Provider Readiness Packet

NJ FamilyCare Behavioral Health Integration

NJ Department of Human Services
Prepared jointly by the NJ Division of Medical Assistance and Health Services (DMAHS) & NJ Division of Mental Health and Addiction Services (DMHAS)

For more information, contact dmahs.behavioralhealth@dhs.nj.gov

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About this guide

This guide serves as a resource for current and prospective providers with New Jersey's (NJ) Medicaid Program, NJ FamilyCare, who provide or are seeking to provide behavioral health services.

Within this guide, providers will find:

Introduction

- A brief introduction to NJ FamilyCare
- Overview of NJ's Behavioral Health Integration

Detailed program guidance

- Enrollment with NJ FamilyCare
- Participating in Managed Care Organization (MCO) Networks (i.e., credentialing and contracting)
- Coordination of benefits
- Prior authorization
- Claims and billing
- Care management

Additional readiness guidance and resources

- Best practices for operating under managed care
- Provider readiness checklist to use as a self-assessment tool
- List and links to additional resources
- Important contact information for State and managed care organizations

This guide is not intended to replace detailed guidance provided by each MCO, such as information included in MCO provider manuals, which are an essential resource for any provider seeking to participate with a specific MCO.

Introduction

This section provides a brief introduction to NJ's Medicaid Program (NJ FamilyCare) and gives an overview of NJ FamilyCare's planned integration of select behavioral health services into managed care

Introduction to NJ FamilyCare

NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes core Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion populations.

Who is eligible for coverage?

New Jersey residents who meet certain criteria are eligible to enroll in NJ FamilyCare, including:

- **Adults (19-64):** with income up to 138% Federal Poverty Level (FPL) ($1,732/month for singles, $2,351/month for couples). In general, immigrants must have five years of Legal Permanent Resident status to qualify, but some immigrants (e.g., asylees) may qualify sooner.
- **Children under 19:** with family income up to 355% of the FPL ($9,230/month for a family of four), regardless of immigration status. Coverage requires annual renewal.
- **Pregnant Individuals:** with income up to 205% FPL ($5,330/month for a family of four), with no entry-date restrictions for lawfully present immigrants.
- **Seniors (65+), Blind, Disabled, Long-Term Care Recipients, and Adults with Medicare**: Eligible based on specific criteria.

As of October 2024, NJ FamilyCare has ~2 million enrolled members, providing them access to many of the physical and mental health services they need to thrive.

What services are covered?

NJ FamilyCare is a comprehensive healthcare coverage program that provides a wide range of services, including:

- Doctor visits
- Eyeglasses
- Hospitalization
- Lab tests
- X-rays
- Prescriptions
- Regular check-ups
- Mental health and substance use disorders
- Dental

- Preventive screenings
- Autism services
- Community doula services
- Help with personal care needs

How is the program delivered?

Today, NJ FamilyCare is delivered using two different models:

- **Fee-for-service (FFS)** – traditional model where providers bill the state of NJ directly for services delivered
- **Managed care** – value-based model, predominant for medical services in NJ, where services are managed by five managed care healthcare plans, also known as managed care organizations (MCOs): Aetna, Fidelis Care, Horizon, UnitedHealthcare, and Wellpoint

Key features and differences between the two models are highlighted in the table below:

Exhibit 1: Key features differences between FFS and Managed Care

Fee for service (FFS)	Managed care
• Managed by NJ State • Providers bill state Medicaid directly for services • Used for many behavioral health services for the general population • Also used for members not enrolled in a MCO and members with presumptive eligibility	• Managed by one of 5 MCOs, under contract with NJ State: Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint • Providers bill MCOs for services; MCOs receive funding from state to manage total cost of care • Used for most physical health services and some behavioral health services

Why become a NJ FamilyCare provider?

Providers **must be enrolled** with NJ FamilyCare in order to provide services to NJ FamilyCare members.

By becoming a NJ FamilyCare provider, you not only expand your practice and secure financial benefits but also make a meaningful contribution to public health by helping to serve some of the most vulnerable residents in New Jersey. Your participation is crucial in ensuring that all New Jersey residents have access to high-quality health services.

Overview NJ FamilyCare Behavioral Health Integration

Background

While most physical health (PH) services have transitioned to the managed care model and are now managed by MCOs, many behavioral health (BH) services are still managed through FFS.

On March 30, 2023, NJ FamilyCare received authority from the Centers for Medicare and Medicaid Services (CMS) to integrate BH services – including mental health (MH) services and substance use disorder (SUD) services – from FFS into managed care.

NJ FamilyCare is now embarking on integrating a broader range of BH services into managed care using a phased approach, with the first phase **going live January 1st, 2025**.

MCOs will soon be responsible for most BH services in addition to PH services, creating a single point of accountability and better integration between PH care and BH care.

Goals

The three main goals of NJ BH Integration are

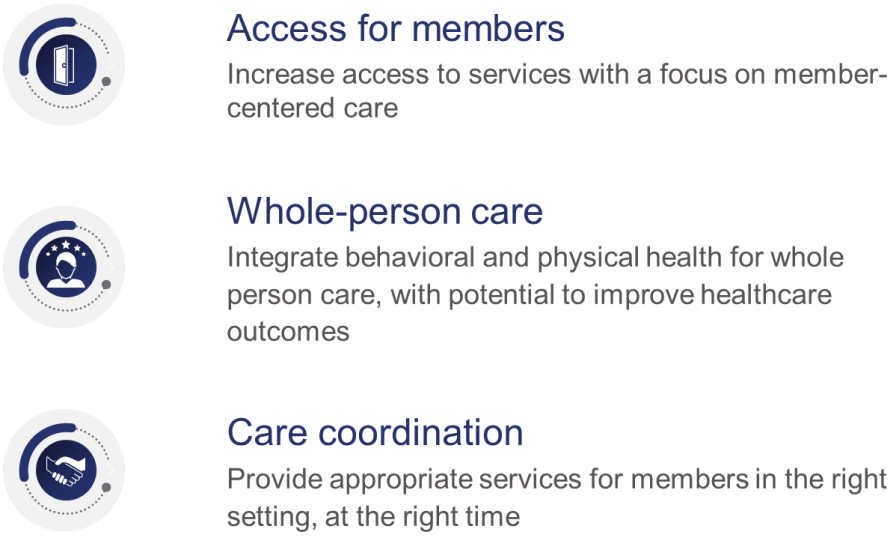


Exhibit 2: BH Integration Goals

Timeline

BH services are being integrated into managed care over three phases, with Phase 1 going live on January 1, 2025:

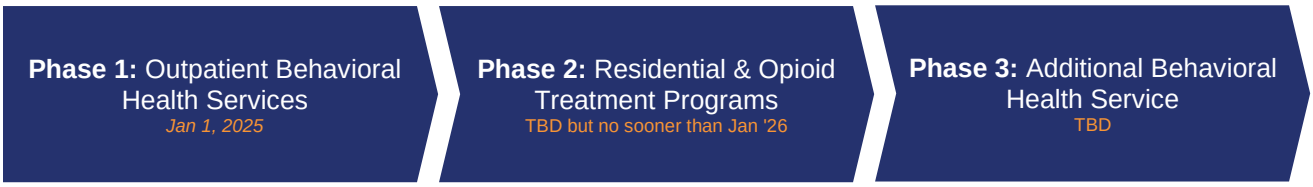


Exhibit 3: BH Integration timeline

- **Phase 1** will expand MCO coverage to all enrollees for outpatient services that are already integrated into managed care for populations enrolled in Managed Long-Term Services & Supports (MLTSS), Division of Developmental Disabilities (DDD), and Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).
- **Phase 2** will focus on residential services and opioid treatment programs (OTPs). The timing of Phase 2 will be determined post Phase 1 implementation, but will be no sooner than January 1, 2026
- DMAHS will be conducting further analysis, stakeholder engagement, and monitoring throughout Phases 1 and 2 to determine any additional BH services to be shifted to managed care in **Phase 3**, with timing to-be-determined

Note: Integration will occur by service and not by provider type. If a provider provides services across phases, they will need to bill integrated services to MCOs and the remaining services FFS.

Members with presumptive eligibility (PE) will continue to be billed FFS

BH services integrating into managed care

Not all BH services will transition from FFS to managed care. In addition, there are some BH services which are already integrated into MCOs for the general population.

BH services already integrated into MCOs for all members

The following BH services are already covered by NJ MCOs for all members:

- Hospital emergency department visits and inpatient stays with BH diagnosis
- Specialty psychiatric hospital admissions provided on an “in lieu of” basis
- Autism services up to age 21

- Office-Based Addiction Treatment (OBAT) for Medication Assisted Treatment (MAT)
- Prescription drugs

BH services planned for integration into managed care

The table below outlines the BH services that are planned for integration in each of the three phases

Exhibit 4: Planned services across three phases

Phase 1 – Outpatient BH services	Phase 2 – Residential & Opioid Treatment Programs (OTPs)	Phase 3 – Additional BH services TBD

• Mental Health (MH) outpatient counseling / psychotherapy (for independent and agency clinicians)
• MH partial hospitalization
• MH partial care in outpatient clinic
• MH outpatient hospital or clinic services
• Substance Use Disorder (SUD) outpatient counseling (for independent and agency clinicians)
• SUD intensive outpatient
• SUD outpatient clinic
  – Ambulatory Withdrawal Management (AWM)
  – Peer support services
  – SUD care management
• SUD partial care
	• Adult mental health rehabilitation (AMHR) / MH supervised residential
	• SUD short-term residential
	• SUD — medically monitored inpatient withdrawal management
	• SUD long-term residential
	• Opioid treatment programs (OTPs)
		Services being explored for integration include:
		• 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) programs:
		  – Program of Assertive Community Treatment (PACT)
		  – Children's System of Care (CSOC)
		  – Intensive Case Management Services (ICMS)

Note that Phase 1 services are already integrated into managed care for MLTSS, DDD, and FIDE-SNP populations and will be integrated for the general population as of January 1, 2025.

What integration means for BH providers

Starting January 1, 2025, BH services in Phase 1 **must be billed to MCOs for all populations**. These services will not be reimbursed through FFS, and you will be directed to the appropriate MCO to obtain prior authorization (for BH services requiring prior authorization) and submit your encounters. For Phase 2 and Phase 3 services, you can continue to submit claims and receive reimbursement through FFS.

Providers new to managed care should prepare to follow MCO procedures, including but not limited to joining MCO networks by credentialing and contracting with MCOs, complying with MCO prior authorization processes, submitting claims to MCOs, and working with MCO BH care managers. This packet provides detail on these procedures.

Providers delivering Phase 1 services to MCO members are highly encouraged to join MCO networks to ensure continuity of care for members. Participating in managed care offers **several key benefits for providers**:

- **Whole person care**:
    - Improved coordination with other providers (e.g., link BH providers to PCPs, referrals)
    - Access to preventative programs (e.g., wellness programs, screenings)
    - Comprehensive data insights (e.g., service utilization and adherence)
- **Dedicated MCO resources**:
    - Care coordination (e.g., referral staff, MCO CMs)
    - Claims and utilization management (e.g., MCO claims staff and systems)
    - Continuing provider education and training (e.g., cultural sensitivity, case management)
- **Opportunity to grow patient base**:
    - MCO Provider directory improves visibility of provider to MCO members
    - Referrals from CMs and in-network providers (e.g., referral from PCPs or other specialty providers)

What integration means for members

Members receiving Phase 1 services will have these services covered and billed under their MCO starting January 1, 2025, along with BH services already integrated into managed care. If a member's Phase 1 provider is not contracted with their MCO, the MCO will work with the member to find another suitable provider. Members receiving BH services that will be integrated in later phases will continue to have these services covered through FFS Medicaid.

BH integration represents a significant opportunity for members to receive more coordinated whole-person care across the continuum of physical and behavioral health, with the potential to increase access to services and improve health outcomes.

Overview of Phase 1 Services

This table summarizes key details for all Phase 1 services, including billing codes, prior authorization requirements, minimum durations for initial authorizations, and maximum turnaround times. See detailed guidance for more information

	Phase 1 Service	Phase 1 Billing Code(s)	Prior Authorization Required?	Minimum duration *(Initial auth only)*
MH	Psychological evaluation / intake	90791-90792	No	
	Individual psychotherapy	90832-90839, REV 914	No	
	Family therapy	90846-90847, 90849, REV 916	No	
	Group therapy	90853, REV 915	No	
	Consultation with family	90887	No	
	MH Partial care transportation (clinic only)	Z0330	No	
	Transcranial Magnetic Stimulation (TMS)	90867-90869	Yes	
	Electro Convulsive Therapy (ECT)	90870, REV 901	Yes	
	Psychological testing	REV 918	Yes	
	Psychological service - other	REV 919	Yes	
	MH Partial care services	H0035	Yes	14 days
	Partial Hospitalization (PH)	REV 912	Yes	14 days
	Acute Partial Hospitalization (APH)	REV 913	Yes	14 days
SUD	Psychological evaluation / intake	90791-90792 HF	No	
	Individual psychotherapy	90832-90839 HF, REV 914	No	
	Family therapy	90846-90847 HF, 90849 HF, REV 916	No	
	Group therapy	90853 HF, REV 915	No	
	Consultation with family	90887 HF	No	
	SUD care management	H0023HF	No	
	SUD peer support services	H0038HF	No	
	SUD partial care	H2036HF	Yes	30 days
	SUD intensive outpatient program	H0015HF	Yes	30 days
	Ambulatory detoxification / withdrawal management	H0014HF	Yes *(auto-approved[1])*	5 days[1]

Turnaround time: Urgent - 24hrs | Can be urgent | Not urgent - 7 days

[1] Auto approval for a minimum of 5 days for alcohol, opioids, and benzodiazepines. For continued treatment, provider must submit an additional authorization request

Detailed Guidance

This section provides detailed guidance for providers across important topics related to BH Integration

NJ FamilyCare / Medicaid Enrollment

> **For BH providers who are new to Medicaid**
> This section of the document is intended for BH providers who are new to NJ FamilyCare and need to enroll with the state as a Medicaid provider. If you are already enrolled with NJ FamilyCare (e.g., if you have already been providing BH services FFS), you can skip this section

Overview

To render and bill for services for NJ FamilyCare members, whether FFS or through an MCO, providers **must be enrolled** with the state as a Medicaid provider.

Enrollment verifies provider qualifications, enables state visibility into the provider network, and drives program integrity – with the ultimate goal of ensuring member access to quality providers for better health outcomes.

Medicaid enrollment is managed by NJ DMAHS and its vendor Gainwell Technologies.

Medicaid Enrolment Process

The diagram below gives a high-level overview of the enrollment process flow.

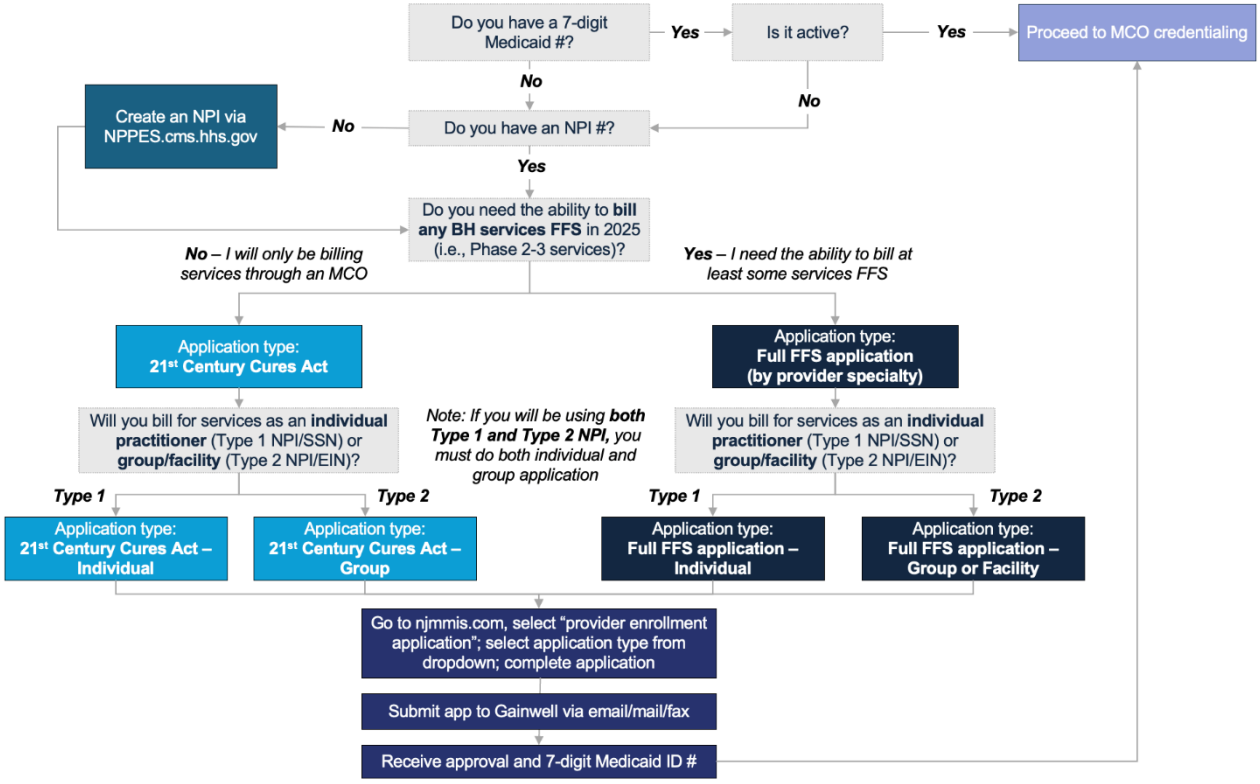
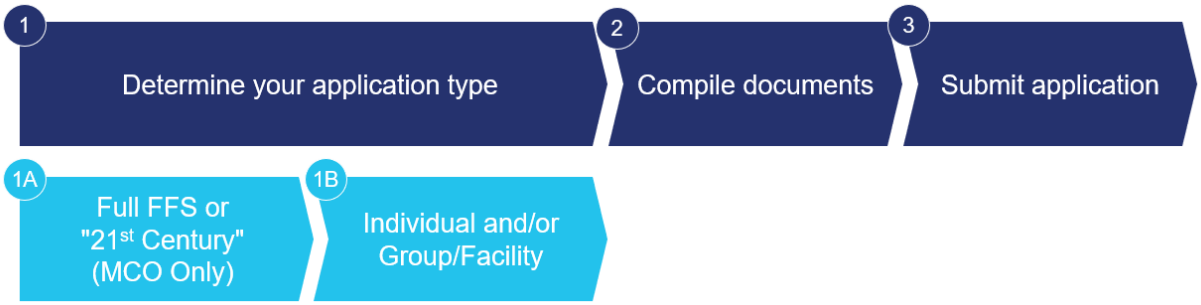


Exhibit 5: NJ FamilyCare Medicaid Enrollment Process Flow

How to check your enrollment
Providers can check their enrollment status by searching the New Jersey Medicaid Management Information System (NJMMIS) Directory. If provider status is NOT ACTIVE, please call Medicaid Provider Enrollment on 1-609-588-6036 to clarify your enrollment

To enroll in NJ FamilyCare, providers must follow three key steps, with two sub-steps for Step 1:



Step 1: Determine application type

The first step to enroll with Medicaid is to determine the correct application to file. This requires determining whether you are:

A. Filing a Full FFS or "21st Century Cures" (MCO Only) application; and
B. Filing as an individual and/or part of a group or filing on behalf of a group / facility

All Medicaid enrollment applications can be found on the NJMMIS website: https://www.njmmis.com/providerEnrollment.aspx.

A: Full FFS vs. 21st Century Cures Act application

In general, there are two types of Medicaid enrollment applications:

- Full FFS – specific to provider type
- "21st Century Cures" (MCO Only) – independent of provider type

The appropriate enrollment application type differs depending on whether any of the services you provide or will provide must be billed FFS or through MCOs.

In general, a Full FFS **application offers providers greater flexibility** to bill for more services. See below for more details.

Exhibit 6: Full FFS vs. "21st Century Cures" (MCO Only) applications

Full FFS If you need or will need the ability to bill any services FFS	**"21st Century Cures" (MCO Only)** If you **DO NOT** need the ability to bill FFS, and will only bill services through MCOs
Under "Provider Type" on the NJMMIS website, select the application specific to your provider specialty type (Exhibit 7). There are separate applications for individuals, groups, and facilities (see step 1B)	Under "Provider Type" on the NJMMIS website, select the "21st Century Cures Act" application. There are separate applications for individuals and groups (see step 1B)

Providers who complete the Full FFS application can bill for services covered under FFS and managed care. This means they can:

- Bill additional services that are not integrated into managed care (e.g., Phase 2 and Phase 3 services)
- Serve new members: When members first apply for NJ FamilyCare they are temporarily FFS
- Serve members changing plans during transition period

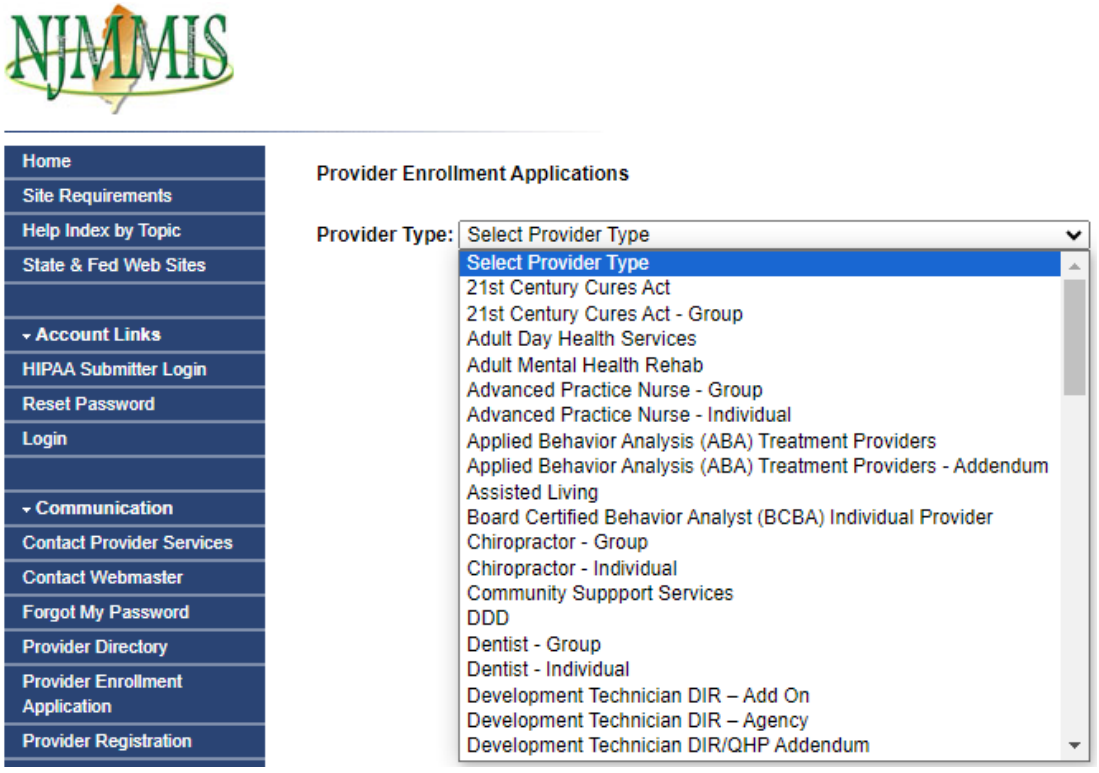


Exhibit 7: NJMMIS Provider Enrollment Application Drop-down

If there is not a relevant application for your provider type on the NJMMIS dropdown, this may mean you are not eligible to enroll as a FFS Medicaid provider or bill FFS. In this case, you must complete the 21st Century Cures Act application and can only bill for services that are integrated into managed care. If you have questions about which application to complete based on your provider type, please contact Gainwell using the contact information on page 21.

B: Individual vs. Group / Facility

Depending on your specific situation, you may be required to complete an 'Individual' application, a 'Group / Facility' application, or both

- **Group Practices and Licensed Facilities:** In general, group practices should submit a Group application, and licensed facilities should complete a Facility application tailored to their specific facility type
- **Individual Practitioners:** May be required to complete an Individual application, a Group application, be included ('linked') on a Group / Facility's application, or any combination of these based on specific circumstances.

Individual practitioners

Your enrollment will depend on whether you meet the criteria to enroll as an individual, as part of a group/facility, or both

Exhibit 8: Individual vs. Group / Facility application

Individual For independent providers who provide services in private practice	**Group / Facility ("Entity")** For providers who provide services within an agency, hospital, clinic, or group practice
• Providers must be fully clinically licensed to enroll individually • For BH, this includes: – Psychiatrists – Psychologists – Neuropsychologists – Advanced Practice Nurses (APNs) – Licensed Clinical Social Workers (LCSWs) – Licensed Professional Counselors (LPCs) – Licensed Marriage and Family Therapists (LMFTs)	• Groups can have one or more providers • Groups include "Groups of 1" – providers who work for themselves through their own company (e.g., psychologist "John Doe" is the sole provider within his LLC, "John Doe Therapy Inc.")

This depends on whether you, as an individual, will act as a **billing provider** or if the organization you are a part of will act as a billing provider:

- **Billing provider:** The provider who directly bills Medicaid entity (FFS or MCO) for reimbursement of services. This provider will be listed as the "billing provider" on the claim for the service

Which NPI appears as the billing provider on the claim?

- Type 1 NPI: issued to individual providers, such as doctors or nurse practitioners
- Type 2 NPI: issued to organizational providers, such as hospitals, nursing facilities, clinics, or group practices

The following table summarizes your enrollment requirements based on your billing / rendering scenario, as an individual:

Exhibit 9: Enrollment scenarios for individual practitioners

Scenario	Requirements	Example
A Always billing provider	**Enroll as individual** with your SSN and Type 1 NPI	Independent providers who provide services in private practice, billing under Type 1 NPI / SSN
B Sometimes billing provider	**Enroll as an individual** with your SSN and Type 1 NPI **AND** Coordinate with entity administrator to be **linked to enrolled group / facility**[2]	Providers who provide services within an agency, billing under Type 2 NPI / EIN **but also** in private practice billing under Type 1 NPI / SSN (i.e., independent & part of entity)
C Never billing provider, rendering provider only	Coordinate with entity administrator to be **linked to enrolled group / facility**[1]	Providers who provide services within an agency, hospital, clinic, or group practice, billing under entity's Type 2 NPI / EIN

Note: An individual practitioner who has their own company and exclusively submits claims to Medicaid entity using the company's **Type 2 NPI** as the billing provider is classified as part of a Group (a 'Group of 1') and must **enroll as a Group**

Group / Facility linking: When is it required?

If you are a **rendering provider** who bills under a Group / Facility you must be linked to that Group / Facility if the Group / Facility is enrolling / enrolled via a **Full FFS application**.

- **Rendering provider:** The provider who delivers or oversees the service to the member. Will be listed as the "rendering / attending" provider on claim

Non-rendering providers (e.g., an unlicensed provider who practices under supervision) **are not required to enroll** in NJ FamilyCare or be linked to an enrolled Group / Facility

[2] Only required for Full FFS applications

If the entity you are a part of is enrolling / enrolled via **21st Century Cures (MCO Only)**, **linking is not required** during enrollment. Instead, it occurs through the contracting / credentialing process with each MCO (see *Joining MCO Networks* on page 23 and onwards)

For group administrators

If you are enrolling a group / facility, select the appropriate group / facility application from the NJMMIS drop-down.

Exhibit 10: Enrollment options for group administrators

Full FFS – Group / Facility If group will be billing any services FFS	**"21st Century" – Group / Facility** If group will be billing MCOs only
• Select application based on group / facility type (e.g., psychologist group) • If a group application, list all providers who will be independently rendering services as part of your group on Question 20 of the application; this is required for these providers to be recognized on a claim	• There is currently no way to "link" individual rendering providers to the group with the 21st Century application (i.e., no analogous "Question 20" of the application) • If there are providers within your Group that will be using their Type 1 NPI and SSN for any billing/rendering, then they should complete a 21st Century INDIVIDUAL application • If providers within your group will only be using Type 2 NPI and an EIN, then they are covered by a 21st Century Group application completed by the Group administrator

Linking rendering providers

The process for linking rendering providers to a Group varies based on whether the entity is enrolling (i.e. 'new group') or is already enrolled ('existing group'), and if the rendering providers have a Medicaid number (i.e. enrolled individually)

Exhibit 11: Linking rendering providers to a Group

	Medicaid ID (i.e. individual enrolled)	**No Medicaid ID** (i.e., individual not enrolled)
New Group	List all rendering providers (including their Medicaid ID if applicable) on **Q20 of Group Application** (FD-23)	
Existing Group	List all rendering providers with Medicaid ID on '**One-page Group Provider Linking**' form (FD-23A)	List all rendering providers on **Q20 of Group Application** (FD-23)

For Facilities, the process varies by application type. Contact Gainwell for more details.

Summary: Which enrollment application should you submit?

For individual practitioners

May need to enroll as an individual and / or be linked to a group / facility depending on your billing / rendering status and services you provide (Full FFS vs. 21st Century):

Exhibit 12: Enrollment summary for individual practitioners

		Full FFS Ability to bill any BH services FFS + MCO services	**"21st Century" (MCO Only)** Ability to bill Phase 1 MCO services only
Billing / rendering status	A Always billing provider	Full FFS – Individual	21st Century – Individual
	B Sometimes billing provider	Full FFS – Individual + Linked to Group / Facility	21st Century – Individual
	C Never billing provider, rendering provider only	Linked to Group / Facility	*N/A – No linking through enrollment[2] Linking through credentialing*

For administrators of groups / facilities

A group / facility is required to submit a Full FFS Group or 21st Century Group application. Groups can have just one or more rendering providers, and may be required to link them during enrollment

Exhibit 13: Enrollment summary for group / facility administrators

	Full FFS Able to bill any BH services FFS + MCO services	**"21st Century" (MCO Only)** Able to bill Phase 1 MCO services only
Application	Full FFS – Group/Facility	21st Century – Group
Requirements to link individuals with group / facility	New Group / Facility List individual providers on **Q20 of Group Application** or where required in specific Facility Application: • All rendering providers • If "Group of 1," list yourself using Type 1 NPI Existing Group Link additional rendering providers: • With Medicaid ID: **One Page Group Provider Linking** form • Without Medicaid ID: **Q20 Group Application** Not required to list non-rendering providers (e.g., an unlicensed provider who practices under supervision)	**Not linking through enrolment** No way to link individual rendering providers to 21st Century Groups via enrollment process. Instead, linking occurs through the credentialing / contracting process

Step 2: Compile relevant information and documents

The enrollment process requires providers to submit detailed information about your practice and background to the State for validation and record-keeping.

A high-level, non-exhaustive summary of key documentation requirements is below, but providers are encouraged to review the Medicaid Enrollment application specific to your provider type:

Information to compile:

- NPI
- TIN (SSN or EIN)
- License number
- Address

Forms:

- Disclosure of ownership and control interest statement (not required for 21st Century individual application)
- Signature authorization form
- Provider agreement
- For individual providers:
- Copy of medical license, board certification and registrations, DEA drug permits
- Copy of SSN card
- W-9 tax form
- For group/facilities:
- Copy of 147C or IRS CP-575

Step 3: Submission

You must either email, fax, or mail a copy of your enrollment application to Gainwell to complete submission. Please only submit via one of these methods:

- **Email:** njmmisproviderenrollment@gainwelltechnologies.com
- **Fax:** 609-584-1192
- **Address:** Gainwell Technologies Provider Enrollment, P.O. Box 4804, Trenton, NJ 08650

If you would like to check the status of your application, please contact Gainwell via the above email address or by phone on 609-588-6036.

Complete Medicaid Enrollment before joining MCO

Providers joining MCO networks will need to also complete the MCO's credentialling and contracting process (see next section).

In general, MCOs require providers to have completed the enrollment process prior to credentialing or submit proof of a submitted application during credentialing:

- **Aetna, UnitedHealthcare:** Require providers to complete NJ FamilyCare registration before completing the credentialing process.
- **Fidelis Care, Horizon, Wellpoint:** Allow for proof of a submitted NJ FamilyCare provider application during the credentialing process

Medicaid enrollment FAQs

Where do I find my NPI number?
You can pull your National Provider Identifier (NPI) from the National Plan & Provider Enumeration System (NPPES).

How do I get an NPI number if I do not have one?
You can create an NPI number on NPPES. Refer to CMS how-to guide here.

Which provider types are eligible to bill independently?
To be able to bill independently, providers must enroll as an individual in Medicaid. Providers must be fully clinically licensed to enroll. For BH services, this includes:

- Psychiatrists
- Psychologists
- Neuropsychologists
- Advanced Practice Nurses
- Licensed Clinical Social Workers
- Licensed Professional Counselors, and
- Licensed Marriage and Family Therapists

Junior licensed providers (e.g., Licensed Social Workers, Licensed Associate Marriage and Family Therapist, Licensed Addiction Counselor) and unlicensed providers (e.g., Peer Counselors, OBAT Navigators) are not eligible to bill independently.

If I am already enrolled with NJ FamilyCare as a FFS provider, do I need to re-enroll if the services I provide are moving from the FFS to managed care?

No, you do not have to re-enroll with NJ FamilyCare. However, you will have to becoming a participating provider with MCOs to render and bill services to MCOs (see next section).

What individual providers need to be listed on Question 20 of the FFS Group application?
Individual rendering providers who are affiliated with your billing group/entity need to be listed on Question 20 of the FFS Group application. Individual providers who are independently billing/rendering and are also part of an entity need to submit an individual FFS application AND be listed on Question 20 of the FFS Group application to be associated with the group.

Will I need to complete a background check / fingerprinting as part of the Medicaid enrollment process?
All providers enrolling in Medicaid are required to undergo a criminal history background check. Additionally, some providers and business owners may need to undergo fingerprinting. You will be notified by the State if you are required to undergo fingerprinting.

What if I enroll as a 21st Century provider but then end up needing to bill FFS Medicaid?
Providers enrolled via the 21st Century Cures Act application cannot bill FFS. To bill FFS, providers must complete a full FFS application. If you have enrolled as a 21st Century Cures Act provider but need the ability to bill FFS, you will need to re-enroll by completing a full FFS application.

Medicaid Enrollment contact information

Gainwell: For questions related to NJMMIS

- **Address:** Gainwell Technologies Provider Enrollment, P.O. Box 4804, Trenton, NJ 08650
- **Email:** njmmisproviderenrollment@gainwelltechnologies.com
- **Fax:** 609-584-1192
- **Phone:** 609-588-6036

DMAHS: For general enrollment questions

- **Email:** Dmahs.behavioralhealth@dhs.nj.gov

Becoming a Participating Provider (i.e., Credentialing and Contracting)

Overview

For providers who want to bill and render BH services covered by MCOs, providers must join the MCO's network, i.e., become a **"participating provider.**"

Joining an MCO network involves completing two processes:

- **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

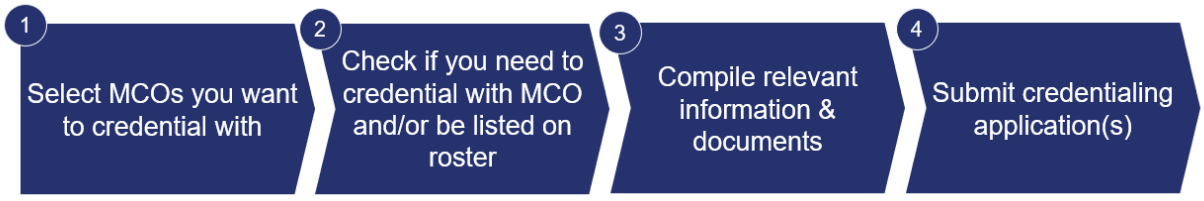
State improvements to credentialing and contracting process

The State has implemented several changes to the standard contract with MCOs to make joining MCO networks easier for BH providers:

- MCOs are required to attempt to **contract and credential with all FFS providers actively (i.e., within the past year) providing Phase 1 services** to their members by the end of December 2024
- MCOs must process complete credentialing applications **within 60 days**, reduced from 90 days
- MCOs **must integrate information from the third-party platform CAQH** into the credentialing process, reducing provider burden by streamlining data entry

Credentialing process

Credentialing with an MCO involves four key steps:



Step 1: Determine which MCOs you need to credential with

If you want to continue providing Phase 1 BH services to Medicaid members that you are currently servicing, you and/or your provider organization will need to credential and contract with all the MCOs that those members are enrolled with.

As eligibility and member MCO enrollment frequently changes, we encourage you to **credential with all five MCOs** to avoid delays in care provision and payment.

MCOs require the following providers to contract and credential:

Exhibit 10: MCO credentialing requirements by provider type

All MCOs require credentialing	Aetna & Fidelis Care require credentialing
• Psychiatrists • Advanced Practice Nurses (including Psychiatric Nurses) • Physician Assistants • Psychologists • Licensed Clinical Social Workers (LCSW) • Licensed Marriage and Family Therapists (LMFT) • Licensed Professional Counselors (LPC) • Neuropsychologists	• Licensed Social Workers (LSW) • Licensed Associate Counselors (LAC) • Licensed Associate Marriage and Family Therapists (LAMFT)

If your provider type is not credentialed by the MCO, you must bill for services under a group / facility and render services under the credential of a supervised provider or group / facility.

Step 2: Determine if you need to individually credential with the MCO

MCOs typically have separate credentialing requirements and processes for:

- **Individuals / groups:** Require each practitioner to credential individually using their Type 1 NPI, even if contracting with MCO as a group. Some MCOs then require each licensed practitioner to be listed on a group roster in order to associate the individual with the group for billing purposes.
- **Licensed facilities / agencies:** Credential the licensed facility or agency as an entity using Type 2 NPI. Typically, MCOs do not require the individual employees working in the facility or agency to credential individually but may require licensed practitioners and peers to be listed on a facility/agency roster.

Depending on your provider type, whether you will be joining the MCO as an individual, part of a group or licensed facility, and the MCO you are joining, you will need to either

individually complete the credentialing process with the MCO, credential as a licensed facility, and/or be listed on a group / facility "roster."

Rostering
The roster captures information about providers affiliated with a group / facility. Horizon is the only MCO that does not require rostering

Individuals / Groups
The following table summarizes the credentialing requirements for independent and group practice providers based on your billing/rendering scenario. Given differences in process by MCO, providers should confirm specific requirements with their MCO.

Exhibit 11: Credentialing & Claims Implications by Provider Billing/Rendering Scenario

Billing scenario	Example provider	Credential process	Billing NPI / TIN	Rendering NPI
Always billing provider	Provider who only does private practice counseling (i.e., independent)	Individual	Type 1 NPI / SSN	Type 1 NPI
Sometimes billing provider	Provider who does both private practice counseling and works in group practice (i.e., independent & part of group)	Individual, and coordinate with group / facility administrator to be listed on roster (except for Horizon)	Type 1 NPI/ SSN when billing independently; Type 2 NPI / EIN when billing under entity	Type 1 NPI
Never billing provider, rendering provider only	Provider who exclusively practices within a group (i.e., part of group)	Individual, and coordinate with group / facility administrator to be listed on roster (except for Horizon)	Type 2 NPI / EIN	Type 1 NPI
Never a billing provider nor a rendering provider	Supervised licensed or unlicensed provider who practices under supervision (i.e., part of group)	Varies by MCO. Unlicensed providers are not credentialed by any MCO or rostered. Supervised licensed providers are credentialed by 2 of the 5 MCOs (Aetna, Fidelis Care) and are required to roster with Aetna	Type 2 NPI / EIN	Supervisor's Type 1 NPI *Note: supervised billing is not permitted by Horizon for Group Practices*

Step 3: Compile relevant information and documents

The credentialing process includes validating multiple types of data about a provider.

According to current NJ state standards (N.J. Admin. Code § 11:24C-1.3), the credentialing process for providers at a minimum must include validation of:

- **Licensing:**
  - Valid license to practice in the specialty being credentialed
  - Data from National Practitioner Data Bank, state Board of Medical Examiners, or other licensing boards
- **Experience:**
  - Graduation from medical school, professional school or relevant educational degree and completion of residency / post-grad training as applicable
  - Work history
- **Liability, sanctions, and insurance:**
  - Professional liability claims history
  - Good standing of clinical privileges at hospital designated by provider as primary admitting facility
  - Malpractice insurance with minimum amounts of $1M per aggregate and $3M per occurrence
  - Any suspension of state license or DEA number
  - Any sanctions imposed by Medicaid & Medicare
  - Any loss of license or hospital privileges and felony convictions
- **Provider health:**
  - Any physical / mental condition that affects current ability to provide care
  - History of SUD
- **Attestations:**
  - Completeness and correctness of application

Individuals can use CAQH:

Licensed providers are strongly encouraged to use the Council for Affordable Quality Healthcare (CAQH) Provider Data Portal, a third-party platform that eases the credentialing process.

The CAQH Provider Portal allows providers to create a profile, storing information about provider education, work history, training, licenses, insurances, etc. Providers can update their information through the portal as needed.
The state recently introduced a standard requiring all MCOs to accept CAQH and to integrate information from CAQH into their credentialing processes (i.e., not request duplicative information). In effect, providers only need to complete this information one time via CAQH to have it flow electronically to all five MCOs, reducing provider burden.

To create a CAQH profile, visit the CAQH Registration Portal. For more information, review the CAQH Provider User Guide.

Additional requirements:

A high-level summary of additional documentation requirements common across all MCOs is below.

Exhibit 12: Additional Documentation Required Across MCOs (non-exhaustive)

Individual providers	Facilities
• NPI and TIN • Servicing location(s) • Disclosure of ownership • Special needs/Aged Blind or Disabled (ABD) form indicating experience with specialty populations	• 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 (or site evaluation) • Facility roster (detail below)

Please note, some MCOs may have additional documentation requirements. For the full list of documents required by each MCO, please refer to their website, guidance, and/or credentialing applications.

Groups and facilities are also required to complete group / facility provider network agreements and submission of a roster. Rosters are MCO-specific and must be submitted to each MCO (except for Horizon, who does not require rosters).

A high-level summary of roster requirements common across all MCOs (excluding Horizon) is below.

Exhibit 13: MCO Roster Requirements

Data required	Roster processes
• Provider name • Group name • SSN, NPI, TIN • Address • DOB • Additional requirements vary by MCO	• Rosters can be updated and submitted regularly (e.g., weekly) • Members of a group must also individually credential if required by the MCO • Some MCOs only require fully licensed providers (and not junior licensed/supervised provider types) to be listed on the roster. However, it is encouraged to list all providers for MCO and state monitoring purposes • Some MCOs require that facility-based providers individually credential or have their supervising provider credential, while for others, listing on roster is sufficient

Please note, additional roster requirements may vary by MCO, and providers are encouraged to reach out to the respective MCO contact for complete, up-to-date roster requirements.

Step 4: Submit credentialing applications

Providers have several options to submit their credentialing applications, summarized below.

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

Exhibit 14: Credentialing Application Submission Options

NJ Universal Physician Credentialing Form	Single application, for physicians only, that can be used across all five MCOs. Link available here.
Electronic Submission	Providers must credential with each MCO separately, with applications available through each MCO's provider portal or website. Application links: • Aetna • Fidelis Care • Horizon • UnitedHealthcare • Wellpoint
Paper Submission	Alternatively, paper applications for each MCO can be requested from the MCO website or MCO credentialing representative.

Expected credentialing timeline

MCOs are contractually required to **process credentialing applications within 60 days of receipt,** recently reduced by the state from 90 days to drive faster entry into MCO networks for providers.

Most applications should be approved or denied within 60 days. Examples of why an application may require additional review include:

- Required fields are missing from the application or have errors
- A provider has been flagged as having past sanctions/suspension of licenses that require further investigation

To avoid processing delays, providers are strongly encouraged to conduct a careful review of all information submitted in the credentialing application and work with MCO representatives on any questions prior to application submission.

Contracting with MCOs

In addition to credentialing with the MCO, you and/or your provider organization will need to contract with the MCO.

Some MCOs require contracting before credentialing, while others conduct both processes concurrently:

Aetna, Fidelis Care, UnitedHealthcare, Wellpoint	Conduct credentialing and contracting simultaneously
Horizon	Conduct contracting before credentialing

Providers are encouraged to work with the network contracting teams at each MCO to confirm and initiate the contracting process relative to the credentialing process.

Coordination of Benefits

Overview

Coordination of Benefits (COB) is an essential process in healthcare billing that ensures payment accuracy when patients are covered by multiple insurance plans. In the context of NJ Family Care, understanding and correctly implementing COB is crucial for providers to receive appropriate reimbursement for services rendered.

As a provider enrolled with NJ FamilyCare, it is your responsibility to verify a member's insurance coverage before delivering services. This verification process includes identifying all active insurance plans the member may have, such as commercial health insurance or Medicare. Proper coordination involves billing these primary insurers first and Medicaid last, as Medicaid is considered the **payer of last resort**.

Consequences of Improper Coordination

Failure to properly coordinate benefits can lead to significant issues:

- **Denied Claims:** If a primary payer is not billed before Medicaid, your claim to Medicaid may be denied.
- **Reduced Payments:** Incomplete COB may result in partial reimbursement, not covering the full cost of services provided.
- **Compliance Risks:** Not adhering to COB requirements can lead to compliance violations, audits, and/or penalties.

Multiple Coverage Scenarios

Medicaid members often have additional coverage, such as:

- **Commercial Health Plans:** Some members maintain private insurance through employers or other means
- **Medicare:** Dual-eligible individuals are covered by both Medicare and Medicaid, requiring careful billing coordination

Both Commercial and Medicare also cover BH services, such as:

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Professional Counselors (LPC) & Licensed Clinical Social Worker (LCSW)
- Intensive Outpatient Program provided by the following:
  - Hospital outpatient

- Federally qualified health centers (FQHCs),
- Opioid treatment programs (OTPs)

Understanding each payer's rules and the order of liability is vital to ensure correct billing and reimbursement.

Illustrative example: Value of being a Medicare enrolled provider

Scenario facts:

- Member is covered by Medicare and MCO Medicaid Plan
- Medicare approved amount for service = $100
- Medicare reimbursement = 80%
- MCO Medicaid contract rate for service = $100

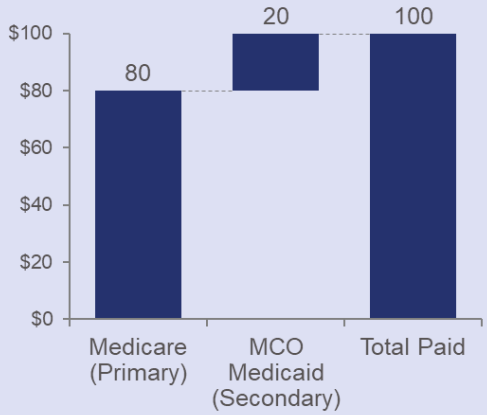
Scenario A: Provider is enrolled in Medicare and Medicaid and properly bills Medicare first:

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

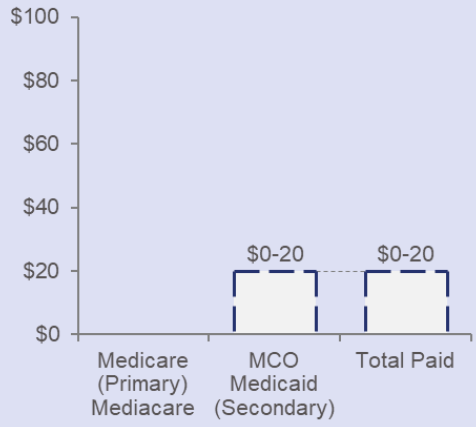
Scenario B: Provider is not enrolled in Medicare and bills Medicaid only:

- MCO will deny claim since primary payer (Medicare) was not billed. A denial from primary payer is required for Medicaid MCO to pay claim.
- Medicaid MCO will not pay full amount because Medicare was not billed

Scenario A



Scenario B



As a general rule, providers are expected to submit claims to the primary payer (e.g., Commercial or Medicare) first. The primary payer will then process the claim according to its coverage guidelines and issue an Explanation of Benefits (EOB). Providers are required to submit this EOB to MCO when submitting Medicaid claim.

Exceptions to COB Requirements

It is important to note that DMAHS has identified specific services that do not require a denial from the primary payer to be processed by the Medicaid MCO. Providers shall bill the Medicaid MCO directly for services that do not require the coordination of benefits. Familiarize yourself with these exceptions to streamline your billing process and avoid unnecessary delays.

BH services that do not require an Explanation of Benefits (EOB) from Medicare or Commercial Plan:

- Adult Mental Health Rehabilitation (AMHR)
- Ambulatory Withdrawal Management (AWM)
- Developmental, Individual-Difference, Relationship-based (DIR/Floortime) Services
- Doula Care Services
- Medical Day Care
- Mental Health Partial Care (PC)
- Peer Recovery Support Specialists (PRSS)
- Personal Care Assistance (including Personal Preference Program)
- SUD Care Management

BH services that do not require an EOB from Medicare:

- Ambulatory Withdrawal Management (AWM)
- Mental Health Partial Care (PC)
- Peer Recovery Support Specialists (PRSS)
- Personal Care Assistance (including Personal Preference Program)
- SUD Care Management
- SUD IOP (covered in OTP only)
- Substance Use Disorder Residential ASAM 3.5, ASAM 3.7, ASAM 3.7WM
- Substance Use Disorder Partial Care (ASAM 2.5)
- Substance Use Disorder Outpatient Licensed Clinic

Prior Authorizations (PA)

Overview

As with FFS, providers must obtain authorization from the MCO for certain services before being able to render and be reimbursed for them. This process, known as prior authorization (PA), serves as a safeguard to ensure that requested services meet criteria for medical necessity, appropriateness, and cost-effectiveness.

Definitions

Key prior authorization terminology that all providers should be familiar with includes:

- **Initial authorization:** The first PA requested for a given service or treatment, allowing providers to confirm coverage and obtain approval based on medical necessity criteria before the patient receives the service
- **Concurrent authorization / Extension authorization:** A PA requested for the continuation or extension of a service already underway, typically reviewed to assess ongoing medical necessity and appropriateness of continued care
- **Automatic approval ('auto-approval')**: A PA granted with no medical necessity review, claims edits, or denials (i.e., "administrative authorization"). MCOs can request additional information post-approval for tracking and discharge planning purposes
- **Retroactive authorization ('retro-authorization'):** A PA that is submitted post service initiation and backdated
- **Turnaround time:** Timeframe in which MCO must make and share PA decision with provider (i.e., approval or denial)
- **Required fields:** Specific information or data points that must be completed in a PA request for it to be processed by the MCO / considered "complete"

Key State Standards and Policies

The State has made an effort to update PA standards to improve the PA process under managed care and smooth the transition for FFS providers.

Key State standards to improve managed care PA process for providers

State has implemented the following standards in the State-MCO contract:

1. Auto-approval of all Phase 1 service authorizations for the first 90-days of Phase 1 BH integration implementation
2. Reduced turnaround times

3. Minimum authorization durations for select BH services
4. Standardized information required for a complete PA request across MCOs
5. Required use of NJSAMS for all SUD Phase 1 Service PA requests. A completed NJSAMS submission will be considered complete and the MCOs will not require further patient information.
6. Auto-approval of all court-ordered services

Additional information on these standards is detailed throughout this section.

High-level process flow

The following diagram shows some of the key actions and decision points in the PA process. Many of these items will be covered in more detail in the following sections.

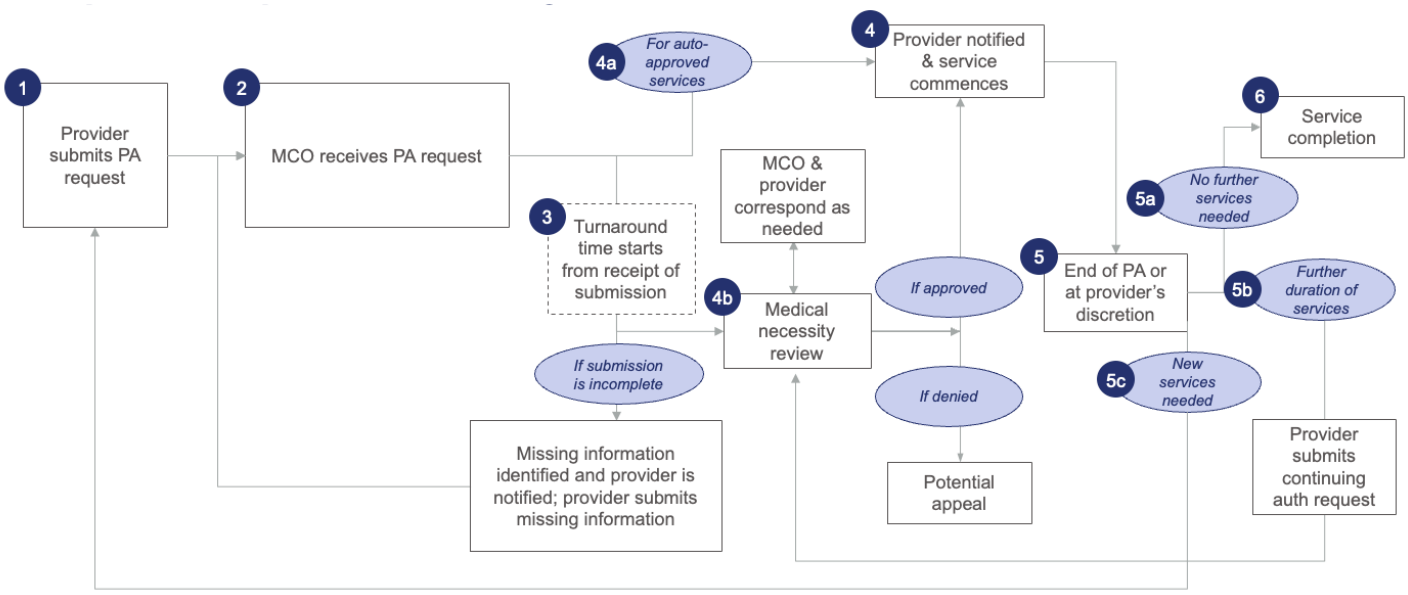


Exhibit 15: High-level prior authorization process

When is PA required?

BH services that do not require PA

The State has updated the State-MCO contract to explicitly prohibit PA for:

- Outpatient MH therapy
- Outpatient SUD counseling

For providers who are not participating with the MCO (i.e., out of network providers or providers who have set up a single case agreement), a PA request may be required for documentation purposes, but it will be auto-approved.

BH services that require PA

The following integrated BH services will continue to require MCO PA as they do today:

- MH Inpatient Psychiatric Hospital Care
- SUD Inpatient Medical Detox

The **following phase 1 BH services** will require an MCO PA starting January 1, 2025:

- Mental Health (MH) Partial Care
- MH Partial Hospital
- Substance Use Disorder (SUD) Partial Care
- SUD Intensive Outpatient
- Ambulatory Withdrawal Management

The **following services** will not be integrated into managed care for the general population until future BH integration phases, but will **continue to require PA through MCOs for specialty populations (MLTSS, DDD, FIDE-SNP)**:

- Adult Mental Health Rehabilitation (AMHR)
- SUD Residential Withdrawal Management (ASAM 3.7 WM)
- SUD Short Term Residential (STR)
- SUD Long Term Residential (LTR)

Services receiving auto-approval

There are some services that “require” PA but will be automatically approved by MCOs without review for medical necessity. This is often referred to as an administrative authorization as the purpose of requiring providers to submit PA request is for MCO visibility and documentation.

The following services will be auto-approved:

- All MH and SUD services for the first 90 days of integration rollout (January 1, 2025 through March 31, 2025)
- All court ordered MH and SUD services
- For ambulatory withdrawal management, auto-approval of 5 days for alcohol, opioids, and benzodiazepines use disorders.

How do I submit a PA request?

How to submit PA requests varies by service:

- MH Phase 1 service
- MH Phase 2 or other BH service, covered under FFS
- SUD Phase 1

Mental health (MH) PA requests

For all MH services integrated into managed care, PA requests must be submitted to each MCO.

All MCOs have electronic portals available for PA submission, and this is the recommended submission method for ease of tracking requests. Some MCOs also accept PA via fax or phone call.

Exhibit 16: MH prior authorization submission information by MCO

MCO	Electronic	Fax or Phone
Aetna	Availity Portal	• **Phone:** 1-855-232-3586 (follow prompts to BH) • **Fax:** 1-844-404-3972 (include PA form)
Fidelis Care	Fidelis Care Provider Portal	• **Phone:** 1-888-453-2534 • **Fax:** 1-888-339-2677 for Outpatient and 1-855-703-8082 for Inpatient
Horizon	Availity Portal	• **Phone:** 1-800-682-9094 • **Fax:** 1-732-938-1375 or 1-855-241-8895 for Outpatient
UnitedHealthcare	Provider Express	• **Phone:** 1-888-362-3368 (Enter TIN#, select option 3, enter member ID, select option for MH)
Wellpoint	Availity Portal	• **Phone:** 1-833-731-2149 • **Fax:** 1-844-451-2794 for Inpatient and Urgent Services; 1-844-442-8007 for Outpatient

Providers should contact specific MCOs for any issues / questions regarding submission method

Note: For all MH services that have not been integrated into managed care (e.g., Phase 2 and 3 services) and covered under FFS, PA requests must be submitted FFS. For

members with presumptive eligibility, MH PA requests should be submitted to MACC offices.

Required fields

DMAHS has worked with MCOs to develop a **standardized set of fields** (shown below) for all initial outpatient MH PA requests. The Medicaid FD-07 was used as a baseline to develop this standardized set of fields.

Exhibit 17: Required fields for complete MH PA request

Category	Fields
General information	• Non-urgent v. urgent (and clinical reason for urgency) • Type of request (initial v. extension, renewal v. amendment)
Patient information	• Name, phone number, address, DOB, member ID, and Medicaid number • Guardian information if member is a minor
Provider information	• Checkbox to indicate referring or servicing • For both requesting provider and facility and servicing provider and facility • Name, NPI, specialty, contact info (phone, address email), tax ID number (TIN), Provider Medicaid ID, In Network v. Out of Network (OON)
Services requested	• Precipitant / reason for admission • Plan of care / treatment plan (e.g., provider narrative of initial goals) • CPT or HCPCS code(s) with modifier(s) if applicable, and units • MH treatment requested with frequency / length, state / end date • Diagnosis description (ICD) and code • Checkmark for level of care required
Clinical documentation	• Brief clinical history (including substance use history and current status) • Present clinical status (including presenting symptoms, presence of psychosis, medications used / medication plan) • Risk of harm to self or others (prior attempts, date / description, risk rating – not present, ideation, plan, means, prior attempt) • Criteria / level of care utilized in past 12 months • Discharge plan (including planned discharge level of care, barriers to discharge, expected discharge date)

MCOs cannot require incremental fields beyond this list to deem a PA request as complete.

Substance Use Disorder (SUD) PA requests

Providers will submit PA requests to MCOs electronically through NJ Substance Abuse Monitoring System (NJSAMS) for the following services:

- Phase 1 services for general and specialty populations (includes Recovery Court and other court ordered services referrals); and
- Phase 2 services for general population

NJ Substance Abuse Monitoring System (NJSAMS)

NJSAMS is an online state system that all licensed SUD providers are required to use to submit member data. The system:

- Has over 20 years of client data
- Determines member level of care
- Fulfills SAMHSA reporting requirements
- Enables reporting on performance / capacity

DMAHS, DMHAS, and MCOs have worked together to configure NJSAMS to allow providers to automatically route Phase 1 SUD PA requests to MCOs via NJSAMS with a click of a button. This is intended to reduce provider burden by eliminating duplicative data entry across NJSAMS and MCO systems.

How does it work?

Step 1 – Data entry into NJSAMS

- Providers enters PA information in NJSAMS

Step 2 – Transmission of data from NJSAMS to MCO

- NJSAMS generates the documentation for a PA request
- Provider clicks button to flow information to MCO systems

Step 3 – MCO data entry into PA portal

- MCO reviews request and enters PA information into their PA system or portal. Any questions or incomplete information will be communicated to the provider by the MCO using their usual communication channels (e.g., phone call, MCO portal)

Step 4 – Communication of PA decision

- MCO will communicate the PA decision to the provider through their usual communication channels (e.g., MCO PA portal, phone). Note that beyond providers sending the PA request to MCOs via the NJSAMS system, all other communications between providers and MCOs regarding prior authorization will occur external to NJSAMS

For more information on how to use NJSAMS, please see below and attend / watch a State training on NJSAMS (recordings to be posted here when complete)

For Phase 2 services for specialty populations and youth (under 18), providers are required to send PA requests to MCOs directly (i.e., via MCO portal/call/fax, not through the NJSAMS system). While NJSAMS cannot be used to electronically route PA requests to MCOs for these services, providers can share copies of NJSAMS reports with MCOs as part of their PA request.

See below for a summary of the appropriate method of SUD PA requests by service.

Exhibit 18: SUD PA submission method by service

Services	Population type	Processed by MCO or IME (as of January 1, 2025)	Providers submit via NJSAMS or MCO process?
Phase 1 integration services • Partial care (PC) • Intensive outpatient (IOP) • Ambulatory withdrawal management (AWM) *Note: Includes Recovery Court referrals*	General population	MCO	NJSAMS
	Presumptive eligibility	IME	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP) population	MCO	NJSAMS
Phase 2 integration services • Short term residential (STR) • Long term residential (LTR) • Residential withdrawal management (ASAM 3.7 WM) *Note: Includes Recovery Court referrals*	General population & presumptive eligibility	IME	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP) population	MCO	MCO portal

Additional guidance on submitting SUD PA via NJSAMS

Providers should be aware of the following information for SUD PA via NJSAMS:

- **PA request fields**:
  - MCOs must use NJSAMS fields as full SUD PA request (see table in next section)
  - 3 PA reports will be generated:
    - Admission
    - Level of care (LOCI)
    - DSM-5
- **Initial authorization vs. extension request**:
  - Providers to select "extension" checkbox if submission is an extension request; by default, submissions will be "initial"
  - File naming convention identifies extension request
  - Note: NJSAMS not responsible for validating / addressing errors, thus providers are urged to review checkboxes prior to submitting
- **Urgent designation**:
  - File naming convention to automatically include level of care – SUD intensive outpatient and ambulatory withdrawal management are "always urgent"
  - If providers want to designate SUD partial care as urgent, they must notify MCO external to NJSAMS (e.g., fax, phone call)
- **Modified level of care**:
  - Providers will first discharge the member from current level of care within NJSAMS
  - Providers will re-submit request to MCOs (applicable information from previous submission will pre-populate into new request) with updated level of care report (ASAM LOCI) and select "modified level of care" checkbox
  - File naming convention identifies modified level of care request
- **Discharges**:
  - Providers to discharge member through NJSAMS and inform MCOs through MCO portal

Required fields

The following state-defined fields through NJSAMS will constitute a complete SUD authorization.

Exhibit 19: Required fields for complete SUD PA request

Category	Fields
Member information	• Name, phone number, address, DOB, member NJSAMS ID and Medicaid number, SSN/citizenship • Admission date and site location
Provider information	• Provider Name • Provider Medicaid number
Clinical information	• Admission report: • Facility / Agency NPI # • Member demographic information (e.g., address, phone number) • Details on living arrangement, household, employment, income, legal status • Details on current substance use • Comment section to include medication history option
	• LOCI report to assess appropriate level of care for members across: • Acute Intoxication/Withdrawal • Biomedical conditions/complications • Emotional, behavioral, or cognitive conditions and complications • Readiness to change • Relapse, continued use, or continued problem potential • Recovery environment • Level of care indicated / recommended, discharge plan, recommendations / clinical justifications, medications planned
	• DSM-5-TR 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

Note: Facility / agency NPI number, medication history, and last date of substance use are not mandatory fields in NJSAMS, but a notation will be added to indicate “required by MCOs” for provider reference. Providers must fill these fields out for a complete PA request.

Retroactive authorization

In some circumstances, providers may be able to obtain retrospective authorization for a service that was delivered without obtaining the necessary approval before initiating the service.

Retroactive authorization is intended for specific, exceptional situations when services are essential for ongoing care and could reasonably have been authorized based on medical judgment at the time. Circumstances may include:

- **Other Insurance Denied Payment:** If another insurer (like Medicare) denies or only partially pays a claim, and it was unreasonable to expect prior authorization from MCO.
- **Eligibility Was Confirmed Later:** The patient was found eligible for NJ FamilyCare after services were provided.
- **Administrative Barriers:** The provider couldn't reach MCO for authorization (e.g., on weekends or holidays), and delaying the service would have been unreasonable. Providers must request authorization within five days of providing the service.
  - Example: A patient is discharged on a Friday evening and needs equipment urgently, but NJ FamilyCare is closed for the weekend.
- **Reasonable Exception:** If a situation doesn't fit the above, but it's reasonable to allow retroactive approval, NJ FamilyCare may make an exception.

Providers should document these situations carefully and submit requests quickly to support continuity of care.

All MCOs are required to allow for the submission of retroactive initial authorizations for a minimum of 5 days post service initiation for any service, regardless of circumstance, to enable flexibility for providers. Retroactive authorizations within the 5-day period can only be denied for lack of medical necessity or eligibility; if a retro authorization is denied, services rendered during the retro window will also be denied.

Beyond the 5-day minimum, MCOs can exercise discretion in approving or denying retroactive authorization on a case-by-case basis.

Retroactive authorization requests should be submitted via the same method as outlined for initial authorization requests for MH and SUD services above.

Discharge reports

To assist providers in submitting PA requests, DMAHS has worked with MCOs to develop a standardized set of fields for discharge reports. These fields are shown in the table below:

Exhibit 20: Required fields for discharge report

Category	Fields
Provider	Name and phone number of provider discharging the patient
Patient	Admittance date
	Anticipated discharge date
	Discharge diagnosis
	Medications at discharge

	Narrative of mental status at discharge
	[If applicable and if member consents] Attending MD name and whether MD was informed of discharge
	[If member consents] Home address and phone number
Discharge plan	[If applicable] Discharge level of care
	[If applicable] Discharge provider name and phone number
	[If applicable] Date / time of discharge appointment
	[If applicable] Is appointment within 7 days of discharge? If not, what was the barrier?

For inpatient discharges, the minimum required timeframe for providers to submit discharge information is 2 business days. For outpatient discharges, the minimum required timeframe for providers to submit discharge information is 30 business days. MCOs may allow for increased number of days if they prefer.

Turnaround time

The maximum time between MCOs receiving a PA request and issuing a PA decision (i.e., approval or denial) is known as the 'turnaround time.'

The following turnaround time policies have been standardized across MCOs to hold MCOs accountable to timely PA review and decisions.

Turnaround time will **begin at MCO receipt of a PA request**, whether the request is complete or incomplete. As soon as an MCO receives a provider PA request, the turnaround time for MCOs making a PA determination begins. If a PA request is incomplete and MCOs indicate needing additional information to make a determination, the turnaround time will stop and restart once providers submit the amended request. The turnaround time will start with each new request or amendment that is submitted.

Turnaround time for modified denials, auto approvals, extension requests, and retroactive authorizations should follow turnaround time for **initial authorizations.**

Turnaround time will depend on the urgency classification of the BH service:

- **Urgent requests:** For outpatient services, turnaround time is **24 hours** on business days and **1 business day** on weekends / holidays but not to exceed 72 hours post-submission (to account for provider-MCO weekend communication). For inpatient / residential services, turnaround time is 24 hours on all days.
- **Non-urgent requests:** Turnaround time is 7 calendar days

Urgency designation

Always urgent

- MH

  - Acute partial hospital (APH)
  - Inpatient psychiatric hospital care
- SUD
  - Ambulatory withdrawal management (AWM)
  - Residential detoxification / withdrawal management (ASAM 3.7 WM)
  - Intensive outpatient (IOP)
  - Short term residential (STR)
  - Inpatient medical detoxification

Can be considered urgent
If admitted through inpatient, residential or ER screening

- MH
  - Partial hospital (PH)
  - Partial care (PC)
  - Adult Mental Health Rehabilitation (AMHR)
- SUD
  - Partial care
  - Long term residential

Please note that any service can additionally be classified as urgent by provider / MCO discretion.

How long will the authorization be granted for?

Minimum Durations

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:

- Phase 1 services:
  - MH Acute Partial Hospital (APH) and Partial Hospital (PH): Minimum 14 days
  - MH Partial Care (PC): Minimum 14 days
  - SUD Partial Care (PC) and Intensive Outpatient (IOP): Minimum 30 days
- Phase 2 services:
  - SUD Short Term Residential (STR): Minimum 14 days
  - SUD Long Term Residential (LTR): Minimum 60 days

Note: These are required minimums that MCOs must follow (i.e., cannot fall below); MCOs can grant longer durations based on member needs at the MCO's discretion.

If you have any specific questions, please reach out to the relevant MCO representatives.

Denials and Appeals

In response to an adverse PA determination (i.e., denial, reduction of requested coverage, suspension or termination of coverage), members (or a provider on behalf of the member with written member consent) **can submit an appeal** to the MCO.

If an initial authorization or extension request is denied, members and providers will receive a letter from MCOs. If for an extension, MCOs must send this notice 10 days prior to end of service authorization. The letter outlines:

- **MCO decision** to reduce or deny PA request
- **Steps member / provider must take** to appeal and continue services
- **List of options for representation** or publicly available resources

Appeals Process

The appeals process is as follows:

Step 1: Request appeal
Members have 60 calendar days from the date on the denial letter to make the request (verbally or in writing). Members can also ask the provider to request an appeal on their behalf. If the member has an individual who is legally authorized to act on their behalf (sometimes referred to as an *Authorized Representative* or *Personal Representative*), the representative can make the request as well.

Step 2: Request continuation of benefits
Members / member representatives must **request continuation of benefits** in the following ways:

- On or before the last day of the current authorization: or
- Within 10 calendar days of the date of receipt of the outcome letter, whichever is later. For example, if the letter is received 5 days before the end of the authorization, the request for continuation of benefits can be filed 5 days after the end of the authorization

There are **3 levels of appeals**

a. **Internal Appeal (i.e., peer review):** Formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.
   If internal appeal is denied, the following options exist:

b. **External/IURO Appeal**: An external appeal conducted by an Independent Utilization Review Organization (IURO)
c. **Medicaid Fair Hearing**: This can take place in parallel with external/IURO appeal or afterwards if decision is not in member's favor

FAQs

Which services will require PA?
Behavioral Health Phase 1 services that may require PA include:

- Mental Health (MH) Partial Care
- MH Partial Hospital
- MH Partial Hospital
- Substance Use Disorder (SUD) Partial Care
- SUD Intensive Outpatient
- Ambulatory Withdrawal Management

Requiring PA requests is prohibited for Outpatient MH/SUD Counseling.

What will happen to my active FFS authorization come January 1, 2025?
All active FFS authorizations as of December 31, 2024 will be automatically transferred to MCOs and remain active for the remaining duration of the original authorization period.

Can we submit PA requests before January 1, 2025?
If providers need to submit PAs from now through to December 31, 2024, please submit as FFS and the authorization will be transferred.

Who do I submit PA requests to after January 1, 2025?
Providers must submit requests to MCO for continued coverage prior to the end date of the original PA.

Will MCOs utilize ASAM-3 or ASAM-4?
SUD level of care determinations will be made using ASAM-3 standards to align with NJ Substance Abuse Monitoring System (NJSAMS).

Do MCOs provide retroactive authorizations?
Yes, MCOs accept retro-authorizations for a minimum of 5 days after service initiation, regardless of circumstance. Approval of retro-authorizations beyond this minimum is up to MCO discretion and will be determined on a case-by-case basis by your MCO. If you have any specific questions, please reach out to your MCO.

Are we allowed to provide more than one service of care on the same day?
Each provider is allowed to provide one behavioral health service per member per day, unless otherwise specified.

Can there be standardized definitions for and applications of medical necessity? For example, while all MCOs use ASAM, they may interpret/apply standards differently.
DMAHS is instituting annual training requirements on ASAM for MCO staff reviewing SUD PA requests, as well as inter-rater reliability testing to ensure consistent application of criteria across MCO UM staff.

What happens when members choose to switch MCO mid treatment/mid authorization? Will providers be required to call the new MCO to get a new authorization?
When a member changes MCOs mid treatment or mid authorization, the provider must first call the new MCO and submit a new authorization request. To prioritize continuity of care, the MCO is required to allow providers to continue providing the service until a new plan of care is identified by the new MCO. Providers must check EMEVS monthly to confirm enrollment and MCO status.

What happens when members choose to switch providers mid treatment/mid authorization? Will providers be required to call the new MCO to get a new authorization?
When a member changes providers mid treatment or mid authorization, the initial / original provider must inform the MCO that there has been a change in provider authorization / service end date. The new provider must then contact the MCO to request a new authorization.

What should SUD Phase 1 providers do if NJSAMS does not directly route NJSAMS PA reports to MCOs?
While NJSAMS and MCOs are in close collaboration to ensure this does not occur, if there is an error, providers can submit NJSAMS information through fax or phone call directly to the MCO.

How will we get a PA when an individual is released from incarceration but their Medicaid still has a Special Program Code of 98/99 listed? Health plans will not authorize when they are still showing incarcerated. Getting this code lifted can be a timely process.
This code should be lifted once an individual re-enters the community post incarceration. However, DMAHS has had to address this issue occasionally. If you are working with a member whose Special Program Code of 98/99 is listed in EMEVS, then please email DMAHS.managedcare@dhs.nj.gov to manually lift this code.

Will MCOs or Medicaid still cover for Partial Care Transportation services?
Yes, transportation services provided by MH Partial Care providers for members in their Partial Care program will be covered by the MCO.

Claims

Overview

When transitioning from FFS to managed care, providers accustomed to submitting claims directly to the State may need to adjust their processes. In a managed care model, claims are submitted directly to MCOs.

The claims process aims to ensure timely and accurate reimbursement, maintain program integrity, and uphold transparency.

By adhering to these principles, providers and MCOs work together to support the financial sustainability and accountability of the healthcare system, enabling better service for members.

Key changes to State-MCO contract to improve provider experience with respect to claims

The State has implemented several changes and updates to rates and claims policies to improve provider experience for BH Integration. Below are some examples of these policies:

- **Introduced FFS rate floor:** MCOs must pay providers at or above the FFS rates for BH services. If the FFS rates increase during an existing contract and your contracted rates become lower than the new FFS rates, the MCO must adjust your rates to match the new FFS rates from the effective date specified by DMAHS
- **Shortened BH claims processing times:** MCOs must adhere to specific timelines for processing behavioral health claims: 90% of electronic clean claims within 15 days, 90% of manual clean claims within 30 days, and 99.5% of all claims within 45 days
- **Reduced minimum weekly payment cadence from 2 weeks to 1 week:** Payments for clean claims must be paid weekly, reduced from bi-weekly
- **Require 'clean claim' definition in MCO provider manual:** Require MCOs to specify fields that must be completed in UB-04 or CMS 1500 to satisfy the definition of a "clean claim"
- **Mandated claims be covered in MCO BH provider trainings:** Claims processes must be covered by MCOs in provider trainings, either as a standalone training or as part of broader BH integration provider training

Claims Process

While many providers are familiar with claims processes, working with MCOs introduces some variations that providers may not have encountered under FFS.

The Medicaid claims process consists of seven essential steps that providers should follow to ensure reimbursement for services delivered to MCO Medicaid members:

- **Billing Codes:** Determine the appropriate billing codes for the service delivered and confirm any additional coding requirements, such as modifiers or authorization numbers
- **Form Selection:** Select the correct form for submission (e.g., CMS1500, UB-04)
- **Required Fields:** Ensure all required fields are complete to create a "clean claim"
- **Claim Submission:** Decide on the method of submission (manual or electronic)
- **Adjudication & Processing:** Track the progress of the claim and understand the expected processing time
- **Denials & Appeals:** Learn common reasons for denial and understand the steps for filing an appeal if needed
- **Reimbursement:** Know the reimbursement amount and confirm the timeline and method of payment

Some of these steps are more standard across MCOs, while others vary.

Step 1: Billing Codes

All five MCOs follow the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient and same date of service. For more information on this initiative, please feel free to visit http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

Correct coding is important when submitting valid claims. Use current ICD 10-CM diagnoses and HIPAA compliant procedure codes to the highest level of specificity. Use the greatest number of digits available to make sure claims are as accurate as possible. The Medicare Claims Processing Manual, Chapter 23, includes information on diagnosis coding, procedure coding, and instructions for codes with modifiers.

Diagnosis Codes

Diagnosis codes identify exactly **why a service is needed**:

- Providers must use ICD-10-CM codes for primary diagnosis
- Under managed care, ICD-10 diagnosis codes must meet MCO Medicaid medical necessity criteria

Procedure Codes

Procedure codes identify exactly **what services were performed**:

- Providers must use the correct CPT or HCPCS codes for procedures and services
- HCPCS Level I and II codes to code all claims procedures, except for inpatient hospitals
- Use ICD-10-PCS codes for procedure coding on inpatient hospital Part A claims
- Level I CPT-4 codes describe medical procedures and professional services

Revenue codes

Revenue codes for hospitals and facilities indicate location or department where service performed:

- In managed care claims, modifiers may be required in specific situations and MCOs may impose payment caps based on the revenue code

Coordination of benefits codes

Providers must follow MCO-specific COB processes.

Authorization numbers

Authorization numbers must be included on claims for any service requiring authorization. Failure to do so may result in the claim being denied.

Step 2: Form Selection

Depending on the type of service provided, providers can submit a claim using one of the following two forms:

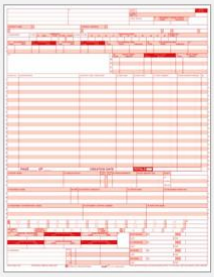
Exhibit 21: Two types of claim forms

CMS 1500 / 837P

For independent medical professionals (outpatient claims)

CMS 1450 ("UB-04") / 837I

For hospitals and facilities (inpatient claims)



CMS 1500 (link to form)
Appropriate for all outpatient claims
837P is the electronic equivalent of CMS 1500

CMS 1450 (link to form)
Appropriate for all inpatient claims
837I is the electronic equivalent

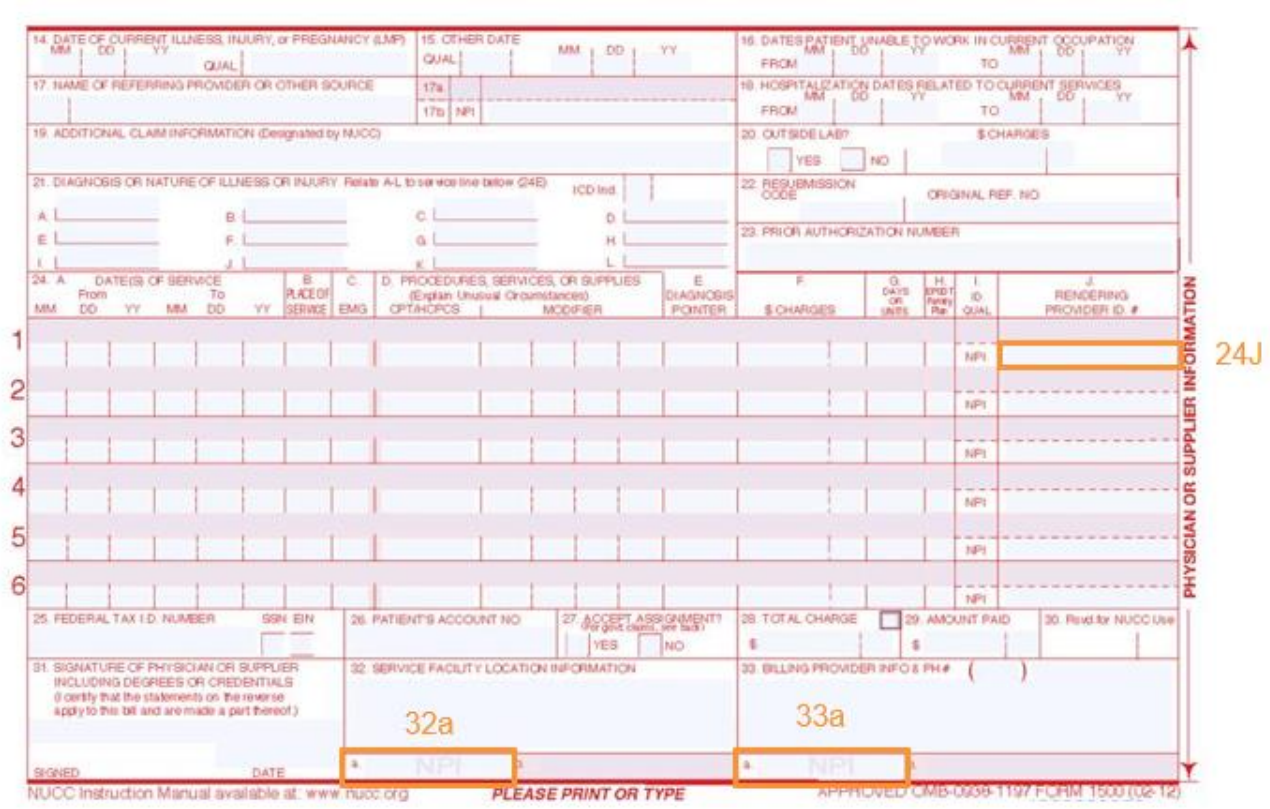
Providers must complete ALL required fields and include additional documentation when necessary. The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. Failure to resubmit the claim in a timely fashion could result in the claim being denied for untimely filing.

NPI Requirements for CMS 1500

Three sections on CMS 1500 form for NPI numbers that providers must fill out correctly:

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

Exhibit 22: CMS 1500 form



In general, if billing under a group:

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

If billing individually:

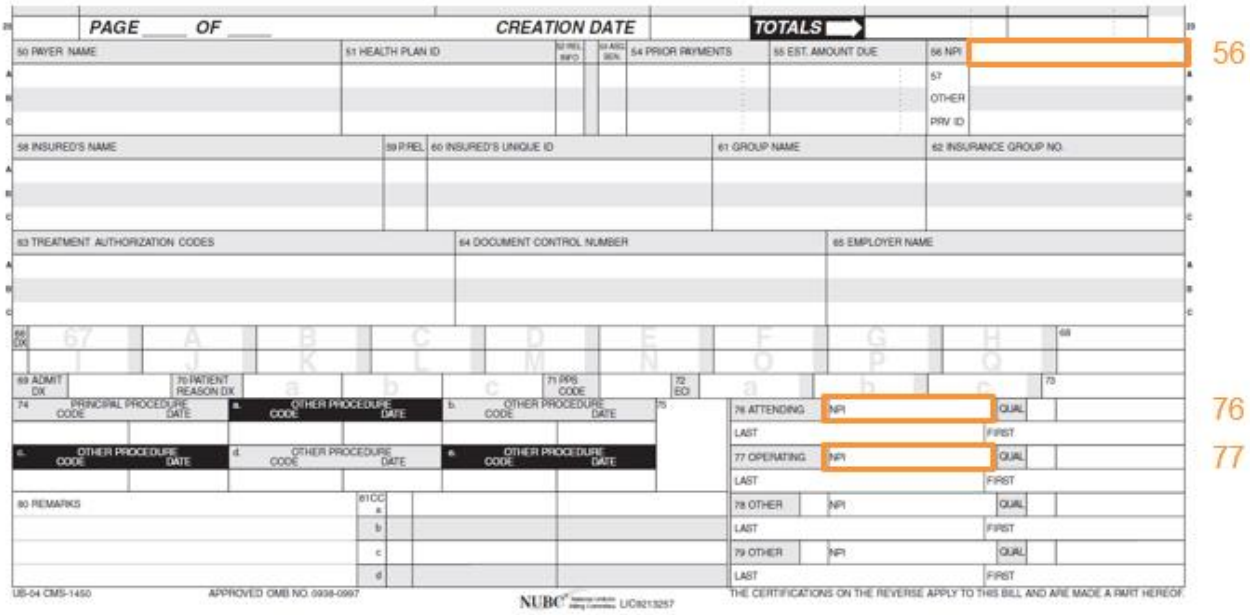
- Type 1 NPI of practitioner in 32a, 33a, and 24J

NPI Requirements for CMS 1450

Three sections to enter NPI:

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

Exhibit 23: CMS 1450 form



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

Billing as a facility:

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

Step 3: Required Fields

According to the division of banking and insurance (DOBI) a "Clean claim" means:

- The claim is for a service or supply covered by the health benefits plan or dental plan;

- The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;
- The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;
- The carrier does not reasonably believe that the claim has been submitted fraudulently; and
- The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file

In order satisfy the definition of a clean claim, providers must be aware of the exact fields that must be filled out on CMS 1500 and CMS 1450 for each BH service.

State driving more transparency on MCO required fields

DMAHS has updated the State-MCO contract to make it easier for providers to understand each MCO's definition of a clean claim (i.e., the exact fields that are required):

Starting January 1, 2025, each MCO will be required to outline their required fields (in CMS 1500 and CMS 1450) for a claim to be considered "clean" and include it in both their:

- Provider manual
- Provider training

Step 4: Submit claim

Managed care claims can be submitted electronically or by mail, however electronic is preferred as it:

- Enables faster processing and payment of claims
- Eliminates cost of sending paper claims
- Allows tracking of each claim sent
- Minimizes data entry errors

Initial claims must be submitted **within 180 days** from the date of service (DOS). If coordination of benefits is involved, where MCO is a secondary payee, most MCOs require COB of claims to be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from DOS, whichever is later.

Below is a summary of the claim submission details for each MCO:

Exhibit 24: Claims submission options by MCO

MCO	Electronic	Paper
Aetna	Availity Payer ID is 46320	Aetna Better Health of New Jersey P.O. Box 982967 El Paso, TX 79998
Fidelis Care	Fidelis Care Provider Portal or Availity Payer ID is 14163	Fidelis Care, Claims Department P.O. Box 31224 Tampa, FL 33631-3224
Horizon	Availity or Horizon NJ Health EDI Payer ID is 22326	Horizon NJ Health Claims Processing Dept. P.O. Box 24078 Newark, NJ 07101
UnitedHealthcare	Provider Express or EDI Payer ID is 87726	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402
Wellpoint	Availity Payer ID is WLPNT	New Jersey Claims, Wellpoint P.O. Box 61010 Virginia Beach, VA 23466

Step 5: Adjudication and processing

There are two types of adjudication:

- **Auto-adjudication:** goes into pay or denial status automatically
  - Moves to post-adjudication immediately
  - Paper/electronic remits are created
  - Check/EFTs are sent to the Provider
- **Manual claims review:** Route to a claim's processor for manual review and processing

Expected decision timelines

State processing timelines for clean claims must be within:

- 15 days for 90% of electronically submitted clean claims
- 30 days for 90% of manually submitted clean claims
- 45 days for 99.5% of all claims

For additional detail on MCO specific processing timelines (which may be shorter), please refer to each MCO.

Check the status of your claim

Some MCOs have a portal to track the status of claims, adjusted claims and appeals. Other MCOs require providers to reach out directly.

Exhibit 25: How to check claim status by MCO

MCO	How to check claim status
Aetna	• Participating providers may confirm receipt and confirm adjudication status of a claim by checking the Secure Provider Web Portal located at https://apps.availity.com/availity/web/public.elegant.login • Providers may also call our Claims Investigation and Research Department (CICR) at (855)-232-3596. The CICR team can assist with claim related questions, such as claims status and inquiries. The CICR staff is available to assist from 8 AM to 5 PM Monday through Friday
Fidelis Care	• Providers can look up claim status in the Fidelis Care Claims Portal • For more information on how to submit and check the status of claims in Fidelis Care Portal, please watch the Fidelis Care's training video
Horizon	• Participating providers may confirm receipt and confirm adjudication status of a claim in Availity: https://apps.availity.com/availity/web/public.elegant.login
UnitedHealthcare	• Claim status can be checked via the Provider Express Portal- Claim Inquiries & Claim Adjustments (video)
Wellpoint	• Providers can access Availity, Wellpoint's provider portal, to answer any questions pertaining to eligibility, benefits, authorizations, claims status, and more at https://apps.availity.com/web/onboarding/availity-fr-ui/#/login

Step 6 (if needed): Denials and Appeals

Reasons for denial

Claims may be denied for a variety of reasons. Below is a list of some of the most common provider errors and steps providers can take to avoid them.

Exhibit 26: Common claims errors and tactics to avoid them

Error	How to avoid
Incomplete claim submission	• Use a checklist to ensure all required fields are completed • Implement Electronic Health Record (EHR) system that flags incomplete sections
Incorrect diagnosis or procedure codes	• Double-check coding before submission • Use coding software or cross-referencing tools that align diagnosis with procedure codes
Missing prior authorization	• Ensure all services that require prior authorization are pre-approved • Utilize automated tracking systems to manage and confirm authorizations
Late claim submission	• Set internal deadlines well ahead of official submission deadlines • Use reminders or automated billing systems to track submission timelines and avoid delays
Duplicate billing	• Implement billing software that flags duplicate claims before submission • Establish a review process to ensure each service is only billed once
Benefit limit exceeded	• Check patient benefit limits before delivering the service • Use billing software that alerts staff when a benefit is close to being exhausted
Services not included in MCO benefit	• Review the patient's benefit plan to confirm coverage • Know the out-of-network claim process for the MCO if applicable
Incorrect claim submission address	• Regularly update records with the correct submission address for all MCOs • Use address validation tools in the billing system to confirm the address before submission
Invalid provider ID number	• Keep a centralized and regularly updated record of provider IDs • Use validation checks in the billing system to alert staff if an invalid ID is entered
Incorrect patient information	• Verify patient demographics at every visit to ensure accuracy • Use EHR systems to access most current patient information and prevent manual errors

Appeals

Providers have the right to appeal denied or underpaid claims if they believe the decision was incorrect.

Appeals must be submitted **within a specified time** after receiving denial, **typically 90-180 days,** depending on the MCO.

Each MCO provides specific contact information and forms for submitting appeals
Most MCOs use a version of the NJ Healthcare provider appeal form.

Process

1. **First level appeal**
    - Submit appeal to MCO for reconsideration
    - Include supporting documentation, such as medical records and billing codes that show why the services are necessary
2. **Second level appeal**
    - If first appeal is denied, some MCOs allow a second appeal within a stipulated timeframe
3. **External Review: PICPA**
    - If appeal is still denied, providers can request an external review through the Program for Independent Claims Payment Arbitration (PICPA)
    - Claims must have completed internal review and be $1,000 or more to be eligible1
    - Submit via Maximus (vendor) here

Office of Managed Health Care

The DMAHS Office of Managed Health Care can help bring a resolution between providers and MCOs.

It specifically focuses on provider inquiries and/or complaints in relation to MCO:

- Contracting & credentialing
- Claims & reimbursement
- Authorizations
- Appeals

Contact details

- **Email:** mahs.provider-inquiries@dhs.nj.gov
- Include detail regarding your claim
- If multiple claims are impacted, the information should be summarized using an Excel file

All information must be sent securely if it includes Protected Health Information (PHI).

Step 6: Rates and Reimbursement

Rates

MCO reimbursement rates are negotiated between providers and each MCO. Some MCOs may be willing to provide a fee schedule upon request. For more information, please reach out to each MCO separately.

State requires contracted rates to be at or above Medicaid FFS

To smooth the transition to managed care and ensure providers are not paid less than before integration, DMAHS requires all MCOs to pay providers at or above Medicaid FFS rates, serving as a "FFS rate floor."

If FFS rates change during existing contract period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS.

Medicaid FFS fee schedule can be found here

Payments

All MCOs allow providers to choose to receive payments electronically or by check:

- Electronic: Most MCOs offer faster payments via electronic remittance, such as ACH transfers
- Check: Paper checks are an option for those without electronic payment capabilities

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

FAQs

What will I be paid by MCOs?
As of January 1, 2025, MCOs are required to pay providers at or above the amount outlined in the fee-for-service (FFS) payment schedule.

Will rates be the same for all MCOs?
Each MCO is legally permitted to negotiate their own rates with individual providers so long as those rates comply with State policy – i.e., above FFS floor.

Will MCOs be required to raise contract rates to match floor if Medicaid FFS rates are adjusted in middle of contract period?
Yes, contract rates, at all times, must be at or exceed the FFS floor, effective on the date indicated by DMAHS.

Can I submit claims online and offline?
Yes. Most MCOs allow submission through their portal or using a paper form.

How long will it take to process my claim?
All MCO BH claims processing timelines must comply with the following requirements:

- 15 days for 90% of electronic clean claims
- 30 days for 90% of manual clean claims
- 45 days for 99.5% of all claims

Care Management

Overview

MCO-led integrated care management consists of a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services across providers/settings in a timely and cost-effective manner. Care involvement includes, but is not limited to, the following activities: case management (e.g., working directly with members to make phone calls and set up appointments), care coordination (e.g., working with members' providers to ensure streamlined care), and advocacy (e.g., working with members' larger community to ensure member is receiving appropriate services).

MCO-led integrated care management is a free service for all eligible members of each MCO, with numerous screening opportunities. If eligible, members will be assigned an MCO care manager to support their care needs.

MCO-led integrated care management is intended to supplement a member's existing care providers, including provider care/case management services. MCO-led integrated care management is differentiated from provider care management due to the MCO's purview over a member's physical and behavioral health needs, access to comprehensive member data, and role in overseeing and coordinating all member services.

MCO care managers have detailed protocols, policies, and training to initiate ongoing outreach with a member's providers and include them in the care coordination process.

Care management enrollment and assessment tools:

The following tools are used to assess a member's eligibility for care management:

- **Initial Health Screen (IHS):** The IHS tool is 9-question screening measure used to determine whether a member's physical and/or BH care needs warrant MCO-led integrated care management. Each new MCO member is outreached for screening via phone and again through mail if unreachable by phone. The IHS is meant to be a brief, nonburdensome way for members to get identified for care management needs.
- **Comprehensive Needs Assessment (CNA):** Members who meet criteria for care management are assigned a care manager who administers a CNA. The goal of the CNA is to identify a member's needs across social, developmental, behavioral, cognitive, and functional dimensions to determine care management level (high intensity, moderate intensity, low intensity) and subsequent level of support.

- **Trigger List:** The trigger list is a list of state-defined events that a member can experience at any time throughout their MCO enrollment that requires an MCO care manager to, at minimum, outreach the member to offer / assess the need for care management. Triggers include:
  - 2+ ER visits in 6 months
  - Exacerbation of chronic condition and / or disability
  - Mental health hospitalization
  - Provider referral (including but not limited to BH (MH/SUD) screening result, transitioning out of intensive BH service, homeless/at risk, referral to housing supports services, pregnant/postpartum, disengagement from behavioral health services – 3+ subsequent missing appointments)
  - Self-referral (including but not limited to death of a loved one, suicide attempt without hospitalization, or homeless/at risk, pregnant/postpartum)
  - Systems data (including but not limited to new terminal illness diagnosis or BH diagnosis, 3+ address changes within past year)

MCO-led integrated care management delivery

The state has worked with MCOs to develop new standards for MCO-led integrated care management delivery to ensure members with BH needs receive the support they need and to standardize processes across MCOs.

Based on screening results (IHS and CNA), members qualifying for BH care management (i.e., BH diagnosis or screening result) are placed into one of 3 stratification levels. Each stratification level mandates a minimum level of member contact to ensure adequate care. MCO care management is intended to be long term with a minimum of 6 months of support. Additionally, members may move between intensity levels throughout their care based on their needs.

Exhibit 27: MCO BH care management member stratification and outreach requirements

	Low intensity	Moderate intensity	High intensity
CM contact with member (Member interaction required to count as contact)	Min 2x per year Telephonic, virtual, or in person	Min 1x per quarter Mandatory annual face-to-face assessment (virtual or in-person)	Min 1x per month Mandatory annual face-to-face assessment in person
Population criteria – (In addition to BH diagnosis or screening result & score 5+ on IHS; MCO CM can exercise clinical judgment beyond these criteria to place members into appropriate tier)	• Under 26 with DCF history • In MH / SUD outpatient counseling	• Hospitalized in past 12 months • Receiving outpatient services other than counseling (e.g., partial care) • In provider care management • Comorbid PH diagnosis and SMI	• Homeless • High utilizers (i.e., 2+ hospitalizations or ER visits within 6 months)
BH / physical health integration	MCO care managers expected to use integrated approach (e.g., BH and PH care managers working together to manage member, 1 care manager that has both BH / PH expertise, 1 care manager with BH or PH expertise who seeks additional input from integrated team)		
BH expertise	"Primary" care manager must be care manager with BH expertise		

MCO care managers are responsible for:

- Early identification of members who have or may have special needs
- Assessment of a member's risk factors
- Development of a member's plan of care
- Referrals and assistance to ensure timely access to providers
- Coordination of care actively linking the members to providers, medical services, residential, social, behavioral, and other support services where needed
- Monitoring of care plan
- Continuity of care for member
- Follow-up and documentation of member progress

Providers are encouraged to:

- Refer members to MCO-led integrated care management if additional support is necessary
- Respond to MCO outreach to give input into an enrolled member's care plan
- Proactively outreach to MCO care managers with updated information on enrolled members
- Remind enrolled members to reach out to their MCO care managers for care coordination support

FAQs

Who is eligible to receive MCO-led integrated care management?
All DCP&P, DDD, and MLTSS members qualify for MCO-led integrated care management and have distinct and separate care management processes. Additionally, all new members of each MCO are screened using a state-approved IHS. Any member who meets criteria based on the results of the IHS (score of 5+) are eligible to receive MCO-led integrated care management. Additionally, members can qualify through a "trigger event" at any time. Members who qualify will be assigned an MCO care manager and undergo a CNA to identify each member's unique needs and subsequent care plan.

How can I refer a member to MCO-led integrated care management?
In addition to all members receiving IHS at MCO enrollment, if a member experiences a "trigger event" at any time, an MCO care manager will outreach the member to offer / assess need for care management. Trigger events include provider referral. If providers think their member(s) would benefit from this service, they can refer to each MCO's core care management team (contact information listed below).

What state standards exist for MCO-led integrated care management?
The care management delivery and staffing model across all MCOs is organized by low, moderate, and high intensity based on members' needs. It features varying population criteria, levels of engagement, and standardized integration and expertise required at each intensity level. Please refer to the table on page 64 for a table of updated standards.

What happens to members who are already enrolled in provider agency care or case management? How will MCO care managers affect services provided by agency care/case management programs?

MCOs are required to offer MCO-led integrated care management to all eligible members, irrespective of their enrollment in other care management programs. MCO care management is intended to complement and support care/case management provided by agencies. MCO care managers are well versed in collaborating with provider care managers to develop a care plan and provide streamlined and relevantcare for members.

Additional readiness guidance and resources

This section includes additional guidance and resources for providers, including managed care best practices, a provider readiness checklist, and key contact information

Best Practices for Success with Managed Care

As New Jersey transitions behavioral health services from FFS to a managed care, providers face new challenges and opportunities. Adapting to these changes is essential for maintaining continuity of care and optimizing service delivery.

In collaboration with the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA), we have identified **four key best practices** to help providers navigate this transition successfully. These practices can help enhance operational efficiency for providers and improve patient outcomes. While not exhaustive, they are critical steps toward readiness for participating in managed care.

The four key best practices are:

1. **Credential/contract with all 5 MCOs** to ensure continuity of care for your patients and grow your patient base
2. **Regularly review State-MCO and MCO-provider contracts and guidance** to understand eligibility, covered services, and prevent payment delays
3. **Collaborate with MCO Care Managers** and use dedicated resources to promote whole person care – integrated across behavioral, physical, and social services
4. **Strategically select platforms and systems to streamline processes** such as prior authorizations, billing, and tracking quality measures, based on your needs

For each best practice, we highlight why it matters and what steps providers can take to implement it.

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1

Credential/contract with all 5 MCOs to ensure continuity of care for your patients and grow your patient base

Why it matters?

- **Ensure patient access:** Enables patients to receive uninterrupted care amid plan changes
- **Expand patient base:** Opens your practice to more patients, filling appointment slots and optimizing practice resources
- **Increase referrals:** Boosts referral opportunities from various health professionals
- **Maximize reimbursement:** Ensures stable revenue and consistent payments

Steps providers can take to implement this best practice:

1. **Review guidance and trainings:** Read the DMAHS credentialing guidance included in this packet and watch DMAHS Enrollment & Credentialling topic training webinar posted here (Sept 25, 2024)
2. **Review MCO-specific materials:** Visit MCO credentialing portals / websites to understand MCO-specific requirements and processes. Reach out to MCO network representatives with any questions
3. **Prepare documentation**: Use guidance to determine your credentialing requirements and collate your documentation
4. **Elect an expert:** For groups and facility providers: Establish a credentialing lead / subject matter expert within your organization
5. **Initiate the process as soon as possible:** Start credentialing / contracting with each MCO you want to join

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2

Regularly review State-MCO and MCO-provider contracts and guidance to increase efficiency and effectiveness

Why it matters?

- **Maximize patient access to care:** Understand the full extent of covered services for eligible members to provide comprehensive care and improve outcomes
- **Ensure timely payment:** Review MCO contracts for key terms, rates, billing codes, and requirements for authorizations, claims, and documentation to ensure accurate payment and prevent rejections / delays
- **Resolve disputes quickly:** Familiarize yourself with the dispute process to protect revenue and prevent delays

Steps providers can take to implement this best practice:

1. **Review state materials**: Review State-MCO contract, DMAHS program guidance and attend state-led topic trainings to gain strong understanding of NJ State requirements
2. **Review MCO materials**: Review your MCO-provider contracts, attend MCO provider trainings, review MCO provider manual to understand MCO specific requirements and processes, especially covered services and claims
3. **Bring it all together**: Summarize key eligibility rules, covered services, reimbursement rates and billing for each MCO where staff can easily access and incorporate into daily workflow
4. **Ask for help**: Flag any problems with State and MCOs early to minimize disruptions to care and help other providers who might be facing similar issues

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3

Collaborate with MCO Care Managers and use dedicated resources to promote whole-person care

Why it matters?

- **Enhance care coordination:** Work with MCO care managers and network providers to provide seamless care, minimizing duplication and gaps in treatment
- **Improve patient outcomes:** Collaborate with MCO care managers to integrate behavioral and physical health care / service delivery, resulting in better health and fewer crises
- **Access specialists:** Partner with MCOs to access a broader network of specialists, enabling comprehensive care for complex needs
- **Gain and streamline referrals:** Build relationships with MCO care managers to increase referrals, and leverage MCO networks for faster, more efficient referrals, improving care quality and patient satisfaction

Steps providers can take to implement this best practice:

1. **Collaborate with MCOs CMs**: Work with MCO CMs in developing integrated care plans, coordinating services and adjusting care delivery for members
2. **Take advantage of MCO referral network**: Collaborate with MCO referral staff, in-network doctors and specialists to create referral pathways for patients
3. **Use shared data systems**: Use shared health records or platforms to keep everyone informed with real-time data
4. **Monitor and adjust care**: Track patient progress and update MCOs timely and proactively; work with MCO to adjust care
5. **Review guidance:** Review DMAHS guidance on Care Management included in this packet and attend State-led training on Care Management on January 28 (recording to be posted here when complete)

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4

Strategically select platforms and systems to streamline processes based on your needs

Why it matters?

- **Reduce admin burden:** Streamline billing, authorizations, and data sharing to free up clinician time and improve MCO workflows
- **Boost revenue cycle management:** Automate billing and claims to reduce errors, avoid rejections, and speed up reimbursements, ensuring predictable cash flow
- **Improve compliance and tracking:** Upgrade systems to track metrics and meet MCO requirements

Steps providers can take to implement this best practice:

1. **Assess current systems**: Identify inefficiencies in billing, prior authorizations, and tracking based on your practice's size and needs
2. **Choose the right tools**: Select platforms and / or protocols that fit your practice. Smaller practices may improve manual processes, while larger ones might invest in automation
3. **Train staff:** Ensure staff are trained on new tools (e.g., MCO portals) and / or protocols. Designate a "super user" to support training and adoption
4. **Track and optimize**: Monitor performance (e.g., claims denial rate) and refine processes for continuous improvement

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Provider Readiness Checklist

Category	Contacts and resources Have you reviewed these items?	Readiness steps Have you completed these steps?
Medicaid Enrollment	❑ DMAHS provider enrollment guidance and FAQs (pg.13-22) ❑ DMAHS / MCO-led Enrollment & Credentialing training (here) ❑ Gainwell Provider Unit: 609-588-6036	❑ Enrolled in Medicaid per guidance instructions
Joining MCOs (Credentialing & Contracting)	❑ MCO's quick reference guide (QRG) & provider manual ❑ DMAHS "Joining MCOs" guidance and FAQs (pg. 23-29) ❑ DMAHS / MCO-led Enrollment & Credentialing training (here) ❑ MCO-led training / onboarding sessions ❑ Points of contact at MCO for credentialing & contracting	❑ Contracted with MCO(s) you wish to join ❑ Completed MCO credentialing process per guidance instructions
Coordination of benefits (COB)	❑ DMAHS COB guidance and FAQs (pg. 30-32) ❑ MCO TPL protocols	❑ Enrolled in Medicare, if applicable
Prior authorization (PA)	❑ DMAHS PA guidance and FAQs (pg. 33-47) ❑ DMAHS / MCO-led PA training (here) ❑ Points of contact at MCO for PA	❑ Created login for MCO portal to submit PAs ❑ Registered to use NJSAMS (SUD providers only)
Claims	❑ DMAHS claims guidance and FAQs (pg. 48-60) ❑ DMAHS / MCO-led Claims training (here) ❑ Points of contact at MCO for Claims	❑ Created login for MCO portal to efficiently submit claims
Care Management	❑ DMAHS care management guidance and FAQs (pg. 61-64) ❑ Points of contact at MCO for Care Management	❑ Identified MCO care manager for each member (strongly recommended)
Member Resources	❑ Heath Equity Administrator at each MCO (if applicable) – refer to MCO for details	❑ Aware of non-emergency transportation services ❑ Aware of language line services ❑ Aware of MCO's cultural competency policies ❑ Understand MCO health equity requirements (refer to contract)

Additional Resources

State Resources

General information related to NJ Family Care

- **NJ Family Care Website:** https://njfamilycare.dhs.state.nj.us/
- **NJ FamilyCare Managed Care Contract:** http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf
- **DMAHS Provider Newsletters**, particularly Volume 34, No 13, which provides an overview of BH Integration

Information specific to BH Integration

- BH Integration Stakeholder Website – Has a wealth of BH Integration information and resources for stakeholders, particularly providers. Key resources include:
  - MCO Behavioral Resource Guide lists specific contacts for each MCO by topic area (e.g., network, prior authorization, etc.)
  - Presentation, recordings and FAQs of previous provider trainings hosted by DMAHS
  - Presentation and meeting summary of all previous bi-monthly advisory hubs
- Behavioral Health Integration Overview and FAQ Pamphlet – A one page overview of BH Integration plus answers to provider's most asked questions
- NJMMIS Provider Enrollment – Where providers can go to enroll in NJ FamilyCare / Medicaid

MCO Resources

MCO	Additional resources
Aetna	Provider Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
Fidelis Care	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
Horizon	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
United Healthcare	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
Wellpoint	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation

Key Contact Information

If you have any questions related to NJ BH Integration, you can reach out to the State or the relevant MCO.

State

Behavioral Health Unit
dmahs.behavioralhealth@dhs.nj.gov

For general NJ FamilyCare information (not specific to BH), contact: **NJ FamilyCare's Medicaid Hotline** at 1-800-356-1561 (TTY: 1-800-701-0720)

Gainwell Technologies
For questions related to NJMMIS

njmmisproviderenrollment@gainwelltechnologies.com

(609) 588-6036

MCOs

MCO	Provider network contact
Aetna	Network Relations (855) 232-3596 + press star (*) AetnaBetterHealth-NJ-ProviderServices@Aetna.com
Fidelis Care	Contract Negotiator (908) 415-3101 wc_njpr@fideliscarenj.com
Horizon	BH Network Manager (800) 682-9091 BHMedicaid_@horizonblue.com
United Healthcare	NJ Network Manager (877) 614-0484 Njnetworkmanagement@optum.com
Wellpoint	Carelon Provider Relations Line (800) 397-1630 provider.relations.NJ@carelon.com

For specific contact information, please refer to our MCO Resource Guide.