NEW JERSEY HUMAN SERVICES

Mental Health Prior Authorization (PA) Guidance and Medical Necessity Training

NJ FamilyCare Behavioral Health Integration

SEPTEMBER 19, 2025

Housekeeping

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

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

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

Submit your **questions using the "Q&A" function** – direct them to State or specific MCO

(Note: we will aim to respond to all questions directly during or after the meeting. Responses to broadly-applicable questions may be shared publicly)

Materials and recording will be published and available on DMAHS website

NEW JERSEY HUMAN SERVICES

Agenda

Welcome and Phase 1 updates Shanique McGowan Power, BH Program Manager, DMAHS	1:30–1:40
Overview of managed care PA review process Geralyn Molinari, Director, Managed Provider Relations, DMAHS	1:40–1:45
Completing MH PA administrative fields Geralyn Molinari, Director, Managed Provider Relations, DMAHS	1:45–1:50
Completing MH PA clinical documentation Jana Lang, BH Program Manager, DMAHS Irina Stuchinsky, Program Support Specialist, DMAHS	1:50–2:10
Medical necessity criteria and sample PAs Shanique McGowan, BH Program Manager, DMAHS Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint	2:10–2:40
Next steps Shanique McGowan, BH Program Manager, DMAHS	2:40–2:45
State and MCO Q&A DMAHS Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint	2:45–3:00

NEW JERSEY HUMAN SERVICES

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[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)

Phase 2 of BH Integration will be delayed to go-live after January 2026

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

DMAHS extended the transition period for all MCOs until at least October 31, 2025

In response to provider concerns and to minimize any risk of disruption of access to care, DMAHS **temporarily extended some transition period flexibilities**. These modified transition period policies will be in effect **until at least October 31, 2025**.

As of July 1, 2025:
• Providers must submit prior authorization (PA) requests   • However, **PAs must be automatically approved and will not be denied for medical necessity** • Claims for PA-required services will be denied if no PA is on file

• MCOs have chosen to continue to pay out-of-network providers using Medicaid FFS rates until October 31st
• These claims must:
  • Be submitted with **no errors**
  • Have a **PA on file for a PA-required services** (*out-of-network PA requirements vary by MCO*)

During this time, DMAHS is **monitoring each MCO's readiness** to determine an **end date for their transition period policies**

NEW JERSEY HUMAN SERVICES

This time before the end of the transition period presents a key opportunity to ensure post-transition readiness

Provider benefits

By submitting PAs to learn MCO systems and expectations now, providers can:

- **Minimize PA and claims denials** in the post-transition period
- **Ensure more rapid processing** of PAs
- **Reduce administrative burden** on staff

Key Dates

- **Oct 22nd:** Providers notified about which MCOs will continue transition period policies
- **Oct / Nov:** In-person provider Office Hours *(date to be confirmed)*
- **Oct 31st:** Final day of transition policies for MCOs deemed 'ready'
- **Nov 1st:** Transition policies lifted for MCOs deemed 'ready'

NEW JERSEY HUMAN SERVICES

Learning goals for today

By the end of today's training, you will:

- Understand the **PA review process** after a PA is submitted to an MCO
- Know how to **complete administrative and clinical PA fields** for Phase 1 mental health (MH) services
- Know which **medical necessity criteria** MCOs use to review PAs for Phase 1 MH services
- Identify **examples of approval and denial PA cases** for each Phase 1 MH service
- Identify **key contacts and resources** for ongoing support and information

An additional training will be held next Friday, September 26th to focus on ASAM medical necessity criteria and SUD PA expectations

PA process | A PA request goes through 3 different types of review once submitted to the MCO

	1 Administrative review	2 Clinical review part 1: Completeness	3 Clinical review part 2: Medical necessity
What is checked?	• Completion of **administrative info** (e.g., member/provider IDs) • Verify member **eligibility**	• Completeness of **clinical info**	• **Clinical appropriateness** and evidence of medical necessity
Who conducts the review?	• MCO **utilization management (UM)** staff	• Licensed **UM** staff (LCSW, RN, LCADC, etc.)	• Licensed **UM** staff or UM **medical director (MD)**

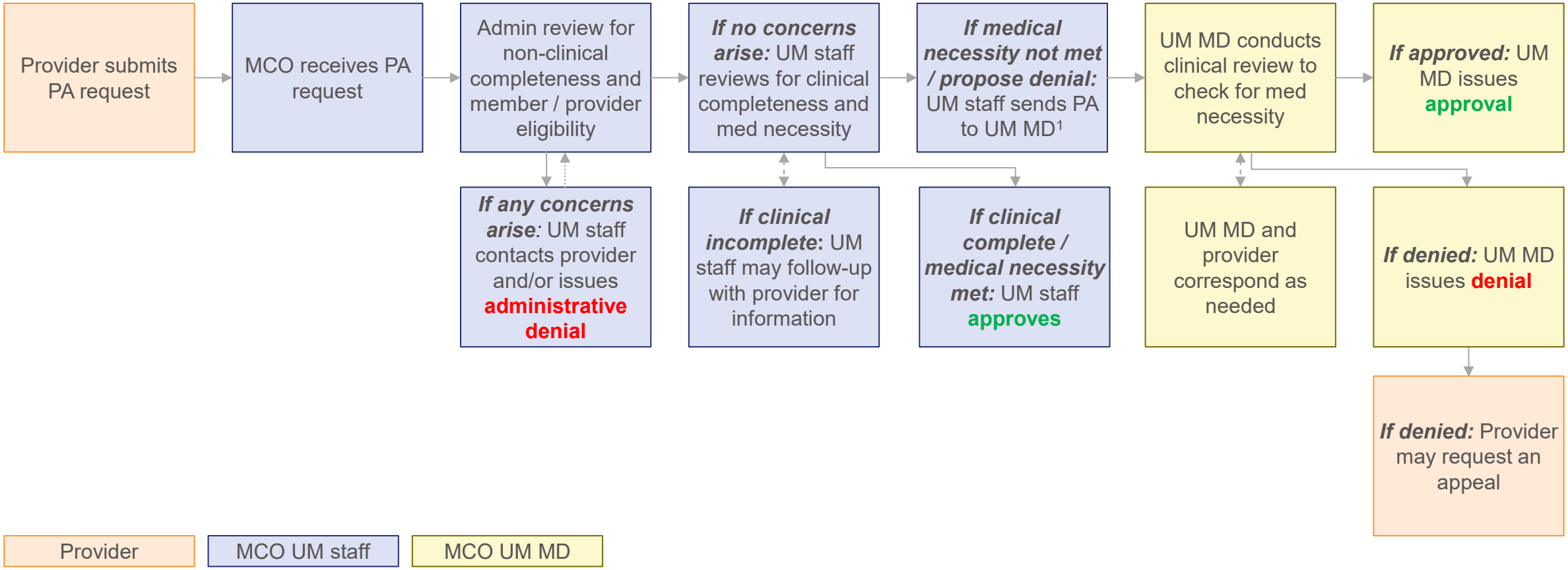
Potential outcomes	• If member is ineligible: **PA is automatically rejected**
	• If admin info is incomplete and member is eligible, MCOs may:
	  - **Administrative denial**[1]
	  - **Follow up with provider for more information**
	  - **Proceed to clinical review**
	• If admin info is complete and member is eligible: **Proceed to clinical review**
		• If clinical information is incomplete: **MCO may follow up with provider for more information**
		• If clinical information is complete: **Proceed to medical necessity review**
			• If medical necessity met: **Approval**
			• If medical necessity not met: **Denial**[1]
			  - *All medical necessity denials must be confirmed by medical director*

This training is designed to help providers submit mental health (MH) PAs that pass each review step

1. During the BH Integration Phase 1 transition period (January 1, 2025 to at least October 31, 2025), MCOs are required to automatically approve all prior authorization requests for Phase 1 services if administrative information is completed and the member is eligible in the MCO

Detail | PA review typically includes non-clinical and clinical reviews by UM staff followed by a clinical review by UM medical director if needed

MCO process for reviewing PA requests under normal operations



1. Medical necessity reviews are typically needed when the requested services involve complex clinical scenarios requiring MD judgement (e.g., SUD partial care), UM staff is uncertain if requested level of care matches clinical standards (e.g., MH partial care), and UM staff is concerned that requested service might be unnecessary/inappropriate

NEW JERSEY HUMAN SERVICES

For MH PAs to pass administrative review, information must be entered on the provider, member, and services requested

Member information

Required fields:

- Name
- Phone number
- Address
- Date of birth
- Member MCO ID
- Medicaid number
- Medicare or third-party insurance *(if applicable)*

Provider information

Required fields (for both **requesting and servicing** provider or facility):

- Name
- NPI
- TIN
- Specialty
- Contact info (phone number, **fax number**, address, email)
- In-network vs. out-of-network

PA and service information

Required fields:

- Urgency designation and rationale
- Type of request (e.g., initial)
- Plan of care
- CPT or HCPCS code(s) and units
- Treatment requested, with frequency, length, start / end date
- Diagnosis description (ICD) and code
- Level of care requested
- Admission date

Field is not required, but strongly recommended by MCOs

NEW JERSEY HUMAN SERVICES

Providers are required to submit clinical documentation for MH PAs

Required clinical documentation

Brief **clinical history**

Present **clinical status** (including admitting diagnosis, presenting symptoms, medications used/medication plan)

Risk of harm to self or others

Level of care utilized in past 12 months

Discharge plan (including anticipated discharge level of care, barriers to discharge, expected discharge date)

Specific content requirements for these categories to follow

Brief clinical history

PAs should include documentation that comprehensively describes the member's medical and psychosocial history

To sufficiently explain a member's clinical history, providers should include the following in a PA…

- Description of member's baseline
- Psychosocial assessment of member across the following areas:
  - Mental health history
  - Social / family history
  - Educational & occupational history
  - Medical history
  - Coping techniques
- Treatment history (e.g., past BH hospitalizations, outpatient services) to highlight past treatment efforts that have been effective vs. ineffective
- History of diagnoses and symptomology
- Past and current medication
  - If on long-term acting injectable (LAI), specify when last administration was and when is next due

Present clinical status

PAs should document the member's current psychiatric, behavioral, and functional status

To sufficiently explain a member's present clinical status, providers should include the following in a PA…

- Description of member's current psychiatric, behavioral, or other comorbid conditions and / or symptoms across the following areas
  - Hygiene
  - Communication skills
  - Coping skills
  - Symptom management
  - Medication adherence
  - Ability to live independently in the community
- Description of impaired functioning in daily living
- Intensity and frequency of impaired functioning and symptoms when applicable
- Description of current professional and informal supports (e.g., supportive housing, family)
- Justification that requested level of care can address member's needs and concerns

Risk of harm

PAs should describe the member’s past and current risk of harm to self or others

To sufficiently explain a member's risk of harm, providers should include the following in a PA…

- History of risk of harm, e.g.,
  - Past suicidal thoughts, plans, or attempts
  - Past homicidal thoughts, plans, or attempts
- Description of member's current risk of harm to themselves and / or to others, e.g.,
  - Suicidal / homicidal ideation
  - Suicidal / homicidal intent or plan
  - Risk of hospitalization
  - Psychotic behaviors
- Safety measures in place for the member to actively engage in treatment
- Supporting documentation should include risk assessment and safety plan if applicable

Previous levels of care

PAs should include documentation of all levels of care the member has used in the past year

To sufficiently explain a member's previous levels of care, providers should include the following in a PA…

- Levels of care used in past year and duration of each treatment
  - Include all traditional outpatient services (e.g., therapy)
  - For Inpatient Hospital, include if voluntary or involuntary
- If applicable, outcomes of treatment and case notes

Discharge plan

PAs should include a brief discharge plan explaining next steps for a member once they leave the requested level of care

To sufficiently explain a member's discharge plan, providers should include the following in a PA…

- Suggested levels of care for member to discharge to and when
- Description of what would be needed for the member to discharge successfully from requested level of care
- Any follow-up appointments to schedule
- Indication that all parties understand the discharge plan

Some MCOs may request a treatment plan, but this should not delay PA determinations for initial PA requests

A member's **treatment plan should include** the following information:

- Summary of member's **psychological history**, diagnoses, and demographics
- **Reason for admission**, including current problems and behavioral changes that need to be made
- Measurable treatment **goals and objectives** to meet those goals
  - Specific interventions and timelines for each objective
  - Any documented progress towards goals
- **Methods for monitoring** progress
- **Strengths and barriers** to progress

Important notes

- For all MCOs, providers are **required to submit** a treatment plan when **requesting a continuing authorization/extension**
- **MCOs may request updates on progress** towards treatment goals after submission

Aetna, Fidelis, and UnitedHealthcare review MH partial care PAs with NJ Administrative Code partial care criteria

To meet NJ Administrative Code Partial Care criteria, a member must:

- **Demonstrate impaired functioning for > 1 year** in one or more of the following areas:
  - Personal self-care
  - Interpersonal relationships
  - Work or school
  - Independent living in the community
  - Ability to maintain safe, affordable housing
- Have **clinical justification for PC services**, confirmed by a psychiatrist or advanced practice nurse and the interdisciplinary treatment team
- **Require psychiatric rehabilitation and active treatment** for at least 2-5 hours per day and no more than 25 hours per week
- **Have a qualifying DSM diagnosis**, including:
  - Schizophrenia or other psychotic disorders
  - Major depressive disorder
  - Bipolar disorder
  - Delusional disorder
  - Schizoaffective disorder
  - Severe affective or personality disorders (if at high risk for hospitalization)
- **Meet acute service need criteria**, such as:
  - Recent contact with emergency mental health services
  - Two or more inpatient psychiatric admissions
  - One psychiatric hospitalization lasting three months or longer

Notes: Fidelis uses NJ Administrative Code 3A:58 Children's Partial Care Programs to evaluate medical necessity of partial care for youth
Source: NJ Administrative Code Partial Care 10:37F

Horizon NJ Health and Wellpoint review MH partial care PAs with Milliman Care Guidelines (MCG) criteria

Admission criteria elements for MCG Partial Care criteria:

- **Risk or severity of behavioral health disorder is considered Mild to Moderate**, for example
  - Symptoms are of a chronic nature and not an acute exacerbation
  - Symptoms may not be very bothersome and are only occasionally present
  - Little pressure to act on delusions
  - Some recent disruptions in self-care below usual or expected standards
  - Some deterioration in social role functioning and meeting obligations but still can maintain roles overall
- **Condition does not require urgent intervention**
  - Symptoms are stable or improving
  - Functional impairment is stable or improving
- **Treatment is necessary to meet needs**
  - Symptoms will improve with treatment and would deteriorate at a lower level of care
- **Situation and expectations are appropriate for level of care**
  - Recommended treatment is not feasible with less intensive intervention
  - Willing to participate voluntarily and can respond to interventions
  - Biopsychosocial stressors are manageable at this level of care

Source: Milliman Care Guidelines (MCG) Criteria

Example approval case for MH Partial Care (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is 52-year-old male with bipolar disorder and mild / moderate depression • Currently resides in supportive housing • Has an extensive psychiatric history with multiple inpatient hospitalizations; most recent as of Dec 2024, where member exhibited explosive behavior requiring police intervention and de-escalation • Disclosed history of sexual abuse (ages 16-24); received trauma treatment but avoids discussing the abuse • Previous outpatient care is insufficient to manage symptoms; has been referred to partial care, confirmed by psychiatrist
Present clinical status	• Member presents mood instability, alternating between depressive and manic symptoms - Depressive phases: Member exhibits poor hygiene, social withdrawal, impaired academic and social functioning - Manic phases: Member presents pressured speech, impulsivity, and poor judgement • Ongoing emotional dysregulation and impaired functioning is leading to - Difficulty maintaining daily routines and work / social relationships since last year - Inability to maintain independent living for three years • Has ineffective coping strategies and poor insight into illness • Medication noncompliance, which is affecting stability of symptoms
Risk of harm	• No current suicidal ideation, but history includes depressive episodes with passive suicidal thoughts • No hospitalizations in the past 90 days
Levels of care	• December 2024 – March 2025: Psychiatric Inpatient Hospitalization • Outpatient therapy for past year, attendance is consistent
Discharge plan	• Step down to Outpatient Counseling and Medication Management after successful completion of treatment plan goals

PA medical necessity outcome: Approved for provider recommendation of **MH Partial Care**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

NEW JERSEY HUMAN SERVICES

Example approval case for MH Partial Care (II/II)

Medical necessity against **NJ Administrative Code Partial Care criteria**

- ✓ Has bipolar, a qualifying DSM diagnosis
- ✓ Demonstrates impaired functioning > 1 year affecting self-care, academic / social life, and independent living ability, including…
  - Repeated mood episodes
  - Poor coping skills and insight into illness
  - Inconsistent medication adherence
- ✓ Lower levels of outpatient care have been insufficient
- ✓ Requires structured psychiatric rehabilitation and active treatment to improve functioning
- ✓ Meets acute service need criteria through history of psychiatric hospitalization

Medical necessity against **Milliman Care Guidelines (MCG) Partial Care criteria**

- ✓ Bipolar and depression is considered mild / moderate
- ✓ Symptoms impair functioning, are of chronic nature, but do not require urgent intervention (e.g., no suicidal ideation)
- ✓ Outpatient treatment and lower levels of care are insufficient, evidenced by…
  - Inability to live independently
  - Previous outpatient care has not been able to manage symptoms
- ✓ Situation is appropriate because…
  - Demonstrates willingness to participate in treatment (e.g., residing in supportive housing, engagement in outpatient therapy)
  - Stressors are manageable at partial care

Example denial case for MH Partial Care (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is 52-year-old male with schizoaffective disorder (F29.0) • 1 past psychiatric hospitalization from January to February 2025; followed by successful partial hospitalization program • Since partial hospitalization, member has consistently attended 3 months of current outpatient treatment (weekly therapy and medication management); therapist notes steady improvement since starting treatment • Lives alone, but close to family who checks in for support

Present clinical status	• Member presents mood instability, alternating between depressive and irritable periods
	  - Depressive periods: Member demonstrates fatigue and low motivation
	  - Irritable periods: Member demonstrates mild psychomotor agitation (fidgeting), pressured speech, and restlessness
	• Member has organized thoughts with good insight to illness, but mood instability leads to some disruptions in functioning
	  - Since hospitalization in Feb, has occasionally missed work shifts at part-time grocery store job due to low energy
	  - Family reports that member neglects personal hygiene and eating during depressive periods
	  - Irritability is straining work and family relationships; prominent issues started to arise a few months ago
	• Therapist referred member to partial care due to recent moderate auditory hallucinations
	• Family and case manager confirm attendance to outpatient treatment and medication compliance

Risk of harm	• No current suicidal ideation, but history includes depressive episodes with suicidal thoughts • No hospitalizations in the past 90 days
Levels of care	• January to February 2025: Psychiatric Inpatient Hospitalization • February 2025: Partial hospitalization program • Outpatient treatment for past 3 months
Discharge plan	• Step down to Outpatient Counseling and Medication Management after successful completion of treatment plan goals

PA medical necessity outcome: Denied for provider recommendation of **MH Partial Care**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

NEW JERSEY HUMAN SERVICES

Example denial case for MH Partial Care (II/II)

Medical necessity against **NJ Administrative Code Partial Care criteria**

- ✓ Has schizoaffective disorder
- ✓ Demonstrates impaired functioning affecting self-care social life, including…
  - Mood instability
  - Strained family and work relationships
  - Auditory hallucinations
- ✗ Improvement noted with outpatient treatment
- ✗ Does not meet acute service need criteria because…
  - Has not been in contact with a screening center / emergency services mental health program
  - Has not has 2 or more admissions in an IP BH program OR
  - Has not had 1 psychiatric hospitalization greater than 3 months

Medical necessity against **Milliman Care Guidelines (MCG) Partial Care criteria**

- ✓ Symptoms impair functioning, are of chronic nature, but do not require urgent intervention (e.g., no suicidal ideation)
- ✗ Outpatient treatment and lower levels of care have been sufficient, evidenced by…
  - Ability to live independently
  - Improvement noted with current outpatient treatment and medication management
  - Consistent attendance to treatment
  - Medication compliance
- ✗ No evidence of deterioration in absence of requested level of care

Aetna, Horizon NJ Health, and Wellpoint review MH partial hospital PAs with Milliman Care Guidelines (MCG) criteria

Admission criteria elements for MCG Partial Hospital criteria:

- **Risk or severity of behavioral health disorder is considered moderate** with symptoms that are persistent and clinically significant, for example
  - Symptoms are present more than half the days of each week
  - Symptoms are somewhat bothersome and are clearly established
  - Pressure to act on delusions

- **Demonstrates significant functional impairment**
  - Symptoms contribute to impaired functioning, contribute dysfunction in daily living, or may increase relapse risk (such as significant deterioration in ability to fulfill responsibilities at school, work, in relationships, etc.)

- **Treatment is necessary to meet needs**
  - Lower levels of care are insufficient to stabilize symptoms
  - Partial hospital is needed to provide structured psychiatric rehab, intensive therapy, and safety monitoring
  - Symptoms will improve with requested treatment

- **Situation and expectations are appropriate for level of care**
  - Passive suicidal / homicidal thoughts, but no imminent attempt or plan to harm
  - No acute crisis or need requiring 24/7 inpatient care
  - Willing and able to participate voluntarily in treatment
  - Can respond to interventions

Notes: Aetna uses MCG Partial Hospital Behavioral Health Level of Care ORG: B-008-PHP to evaluate medical necessity of partial hospital for youth. Horizon NJ Health uses MCG Partial Hospital Behavioral Health Level of Care, Child or Adolescent, ORG: B-902-PHP to evaluate medical necessity of partial hospital for youth
Source: Milliman Care Guidelines (MCG) Criteria

Fidelis Care reviews MH partial hospital PAs with InterQual 2025 BH Criteria

Partial Hospitalization (PHP) is a structured, intensive outpatient behavioral health program designed for individuals who require more support than traditional outpatient care but do not meet criteria for inpatient hospitalization

Admission criteria elements:

- Stable housing for member is available
- Member's support system can provide required care and supervision during non-program hours or after-hours outreach services available
- Member's demonstrates functional impairment through one of the following ways:
  - Functional impairment is severe or there is a change in baseline in the past month
  - Member has been transferred from an inpatient or residential treatment center within the past week
- Member exhibits psychiatric symptoms within the last week
- Treatment is not expected to be successful in less intensive level of care

Source: InterQual 2025 Behavioral Health Criteria

UnitedHealthcare reviews MH partial hospital PAs with Level of Care Utilization System (LOCUS) criteria

The LOCUS tool is a comprehensive assessment to evaluate the level of care needed for individuals with mental health conditions developed by the AACP (American Association of Community Psychiatrists). It includes six dimensions, each with a scoring system that helps determine the appropriate level of care based on the individual's needs and circumstances.

Dimension 1 – Risk of Harm

- Assesses potential for harm to self or others, with emphasis on recent behavior patterns

Dimension 2 – Functional Status

- Measures ability to fulfill social responsibilities, interact with others, maintain physical functioning, and perform self-care

Dimension 3 – Medical, Addictive and Psychiatric comorbidity

- Evaluates potential complications from co-occurring medical illnesses, substance use disorders, or psychiatric disorders

Dimension 4 – Recovery Environment (level of stress and level of support)

- Considers environmental, social, and interpersonal determinants of health and well being, that may contribute to or reduce risk of addiction and / or mental illness

Dimension 5 – Treatment and Recovery History

- Assesses past treatment experience as predictors of future responsiveness to treatment

Dimension 6 – Engagement and Recovery Status

- Considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process

A member must have **a composite score of 14-16** across these dimensions to **meet UHC's criteria for partial hospital**

Note: UHC uses Child and Adolescent Level of Care Utilization System and Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) to evaluate medical necessity of partial hospital for members ages 6-18; UHC uses Early Childhood Service Intensity Instrument (ECSII) to evaluate medical necessity of partial hospital for members ages 0-5
Source: LCOUS

Example approval case for MH Partial Hospital (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is 21-year-old female with Major Depressive Disorder (recurrent) • Has 2-year history of mood instability with depressive episodes; family history of depression on maternal side • First psychiatric contact was psychiatric inpatient hospitalization due to suicidal ideation • Outpatient therapy and medication management initiated one year ago; however, has poor adherence to both • Symptoms have escalated, prompting referral to partial hospitalization

Present clinical status	• Presents persistent depressive symptoms, including low mood, anhedonia, fatigue, and feelings of hopelessness
	• Has demonstrated long-term, significant functional impairment in daily life and academic and social domains due to mood instability
	  - Member tends to isolate and ruminate on negative thoughts; has minimal coping skills
	  - Albeit supportive family, member reports strained relationships during mood episodes
	  - Declining academic performance; member is currently on leave from college
	  - Hygiene is poor; member reports difficulty completing basic self-care tasks
	• Symptom management is impaired due to inconsistent medication adherence and lack of engagement in therapy

Risk of harm	• Member has no current suicide intent / plan, but documented history of suicidal ideation • Ongoing safety concerns due to poor coping skills, social isolation, and limited support system
Levels of care	• Outpatient therapy and medication management for past 1 year
Discharge plan	• Discharge when member demonstrates improved mood, consistent medication adherence, and use of coping strategies • Step-down services may include intensive outpatient therapy, medication management, and community-based supports • Follow-up appointments will be scheduled with outpatient psychiatrist and therapist for continuity of care

PA medical necessity outcome: Approved for provider recommendation of **MH Partial Hospital**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

NEW JERSEY HUMAN SERVICES

Example approval case for MH Partial Hospital (II/II)

Medical necessity against **Milliman Care Guidelines (MCG) Partial Hospital criteria**

- Severity of Major Depressive disorder is moderate to severe evidenced by persistent depressive symptoms
- Demonstrates impaired functioning, evidenced by
  - Declining academic performance
  - Poor self-care
  - Social and family isolation
- Outpatient care is insufficient given poor adherence to both therapy and medication management
- Situation is appropriate because…
  - No acute crisis, but needs monitoring due to history of suicidal ideation
  - Able to participate in treatment

Medical necessity against **InterQual Partial Hospital Criteria**

- Demonstrates impaired functioning within the past month which affects daily, academic, work, and social life
- Has demonstrated depressive symptoms within the past week
- Outpatient care is insufficient
- Requires structured psychiatric rehabilitation and active treatment to improve functioning
- Partial hospitalization is necessary to provide intensive therapeutic support and address safety concerns

Medical necessity against **Level of Care Utilization System (LOCUS)**

- **D1:** History of suicidal ideation with ongoing safety concerns despite no current plan
- **D2:** Demonstrates significant functional impairment in self-care, academics, and social interaction
- **D4:** Has major depressive disorder with poor medication adherence and therapy engagement, increasing risk of worsening mental illness
- **D5:** Outpatient treatment has been insufficient
- **D6:** Demonstrates low engagement in treatment and poor adherence to medications

Example denial case for MH Partial Hospital (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is 32-year-old female with recurrent, moderate Major Depressive Disorder and Generalized Anxiety Disorder • No psychiatric hospitalizations or past suicide attempts • Attended outpatient treatment in the past, but not in the last 2 years

Present clinical status	• Increased anxiety and low mood over the past month
	  - Persistent, excessive worry and anxiety-related fatigue
	  - Member reports emotional eating has worsened; does not have eating disorder diagnosis
	  - No recent hospitalization or suicidal attempt
	• Stressors related to work performance (which anxiety has impacted) and interpersonal conflict with roommate
	• Coping skills are limited; member uses avoidance and rumination, which exacerbate anxiety
	• Observations for mental status:
	  - Notable depressed mood; affect is congruent
	  - Has somewhat slowed psychomotor activity
	  - Insight, judgement, and concentration are fair; no auditory or visual hallucinations; no homicidal ideation
	• Member continues to attend work, maintain ADLs, and consistently take Prozac (prescribed by PCP)
	• Support system includes both biological parents, a twin sister who lives nearby, and one close friend (not roommate)

Risk of harm	• Low; no suicidal or homicidal ideation • No self-harm behaviors, psychosis, or imminent safety concerns, but anxiety symptoms contribute emotional distress
Levels of care	• None
Discharge plan	• Return to outpatient therapy • Consider medication management

PA medical necessity outcome: Denied for provider recommendation of **MH Partial Hospital**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

NEW JERSEY HUMAN SERVICES

Example denial case for MH Partial Hospital (II/II)

Medical necessity against **Milliman Care Guidelines (MCG) Partial Hospital criteria**

- ✓ Major Depressive Disorder is moderate with persistent symptoms
- ✗ Functional impairments do not interfere with ability to fulfill usual responsibilities, evidenced by
  - Continued work attendance
  - Maintained ADLs
  - Medication adherence
- ✗ Symptoms can improve with outpatient services through psychoeducation, coping skill development, and medical evaluation
- ✗ Situation is not appropriate, evidenced by…
  - No passive suicidal ideation
  - Able to contract for safety

Medical necessity against **InterQual Partial Hospital Criteria**

- ✗ Symptoms are moderate; do not require intensive or inpatient treatment
- ✗ Outpatient services can address anxiety, improve coping strategies, and support functional recovery
- ✗ Functional impairment is moderate; anxiety and depression affect work and relationships, but not to the extent requiring partial hospital

Medical necessity against **Level of Care Utilization System (LOCUS)**

- ✗ **D1:** Low acute risk due to no history of suicide attempts or current suicidal / homicidal ideation
- ✗ **D2:** Functional impairment is present but does not interference with ability to fulfill daily responsibilities
- ✗ **D4:** Anxiety and depression is stable on Prozac; has strong support system and environment (e.g., family and friends)
- ✗ **D6:** Demonstrates strong understanding of importance of treatment through medication adherence

Aetna and Fidelis Care review acute partial hospital PAs with NJ Administrative Code criteria

To meet NJ Administrative Acute Partial Hospital criteria, a member must:

- Be at least 18 years of age or older
- Have at least one of the following primary diagnoses on Axis I
  - Schizophrenia or Other Psychotic Disorders (298.9, 295.xx)
  - Major Depressive Disorder (296.xx)
  - Bipolar Disorders (296.xx, 296.89)
  - Delusional Disorder (297)
  - Schizoaffective Disorder (295.7)
  - Anxiety Disorders (300.xx)
  - A covered psychiatric disorder diagnosis consistent with codes Axis I-V of DSM-IV-TR
- Demonstrate disordered thinking or mood, bizarre behavior, or psychomotor agitation or retardation that…
  - Significantly impairs daily functioning or abilities to fulfill family, student, or work roles
  - Cannot be managed at a lower, less restrictive level of care
- Must have need for psychotropic medications or help with adherence
- Be **referred by a designated screening center, psychiatric emergency service, or inpatient psychiatric facility / APN** with documentation supporting medical necessity

To be authorized to receive acute partial hospital, a member cannot:

- Have a primary diagnosis of substance abuse or dependence
- Be an imminent danger to self or others
- Need acute medical care
- Need detoxification
- Have a primary diagnosis of "developmentally disabled"
- Be currently participating in a PACT program

Source: NJ Administrative Code Acute Partial Hospital 10:52A 3.1

Horizon NJ Health and Wellpoint review acute partial hospital PAs with Milliman Care Guidelines (MCG) partial hospital criteria

Admission criteria elements for MCG Partial Hospital criteria:

- **Risk or severity of behavioral health disorder is considered moderate** with symptoms that are persistent and clinically significant, for example
  - Symptoms are present more than half the days of each week
  - Symptoms are somewhat bothersome and are clearly established
  - Pressure to act on delusions
- **Demonstrates significant functional impairment**
  - Symptoms contribute to impaired functioning, contribute dysfunction in daily living, or may increase relapse risk (such as significant deterioration in ability to fulfill responsibilities at school, work, in relationships, etc.)
- **Treatment is necessary to meet needs**
  - Lower levels of care are insufficient to stabilize symptoms
  - Partial hospital is needed to provide structured psychiatric rehab, intensive therapy, and safety monitoring
  - Symptoms will improve with requested treatment
- **Situation and expectations are appropriate for level of care**
  - Passive suicidal / homicidal thoughts, but no imminent attempt or plan to harm
  - No acute crisis or need requiring 24/7 inpatient care
  - Willing and able to participate voluntarily in treatment
  - Can respond to interventions

For acute partial hospital, the **member must also be referred** by a designated **screening center**, **psychiatric emergency service**, or **inpatient psychiatric facility / APN** with documentation supporting medical necessity

Source: Milliman Care Guidelines (MCG) Criteria

NEW JERSEY HUMAN SERVICES

UnitedHealthcare reviews acute partial hospital PAs with Level of Care Utilization System (LOCUS) criteria

The LOCUS dimensions have a scoring system to determine the appropriate level of care

Dimension 1 – Risk of Harm
- Assesses potential for harm to self or others, with emphasis on recent behavior patterns

Dimension 2 – Functional Status
- Measures ability to fulfill social responsibilities, interact with others, maintain physical functioning, and perform self-care

Dimension 3 – Medical, Addictive and Psychiatric Comorbidity
- Evaluates potential complications from co-occurring medical illnesses, substance use disorders, or psychiatric disorders

Dimension 4 – Recovery Environment (level of stress and level of support)
- Considers environmental, social, and interpersonal determinants of health and well being, that may contribute to or reduce risk of addiction and / or mental illness

Dimension 5 – Treatment and Recovery History
- Assesses past treatment experience as predictors of future responsiveness to treatment

Dimension 6 – Engagement and Recovery Status
- Considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process

A member must have **a composite score of 17-19** across these dimensions to **meet UHC's criteria for acute partial hospital**

For acute partial hospital, the **member must also be referred** by a designated **screening center**, **psychiatric emergency service**, or **inpatient psychiatric facility / APN** with documentation supporting medical necessity

Note: UHC uses Child and Adolescent Level of Care Utilization System and Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) to evaluate medical necessity of acute partial hospital for members ages 6-18; UHC uses Early Childhood Service Intensity Instrument (ECSII) to evaluate medical necessity of acute partial hospital for members ages 0-5
Source: LCOUS

Example approval case for Acute Partial Hospital (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is a 27-year-old female with Schizoaffective Disorder (295.7) • 3-year history of mood instability and psychotic episodes; first psychiatric contact was ED presentation after a suicide attempt at age 24 • Admitted into inpatient psych 2 months ago due to episode, which include erratic behavior and auditory hallucinations - Ater stabilization, was discharged 5 weeks ago with outpatient follow-up • Recently presented again to local emergency room due to psychotic symptoms; seen by crisis screening center and referred to APH program • Currently on risperidone and antidepressant; adherence is inconsistent

Present clinical status	• Presents with persistent auditory hallucinations, paranoid thoughts, and other disorganized behavior (such as making sexually inappropriate comments to strangers, neglecting hygiene, and pacing at night due to hearing "voices")
	• Symptoms are leading to significant impairment:
	  - Unable to sustain job as part-time barista; manager reports unexpected absences or bizarre behavior to customers
	  - Isolates from family despite living at home with parents
	• Observations for mental status: Affect blunted, psychomotor retardation, impaired judgment; expresses hopelessness

Risk of harm	• Member has no current suicide intent / plan, but documented history of a suicide attempt and ongoing suicidal ideation • Elevated risk for rehospitalization given psychosis and medication non-adherence • Family expresses serious concern about safety if intensive treatment is not maintained
Levels of care	• Inpatient hospitalization (2 months ago) followed by outpatient therapy and medication management after discharge
Discharge plan	• Discharge when member demonstrates reduced hallucinations, consistent medication adherence and self-care • Step-down to either partial hospital or intensive outpatient with continued medication management and therapy

PA medical necessity outcome: Approved for provider recommendation of **Acute Partial Hospital**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

NEW JERSEY HUMAN SERVICES

Example approval case for Acute Partial Hospital (II/II)

Medical necessity against **NJ Administrative Code Acute Partial Hospital criteria**

- Has Schizoaffective Disorder
- Demonstrates disordered thinking and bizarre behavior, as evidenced by…
  - Auditory hallucinations
  - Inappropriate comments to strangers
- Symptoms significantly affect family relationships and daily functioning, as evidenced by…
  - Poor work attendance and bizarre behavior on work shifts
  - Poor personal self-care
- Relapse despite outpatient treatment
- Needs help with adhering to psychotropic medication
- Referred as a diversion to hospitalization by crisis screening center at local emergency room

Medical necessity against **Milliman Care Guidelines (MCG) Partial Hospital criteria**

- Has Schizoaffective Disorder
- Risk or severity of BH disorder is considered moderate given auditory hallucinations, paranoid thoughts, and other disorganized behavior
- Demonstrates moderate dysfunction in daily living, as evidenced by…
  - Poor work attendance and bizarre behavior on work shifts
- Symptoms will improve with treatment and would deteriorate at a lower level of care
- Has no recent attempt or plan for harm to self/others
- Demonstrates no need for around the clock nursing care

Medical necessity against **Level of Care Utilization System (LOCUS)**

- **D1:** Has history of suicide attempt with ongoing ideation
- **D2:** Demonstrates inability to fulfill social responsibilities, interact with others, and maintain self-care
- **D4:** Major psychiatric disorder with poor medication adherence drives instability
- **D5:** Previous treatment has been insufficient given repeated relapses
- **D6:** Demonstrates impairment in understanding treatment and low willingness to engage, as evidenced by medication non-adherence

Example denial case for Acute Partial Hospital (I/II)

Category	Clinical information submitted[1]
Brief clinical history	• Member is a 34-year-old female with Bipolar II Disorder and experiencing current depressive episode • First psychiatric contact was hospitalization 18 months ago for severe depression with suicidal ideation - Since discharge, has been managed with outpatient therapy and medications (lamotrigine + quetiapine) • Recently lost her job, which has worsened her mood and anxiety

Present clinical status	• Reports persistent low mood, anhedonia, and fatigue over the past 6-8 weeks since losing job
	• Passive suicidal thoughts (“sometimes I wish I wouldn't wake up”) but denies plan or intent
	• Demonstrates functional impairment in social life; rarely leaves home except for essentials and avoids friends
	• ADLs are partly impaired
	  - Sometimes neglects showering and eating
	  - Maintains some household routines (e.g., paying rent, cleaning up sometimes)
	• Missed several therapy appointments in the past month, but remains generally engaged with psychiatrist
	• Adherent to medications; psychiatrist adjusting quetiapine dose
	• Lives with supportive partner who actively helps monitor safety; partner notes irritability and occasional verbal outbursts
	• Observations for mental status: depressed mood, tearful affect, slowed speech, no psychosis, judgment intact

Risk of harm	• Moderate chronic risk given diagnosis and depression, but low acute risk (no suicidal intent or psychosis) • Protective factors include strong partner support, housing stability, and ongoing engagement in treatment (albeit limited)
Levels of care	• Inpatient hospitalization (18 months ago) • Outpatient therapy since discharge
Discharge plan	• Discharge to outpatient therapy when member demonstrates increased coping skills and mood • Refer to community case management and ensure partner is aware of safety plan

PA medical necessity outcome: Denied for provider recommendation of **Acute Partial Hospital**

1. Clinical information is SUMMARIZED. Please refer to previous section on "Clinical Review part 1: Completeness" to ensure you are specifying clinical information comprehensively

Example denial case for Acute Partial Hospital (II/II)

Medical necessity against **NJ Administrative Code Acute Partial Hospital criteria**

- ✓ Has Bipolar Disorder
- ✓ Requires psychotropic medication to treat disorder
- ✗ Demonstrates some bizarre behavior (e.g., verbal outbursts) and impaired functioning, but not significant enough to full impact daily functioning
- ✗ Lower levels of care (e.g., partial care) with structured programming could improve attendance to therapy and coping skills
- ✗ Referred from outpatient after worsening mood, instead of emergency or inpatient

Medical necessity against **Milliman Care Guidelines (MCG) Partial Hospital criteria**

- ✓ Has Bipolar Disorder
- ✗ Risk or severity of behavioral health disorder is not considered Moderate
- ✗ Demonstrates only mild dysfunction in daily living, as evidenced by
  - Sometimes neglects showering and eating
  - Maintains some household routines
- ✗ Remains generally engaged with psychiatrist
- ✓ Has no recent attempt or plan for harm to self/others
- ✓ Demonstrates no need for around the clock nursing care

Medical necessity against **Level of Care Utilization System (LOCUS)**

- ✓ **D1:** Has passive suicidal thoughts
- ✗ **D2:** Demonstrates some impairment, but not significant enough to disrupt daily life and social responsibilities
- ✗ **D3:** Bipolar disorder is managed through medication
- ✗ **D4:** Has strong environmental protective factors (e.g., supportive partner, stable housing, engagement in treatment)
- ✗ **D5:** Not a stepdown from an ER or inpatient unit; outpatient care has managed symptoms since discharge
- ✗ **D6:** Demonstrates some avoidance to treatment through missed appointments, but still willing to engage with psychiatrist

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 **Provider Resources webpage**[2] of the BH stakeholder website has the following materials on PAs for providers:

- Prior Authorization Refresher Training materials
- Prior Authorization Training materials
- NJSAMS Training materials
- NJSAMS, IME, and MCO contact information
- Provider guidance packet

Member's Managed Care Organization

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

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

UnitedHealthcare **Wellpoint**

*Find more MCO-specific PA resources in the **appendix***

DMAHS – Office of Managed Health Care

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

mahs.provider-inquiries@dhs.nj.gov

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

DMAHS Behavioral Health Unit

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

dmahs.behavioralhealth@dhs.nj.gov

1-609-281-8028

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder/ 2. https://www.nj.gov/humanservices/dmhas/information/stakeholder/providerresources.html

NEW JERSEY HUMAN SERVICES

Q&A

DMAHS or MCO Prior Authorization questions


NEW JERSEY
HUMAN SERVICES

Appendix

Aetna | Additional PA resources

MH PA contact information

Option 1

Call us at:

- Aetna Better Health of NJ: 1-855-232-3596
- Aetna Assure Premier Plus (HMO D-SNP): 1-844-362-0934

Option 2

Click the Authorization form below and fax the request:

- Aetna Better Health of NJ
  - Medical Authorization Form
  - Fax: 1-844-404-3972
- Aetna Assure Premier Plus (HMO D-SNP)
  - Medical Authorization Form
  - Fax: 1-833-322-0034

Option 3

Availity Provider portal. Click below to register.

- Aetna Better Health of NJ: Provider Portal
- Aetna Assure Premier Plus (HMO D-SNP): Provider Portal

Additional PA resources

- PA / MCO Portal
- MCO Provider Manual
- MCO Quick Reference Guide
- New Provider Orientation
- [Links of where to register for PA OH / trainings]

Fidelis Care | Additional PA resources

PA contact information

For more information on PAs, please contact:

Enola Joefield-Haney, LMHC, LCMHC, Manager, Utilization Management Behavioral Health
813-206-3367
Enola.d.Joefieldhaney@centene.com

Additional PA resources

- PA / MCO Portal
- MCO Provider Manual
- MCO Quick Reference Guide
- New Provider Orientation and PA Office Hours Training

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Additional PA resources

PA contact information

For more information on PAs, please contact:

Provider Services

Phone: (800) 682-9091

Email: BHMedicaid_@horizonblue.com

Additional PA resources

- Credentialing Application Link
- HNJH Provider Manual
- HNJH Quick Reference Guide
- New Provider Orientation
- DMAHS BHI Stakeholder Information

UnitedHealthcare | Additional PA resources

PA contact information

For more information on PAs, please contact:

- Provider Service Line- 1-888-362-3368

Links of where to register for PA Office Hours:

- Tuesday, Sept. 23 10-11:30
- Tuesday October 14 12-1:30

Additional PA resources

Provider Express PA Portal

Provider Manual

Quick Reference Guide

New Provider Orientation

Wellpoint | Additional PA resources

PA contact information

Where to submit MH PA requests:

Call or Fax:

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

Where to submit SUD PA requests:

- Submitted through **NJSAMS**
- Decisions communicated to provider via fax or phone call

Ann Basil, LCSW, Director of Behavioral Health
Ann.Basil@Wellpoint.com

Additional PA resources

Links:

- Availity Portal (access here)
- Wellpoint Provider Manual
- Wellpoint ProviderQRG.pdf
- New BH Provider Orientation