiry (EB), Authorizations & Referrals (A&R), View Essentials Plans (EP), and Patient Care Summary Inquiry (PCS). A red circle with the number 2 highlights the 'Authorizations & Referrals' link. The main content area is titled 'Authorizations & Referrals' and displays several options: 'Authorization/Referral Inquiry', 'Authorization/Referral Dashboard', 'Authorization Request' (with a red circle with the number 3), and 'Referral Request'. Each option has a 'View Payers' link. Below the main content area, there is a section for 'Additional Authorizations and Referrals' with links for 'Premera Code Check (including Premera and its suite of plans)', 'New Authorization/Referral Dashboard', and '(CoverMyMeds)'.

1. Select Patient Registration in the top navigation bar.
2. Select Authorizations & Referrals
3. Select Authorization Request.

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

