New Jersey Medicaid Mental Health and Substance Abuse Provider Training

Agenda

Overview Behavioral Health Integration

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Continuity of Care

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Overview Behavioral Health Integration

New Jersey Medicaid Behavioral Health Service – Managed Care BH Integration Effective 01/01/2025:

Existing New Jersey FamilyCare Medicaid Membership - Inpatient and Outpatient BH, OBAT and ASD Benefits

Office Based Addiction Treatment (OBAT) Services

- MAUD/MOUD prescriber that also has a "Navigator" on staff to do case management
- Services provided by both Medical (PCP, Internist, etc) and BH (Psychiatrist, Advanced Practice Nurse) provider types

Autism Spectrum Disorder (ASD) Services (EPSDT Benefit):

- Applied Behavioral Analysis (ABA)
- Developmental Services
  - DIR/Floortime
  - DRBI
  - NDBI/EDSM
  - Developmental services are provided by both BH provider types, and Physical Health (OT, PT, ST) provider types

Mental Health (MH) Services:

- Independent practitioner(s):Psychiatry, APN, Physician Assistant
- Independent practitioner(s)L Psychologists, Licensed Clinical Social Workers (LCSWs)
- Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs)
- Independent practitioner(s)l Neuropsychologist
- Outpatient Mental Health
- Partial Care Mental Health
- Acute Partial Hospitalization / Mental Health Psychiatric Partial Hospitalization
- Mental Health Inpatient Services

Substance Use Disorder (SUD) Services:

- Inpatient Medical Detoxification / Medically Managed Inpatient withdrawal management ASAM 4 & 4WM
- Ambulatory Withdrawal Management with extended onsite monitoring/detoxification ASAM 2WM
- SUD Partial Care ASAM 2.5
- SUD Intensive Outpatient Program (IOP) ASAM 2.1
- SUD Outpatient ASAM 1
- Medication Assisted Treatment (MAT)
- Peer Recovery Support Services (PRSS) provided by independent Clinics Drug/Alcohol
- SUD Care Management Services
- Independent Practitioner(s) SUD (Licensed MD or SUD professionals authorized by state licensing board)

Additional BH Services covered for MLTSS, DDD and HIDE-SNP

Mental Health Services:

- Adult Mental Health Rehabilitation (AMHR) – long-term group home for SMI members

Substance Use Disorder (SUD) Services:

- Inpatient SUD Non-Medical Detoxification Services
- SUD Inpatient Rehabilitation
- SUD Residential
- Opioid Treatment Programs (OTPs) / Methadone Clinics

Enrollment and Credentialing

Credentialing – providerexpress.com

- Online credentialing requests
- Specific application link for each provider type; Facility, Agency, Group, Clinician
- License type determines application, credentialing, and roster requirements.
- Submission requirements vary based upon the application submitted
- Per New Jersey State requirements, clean applications processed within 60 days

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- CAQH profile required
- Documentation – Follow state standards & compliant with disclosure of ownership form (DOO)

- Roster template found at: Optum Forms
- Dedicated New Jersey Advocate support

21st Century Cures Act: Medicaid Enrollment Requirements

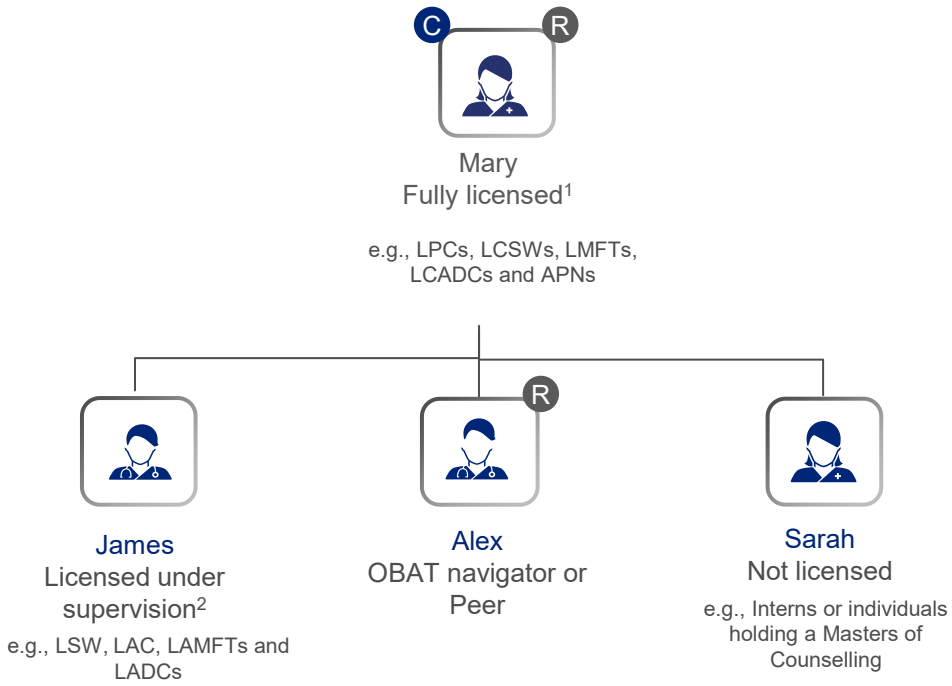
- The 21st Century Cures Act (Cures Act) 114 P.L. 255 requires all States to screen and enroll **all Medicaid providers**, both those in Medicaid Fee-for-Service (FFS) and Managed Care Organizations (MCOs)
- Medicaid managed care network providers are required to be screened by and enrolled with the State Medicaid Agency.
- Providers who do not comply with this requirement risk being removed from the New Jersey Managed care network. All health care professionals and facilities must hold a current New Jersey Medicaid ID number.
- Beginning Jan. 1, 2023,claims will deny for providers not registered with Medicaid or who do not have a Medicaid ID.
- The Medicaid provider enrollment process is to ensure appropriate and consistent screening of providers and improve program integrity. You can register with Medicaid by enrolling as a fee for service provider or through the 21st Century Cures Act. More information can be found by visiting the NJMMIS website Welcome to New Jersey Medicaid 2

Review credentialing requirements

Specific items to check:
- For licensed facilities / agencies, are fully licensed and OBAT navigators / peers always required to roster? **YES**

Individuals / Group

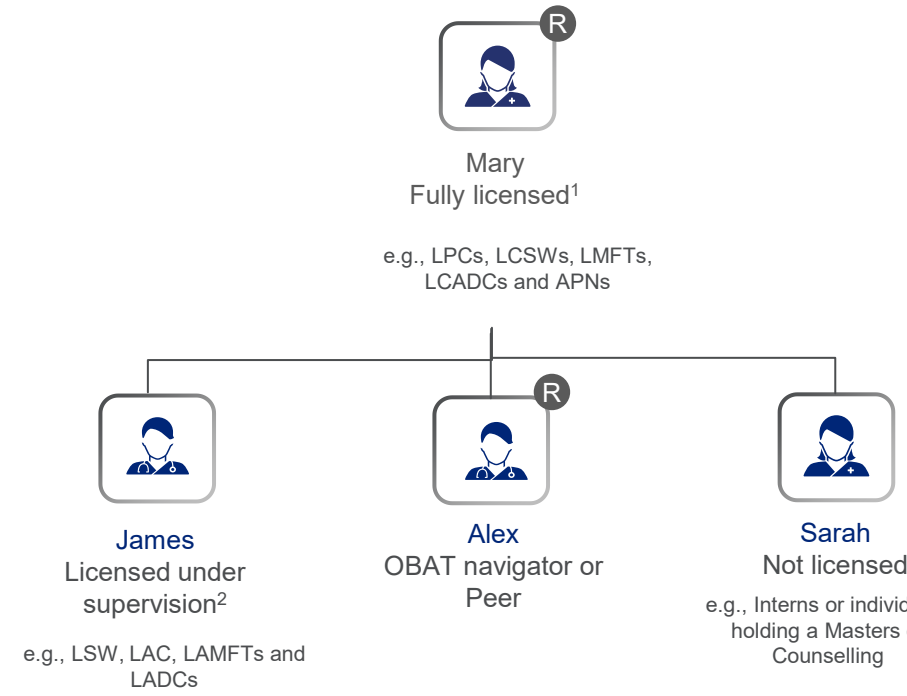
Licensed practitioners are required to **credential individually** with UHCCP
Specific individuals are also required to be listed on Group roster



Licensed Facility / Agency

C

Each licensed facility location is required to credential as an entity
Employees of organization are authorized to serve Medicaid members



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

C Credential as an entity

C Credential individually

R List on roster

Prior Authorization Process

Medical Necessity

Care Advocates use Level of Care Utilization System (LOCUS), Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), Early Childhood Service Intensity Instrument (ECSII), and ASAM Clinical Criteria when making medical necessity determinations and as guidance when providing referral assistance.

Generally accepted standards of practice

- Based on credible scientific evidence
- Generally recognized by the relevant medical community
- Use evidenced-based outcomes to validate the practice

Clinically appropriate

- Type, frequency, extent, and duration of services
- Considered effective for the treatment of mental illness, substance use disorder, or associated symptoms

Determinations of medical necessity

- Informed by:
  - Unique aspects of the case
  - Member's benefit plan
- Available services:
  - Ability of provider to meet the member's immediate needs
  - Alternatives that exist in the service area

How to Obtain a Prior Authorization

Electronic Submission – Higher Levels of Care	• Electronic Prior authorization for higher levels of care can be submitted through Provider Express secure transactions > Authorization Inquiry. • Providers are required to log into the system and can search for members using member ID, name, and date of birth • **Existing Users:** must log in with One Healthcare ID or email address and password • **New Users:** New User Registration can be found by selecting "First-time user" on upper right corner of page • Once the authorization information is received, a UHCCP NJ BH UM Care Advocate will have the ability to review and process the information and authorize care via the portal as applicable. • If additional information is needed the Care Advocate will outreach to the provider via phone or chat directly on the portal.
Electronic Submission – MH Partial Care	• Electronic Prior Authorization for partial care mental health can be submitted through Provider Express. To access the request form, go to: Providerexpress.com > Our Network > State-Specific Provider Information > New Jersey > Authorization Template • Complete the online request form. • Use the "Attesting Individual's Email Address" to track where the request is in the authorization process.

Telephonic – Available for all requests	• Call Toll-free Provider Line (on the back of the Member's ID card): **1-888-362-3368**
	• Follow the below system prompts:
	  ○ Enter TIN#
	  ○ Select option 3 (intake)
	  ○ Enter member ID/DOB
	  ○ Select option for "Mental Health"
	• After-hours care advocates available during evenings, weekends and holidays only for initial higher-level authorizations (e.g., IP MH, IP SUD, Residential Detox, IP Detox) 24 hours a day / 7 days a week.

- Standard TAT 14 days, Expedited TAT 24 hours of receipt of necessary information

Behavioral Health Prior Authorization Requirements through MCO

Hospital based services

- Inpatient (non-urgent MH and SUD) Acute Inpatient MH
- Inpatient Medical Detoxification
- Mental Health Electroconvulsive therapy ECT (Inpatient/Outpatient)
- Mental Health Partial Hospitalization Program (PHP)
- Substance Use Disorder (SUD) Nonhospital based detoxification – ASAM-3.7WM

Outpatient services

- Mental Health Intensive Outpatient Program
- Psychological Testing
- Mental Health Partial Care

Residential services

- Substance Use Disorder (SUD) Short Term Residential – ASAM -3.7
- Adult Mental Health Rehabilitation (AMHR)
- Long Term Residential (LTR) – ASAM 3.5

*All Out of Network Services require Authorization

Level of Care Guidelines for Mental Health and Substance Use Disorders found on Provider Express at: Standard Clinical Criteria (Providerexpress.com); ASAM Clinical Criteria Information

For more information regarding Authorization Requirements, please reference the Behavioral Health Benefits Table (pages 14-20) - New Jersey Provider Network Manual Addendum

New Jersey Substance Abuse Monitoring System Prior Authorization Requirements

Effective 1/1/25 prior authorization is required to be completed through NJ Substance Abuse Monitoring System NJSAMS – Portal for the following SUD services:

- Substance Use Disorder (SUD) Intensive Outpatient Program – ASAM-2.1
- Ambulatory Withdrawal Management ASAM 2-WM
- Substance Use Disorder (SUD) Partial Hospital – ASAM-2.5

NJSAMS will then transmit the authorization request to the member's MCO. The MCO will process the authorization and notify the provider according to standard MCO procedures and timeframes

Administrative Days/Clinical

If the individual does not meet the discharge planning needs and cannot be safely discharged or transferred to an alternate level of care, an administrative level of reimbursement shall be offered:

- A separate authorization will be required from the IP acute stay
- When prior authorized, administrative days will be reimbursed by Optum/UHC through a Single Case Agreement-accommodation process
- The Clinical team will load a single case agreement authorization
- Rev code **0199** will be utilized

Mental Health Partial Care and Mental Health Partial Hospital HCPC vs Revenue Codes Authorization Guidance

Service UnitedHealthcare Community Plan New Jersey - OBH Provider Contract Type Billing Form	UHCCPNJ- OBH Provider Contract Billing Code	UHCCPNJ -OBH UM Authorization Code (Provider Express Authorization View)	UHCCPNJ- OBH Service Units - (Authorization and Billing)	New Jersey State FFS Billing Units
MH Partial Care (adult 18+) OP Agency Contract CMS 1500	H0035	H0035	Hour	Hour
MH Partial Care (youth under 18) OP Agency Contract CMS 1500	H0035	H0035	Hour	Hour
MH Acute Partial Hospital (APH) (adult 18+) Facility Contract UB-04	913	H0035	Per Diem	Hour
MH Partial Hospital (PH) (adult 18+) Facility Contract UB-04	912	H0035	Per Diem	Hour
MH Partial Hospital (PH) (youth under 18) Facility Contract UB-04	913	H0035	Per Diem	Hour

01/01/2025 Prior Authorization Standards

The NJ guiding principles for prior authorization standards include standardization for MCOs and providers and timely service authorization for members.

Approval Structure

Beginning July 1,2025 until further notice:

Prior authorizations will be required to be submitted for the services below. Prior authorizations that are submitted will be auto-approved. Claims may be denied if the appropriate PA was not received but cannot be denied for medical necessity.

- MH Partial Hospitalization
- MH Partial Care in an outpatient clinic
- MH Acute Partial Hospitalization
- SUD Intensive Outpatient services
- SUD Ambulatory ASAM 2WM or Residential Withdrawal Management ASAM 3.7WM (auto approval for a minimum of 5 days for alcohol, opioids, and benzodiazepines)

- if a requested level of care for SUD services does not meet the level of care criteria/not authorized, the highest level of care will be authorized that is appropriate according to ASAM
- No PA for MH therapy/SUD counseling (auto approval only permitted for OON providers/ single case agreements)
- All court ordered services will be auto approved

Minimum duration for initial authorizations:

- MH Acute & Partial Hospital - 14 days
- MH Partial Care - 14 days
- SUD Partial Care - 30 days
- Short Term Residential - 14 days
- Long Term Residential - 60 days

01/01/25 Prior Authorization Standards

Turnaround time

- Urgent: Outpatient and inpatient/residential services within 24 hours and no more than 72 hours of original receipt
- Non-urgent: 7 calendar days
- Retroactive authorizations dependent on service urgency designation

Urgent designation

- MH: Acute partial hospital, inpatient psychiatric hospital care
- SUD: Ambulatory withdrawal management, residential detoxification/withdrawal management, intensive outpatient, short term residential, inpatient medical detoxification
- Considered urgent if member admitted through inpatient, residential, or ER screening (MCO discretion):
  - MH: Partial hospital, partial care, adult rehab
  - SUD: Partial care, long term residential

Retroactive authorization

- Authorization approved for a minimum of 5 days for any service regardless of circumstance
- Additional information may be required beyond 5 days

Turnaround time

- Begins once we receive a prior authorization request
- Clock will re-start for incomplete requests requiring additional information

Higher Level of Care Authorizations

From now through **July 20, 2025**, providers should submit all “higher levels of care” administrative (no medical necessity applied) prior authorization requests telephonically to 1-888-362-3368 for the following impacted services:

- Acute Partial Hospitalizations Mental Health
- Psychiatric Partial Hospitalization Mental Health
- Medically Monitored Intensive Inpatient Services/Short-Term Residential (STR) ASAM 3.7
- Medically Monitored Intensive Inpatient Service Withdrawal Management ASAM 3.7-WM
- Substance Use Disorder Long Term Residential (LTR) ASAM 3.5

As of **July 21, 2025**, UHC providers can submit authorization requests for all services that require a Prior Authorization through:

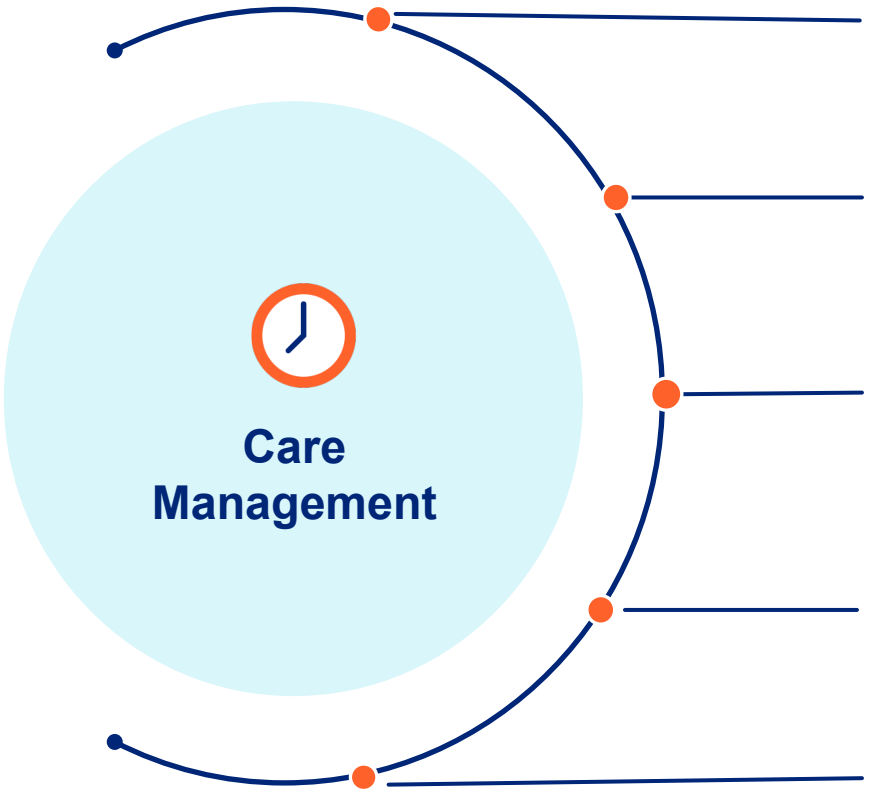
- Provider Express secure transactions > auth inquiry, or
- Telephonically to 1-888-362-3368

There is no impact to prior authorization requests for:

- Mental Health Partial Care
- Services submitted via New Jersey Substance Abuse Monitoring System:
  - Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM
  - Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1
  - Substance Use Disorder Partial Care (PC) ASAM 2.5

Behavioral Health Care Management

Our Care Management Services



Determine Needs/Strengths

- Early identification of high-risk members in need of care coordination support.

Develop Individual Case Plan

- Comprehensive assessments completed to identify member strengths, risk factors, gaps in care and barriers to health access, including SDOH

Locate Community Resources

- Creating important linkages between members, providers, and community resources and other support services where needed
  - Validate resource availability

Reinforce Treatment Plan

- Provide on-going education about complex behavioral health and basic medical issues, in easy-to-understand language

Reassess/Measure Progress

- Monitoring and Continuity of Care

New Jersey Medicaid Behavioral Health Care Management Referral

- The most direct way for **provider staff** to reach Behavioral Health Care Management is through direct email: NECSBHCCA@UHC.com
- **Reminder:** This is a **provider facing email only and** should not be given to members as there would then be a risk of member crisis issues waiting in an email inbox.
- If staff are **sitting with a Member/wanting Member facing referral/care coordination**, they should use: **Special Needs Hotline 1-877-704-8871**
- The Hotline is **available to all members and providers.** All calls are routed to Behavioral Health **and** Medical Care Management for care coordination activities.

Continuity of Care

Member Continuity of Care

Continuity of Care – A plan of care that should assure member progress without unreasonable interruption.

The following New Jersey State requirements apply to ensure member continuity of care:

- Applies to members with a change in Medicaid MCO or from New Jersey Medicaid Fee-for Service (FFS)
- Approved BH services with an active authorization will be honored for 60 days, unless there is a change in treatment plan

UnitedHealthcare Community Plan New Jersey support

New Jersey Behavioral Health Network staff outreach to all New Jersey Medicaid FFS BH providers seeing UHCCPNJ members to assist with:

- Initial UHCCPNJ contracting and credentialing if needed
- Existing UHCCPNJ BH contract updates if needed
- Other provider support as needed

- Out of network providers can request single-case agreements from UHCCPNJ BH Utilization Management for existing UHCCPNJ members while contracting / credentialing is in process
- During the continuity of care period, UHCCPNJ BH Case Management is available to actively provide care coordination for members that need to transition to an in-network provider (i.e., if the current provider declined to participate with UHCCPNJ BH)

Utilization Management Appeals

What happens if the Prior Authorization request is denied?

- A Peer-to-Peer Review will be scheduled to discuss the Adverse Benefit Determination:
  - For an inpatient case involving a clinical determination, the appeal reviewer will be a board-certified psychiatrist or addiction-medicine specialist (from the same or similar specialty area as the treating clinician) with an active, unrestricted license
  - For an outpatient case involving a clinical determination, the appeal reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license

Utilization Management Appeal Process: Service Denial/Limitation/ Reduction/Termination based on Medical Necessity

You, the Provider, and the member should receive a notification letter of any decision to deny, reduce, or terminate a service or benefit. If you or the member disagrees with our decision you (or the member) can challenge our decision by requesting a *Utilization Management Appeal* submitted with the member's written permission.

- If a member is currently receiving the services being appealed and want them to continue automatically during the appeal process, the appeal must be received on or before the final day of the previously approved authorization, or within 10 calendar days of the date of the denial letter, whichever is later.

Appeals and grievances process and requirements

Stages	Timeframe for Member/Provider to Request	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached	FamilyCare Plan Type
Internal Appeal First Level – formal appeal administered by the health plan Performed by professional with appropriate expertise and not involved in original determination	60 calendar days from date of initial notification/denial letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date of the notification letter, **whichever is later**	30 calendar days or less from health plan's receipt of the appeal request	A/ABP B C D
External/IURO Appeal Conducted by Independent Utilization Review Organization (IURO)	60 calendar days from date on Internal Appeal notification letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, **whichever is later**	45 calendar days or less from IURO's decision to review the case	A/ABP B C D
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	**Whichever is the latest of the following:** • On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter; or • Within 10 calendar days of the date on the External/IURO appeal decision notification letter	A final decision will be reached within 90 calendar days of the Fair Hearing request	A/ABP

How to submit an Internal UM Appeal:

The **Internal UM Appeal** is the first level of appeal, administered by the health plan. Is performed by someone with expertise appropriate to the case in question, and who were not involved in the original determination. Submit with member's written consent.

Submit by mail:

New Jersey FamilyCare / Medicaid:
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claims Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

UHC Dual Complete NJ-Y001 (HMO D-SNP):
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claims Appeals
P.O. Box 6103
Cypress, CA 90630-9998

Or online:

UHCprovider.com

Click the Sign In button in the top-right corner. Click Prior Authorizations & Notifications > View existing submissions > Locate Authorization for appeal > File a pre-service appeal and grievance

Resolution times:
Standard appeals within 30 business days
Urgent appeals within 72 hours

What if I disagree with the Internal UM Appeal decision?

The IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO), also referred to as the **External (IURO) Appeal**.

The deadline to request an External Appeal is ***60 days*** from the notice of adverse outcome of the Internal Appeal.

The timeframe for the IURO to resolve the External (IURO) Appeal (either by overturning or upholding the original denial) is ***45 days.***

IURO requests can be submitted by mail:

Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534

Or Fax: 1-585-425-5296

Or Online: njihcap.maximus.com

What if I disagree with the Internal UM Appeal decision? (continued)

Members who have FamilyCare Plan Types A /ABP ***only*** may also file a **Medicaid Fair Hearing.**

You can appeal to the IURO before you request a Medicaid Fair Hearing and wait for the IURO's decision, or you can appeal to the IURO at the same time that you request a Medicaid Fair Hearing.

- The deadline to request a Medicaid Fair Hearing is ***120 days*** from the notice of adverse outcome of the Internal Appeal.
- A final decision will be reached within 90 calendar days of the Fair Hearing request.

Requests for a Medicaid Fair Hearing can be submitted by mail:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712

Or Fax: 1-609-588-2435

Billing and Claims

Claim and Contact Information

Find Claim Tips on Provider Express website at: Claim Tips

Topics include:

- Claim Entry through Provider Express
- Claim Corrections or Resubmission
- Claim Submission Hints
- Electronic Claim Submission (EDI)
- Optum Pay
- Improve the Speed of Processing
- Where to Submit our Optum Claim
- Frequently asked questions

Contact information:

- Provider Service **1-888-362-3368**
- Network Management (escalated issues):
  - njnetworkmanagement@optum.com

Coordination of Benefits

If coordination of benefits is involved, attach evidence of payment from the first payer (traditional Medicare, Medicare Advantage or Commercial insurance) when billing us as the second payer.

Secondary claim submissions;

- Submitted within 60 days from the date of the primary insurer's explanation of benefits (EOB) or
- 180 days from the dates of services, whichever is later

UHCCPNJ handles Medicare and Medicaid claim adjudication for FIDE/HIDE SNP members

If the member is enrolled in UHC Dual complete NJ-Y001 (HMO D-SNP), submit the Medicare claim to us. We will coordinate the benefits through automatic claim adjudication.

Clean Claim

Clean Claim - A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim. All required fields must be complete & legible

All claim submissions must include, but are not limited to:

- Member's name, identification number and date of birth
- Provider's Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- Taxonomy Code
- A complete diagnosis (ICD-10-CM)
- Value, Rate Code, Revenue, Modifiers, etc.
- Date of Service
- Revenue Codes

Most common denial reasons:

✓ Provider not contracted with UHCCPNJ – Follow enrollment process
✓ Duplicate Claim submitted and previously processed
✓ Coordination of Benefits – missing primary EOB/incorrect member COB information requiring update

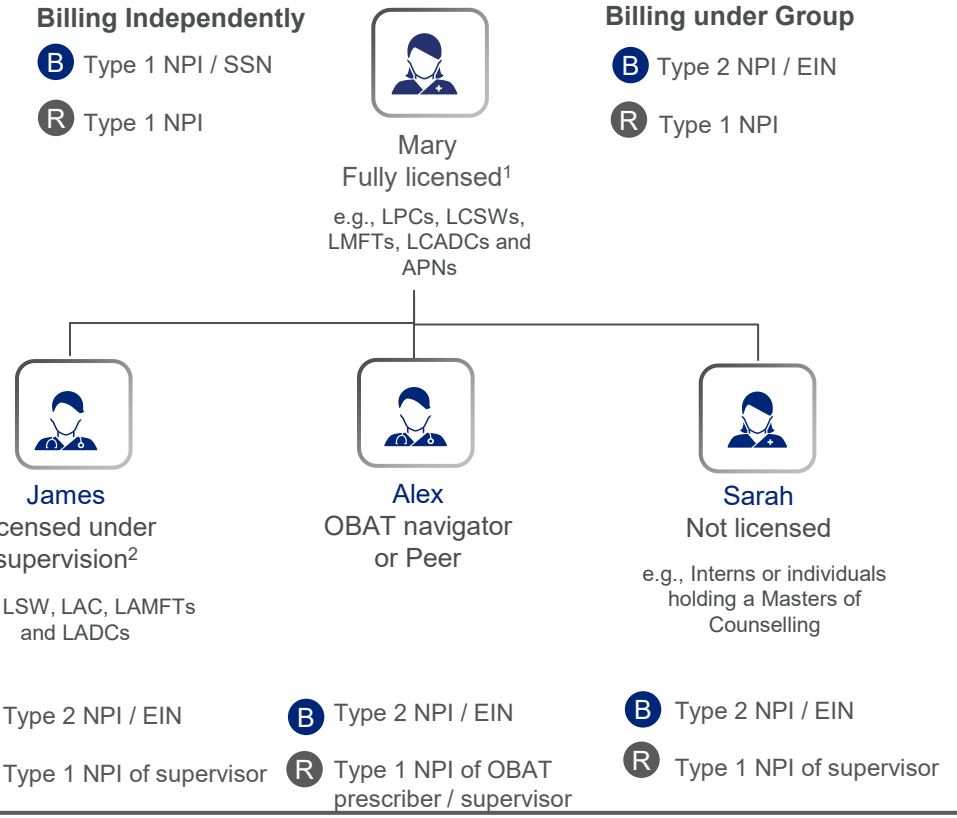
Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Review billing NPI requirements

Specific items to check:
- For individuals / groups, is supervised billing allowed for interns and other non licensed individuals? **Facilities and agencies with licenses permitting supervisory protocol are allowed.**
- Should facilities / agencies use the Type 1 NPI of the OBAT prescriber / supervisor when billing for OBAT and peer services? **No contracted facilities and agencies should always bill with type 2/NPI/EIN**

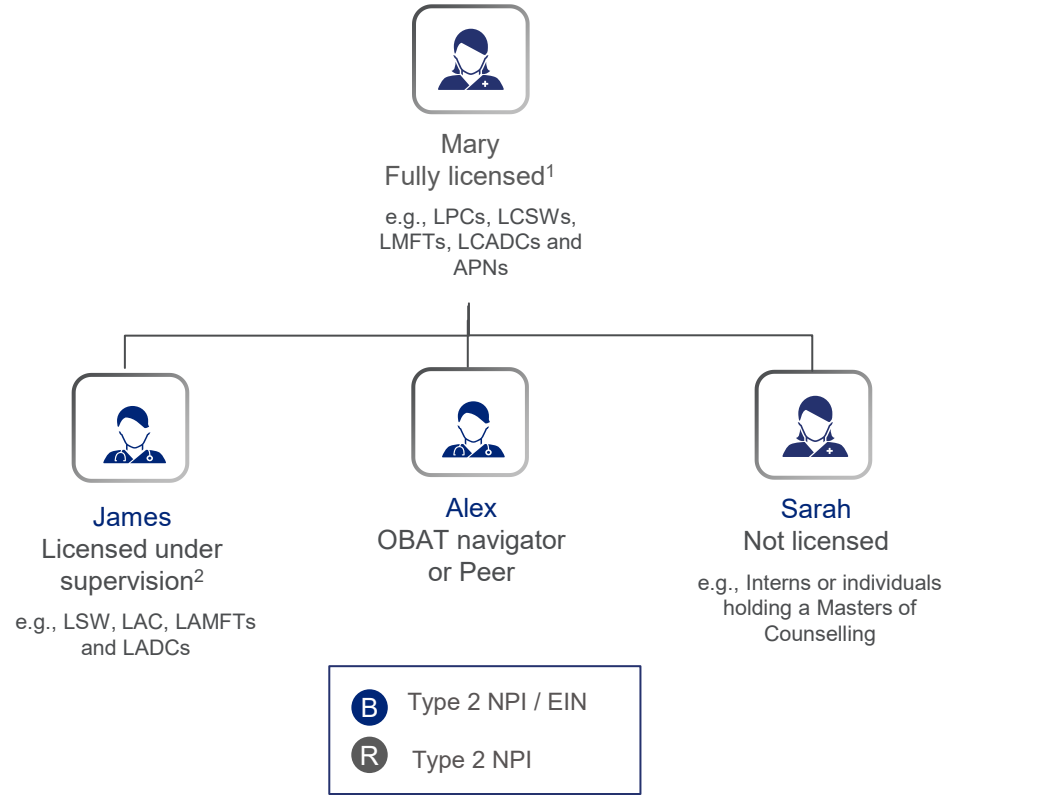
Individuals / Group

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



Licensed Facility / Agency

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



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

B Billing provider R Rendering provider

Mental Health and Substance Use Disorder Claims

- Inpatient claims should be submitted on a UB-04 claim form or 837i (electronic) using your contracted billing revenue codes.

- Contracted providers for the below services must submit claims on a UB-04 claim form or 837i (electronic) using the contracted revenue code(s) and HCPCS code(s) listed on your facility payment appendix document:
  - Detoxification
  - Intensive Outpatient Treatment (IOP)
  - Ambulatory Detoxification
  - Short-term Residential

- Outpatient claims must be billed on a 1500 claim form (version 02/12)
  - These claims are for the services listed on your group contracted fee schedule

Claims filing made easy

Electronic submission through the Claim Entry feature on Provider Express or as an Electronic Data Interchange (EDI) transaction.

Benefits of Electronic Filing:

- It’s fast – Eliminate mail and paper processing delays
- It’s convenient – Easy set up and intuitive process
- It’s secure – Data security is higher than with paper-based claims
- It’s efficient – Electronic processing helps prevent errors
- It’s cost-efficient – You eliminate mailing costs, and the solutions are free or low-cost

Electronic Data Interchange

- Electronic Data Interchange (EDI) is an electronic-based exchange of information
- Transactions are conducted through a clearinghouse vendor
- Submit batches of claims electronically, right out your practice management system software:
  - Ideal for high volume providers
  - Can be configured for multiple payers
  - Clearinghouse may charge fee
- Payer ID – 87726
- Electronic Remittance Advice (ERA) Payer ID - 87726

Claim Entry on Provider Express

Registration for an Optum One Healthcare ID is required:

- Get started by clicking this link First-time User

Benefits of Claim Entry:

- Free
- Available 24/7
- Intuitive and easy-to-use
- Real-time, quick claim processing
- Available to clinicians and groups
- Outpatient behavioral and EAP claims billed on a Form 1500

Receive payments faster

Benefits of Optum Pay™:

- Easy set-up
- Payments deposited into your bank as soon as possible (up to 5-7 days faster than by paper checks)
- Simplified claims reconciliation
- 24/7 access to your information
- Secure payment and remittance advice

Registering for Optum Pay is easy

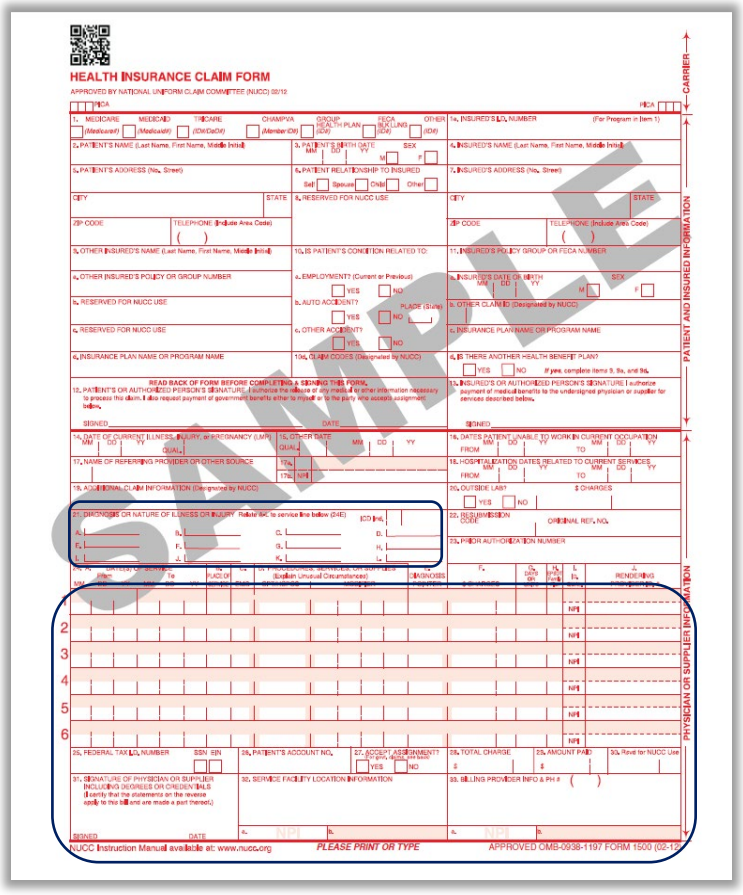
- Log in to *Provider Express* with your One Healthcare ID
- Select “Optum Pay” and provide the information necessary to enroll
- Contact Optum Financial Services for assistance: **1-877-620-6194**

Filing paper claims

- Use an original 02/12 1500 Claim Form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis
  (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
- Complete all required fields (including ICD indicator and NPI number)

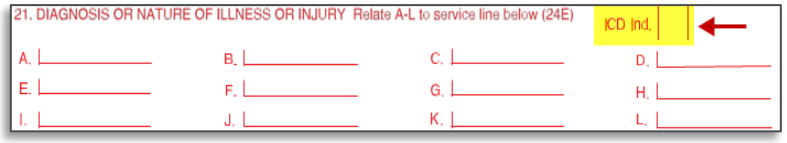
Filing paper claims

National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual

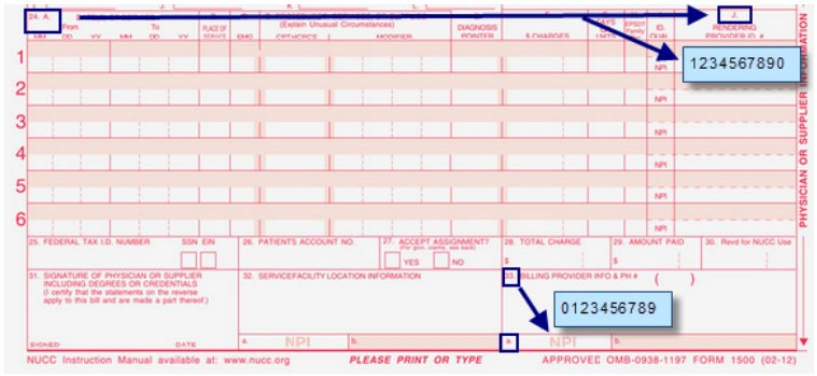


Include the ICD indicator:

0 for ICD-10



There are two distinct fields for placement of an NPI number



Important information related to claims payment for a non-rostered group entity

Your 1500 claim form should include the following information:

1) **Group/agency name** (Box 31)

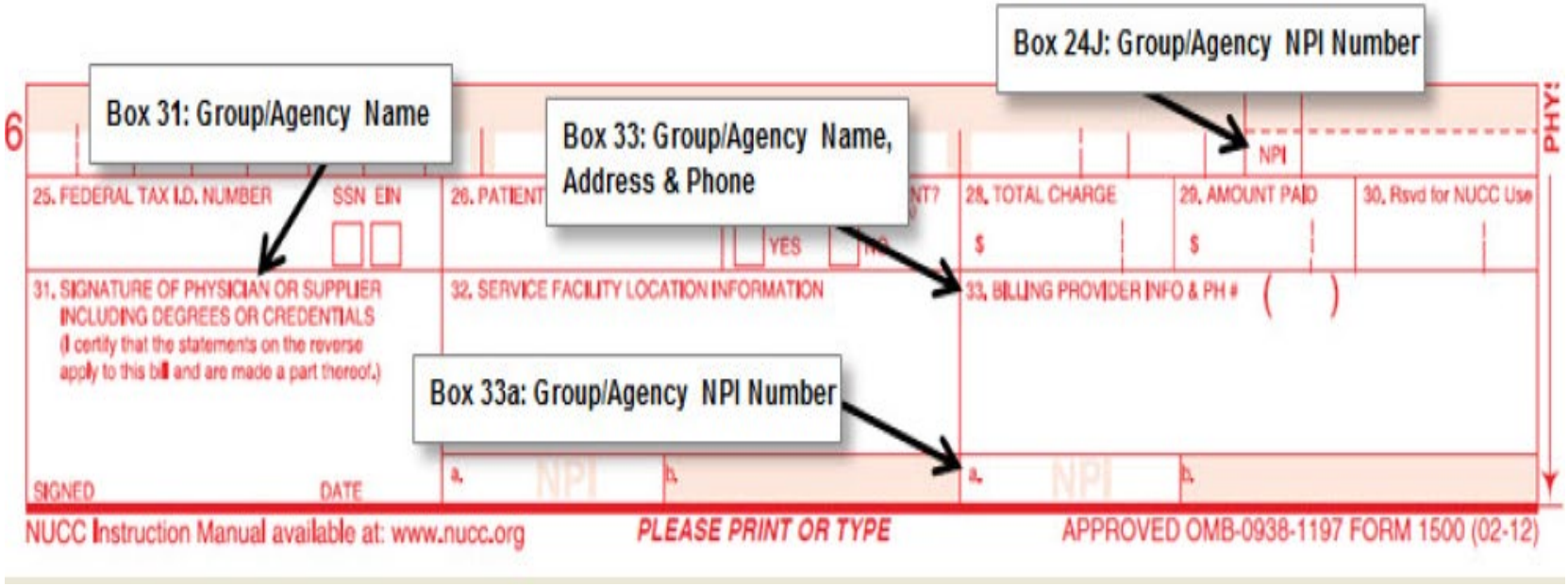
2) The **NPI number** (Box 24J)

3) The **group/agency name , address, and phone number** (Box 33)

4) The **group/agency NPI number** (Box 33a)

- Do not put the name of the rendering clinician on the claim form
- It is important to bill with the CPT codes shown on the group/agency fee schedule for claims to be processed and paid correctly
- For Community Mental Health Centers/Licensed Outpatient Agencies (CMHCs) contracted and credentialed at the group/agency level for outpatient services, authorizations for services will be issued at the group/agency level, not under the specific treating clinician's name. The authorization will cover services rendered by any of the clinicians of the group

Important information related to claims payment for a non-rostered group entity (continued)



If your claims are not submitted following the guidelines above or if information is incomplete, you run the risk of receiving claim denials.

Mental Health Partial Care Transportation

Service Code	Description	Modifier	Comments
A0120	Load fee for partial care transportation	UC	Cannot be billed with Z0330
Z0330	Load fee for partial care transportation	N/A	Cannot be billed with A0120
A0425	Mileage Add-on partial care transportation	UC	Billed with codes Z0330 or A0120
H0035	Partial Care Mental Health	UC	Included when A0120, Z0330, and/or A0425 billed

Additional information can be found by visiting NJMMIS.com: Behavioral Health Integration Procedure Rate Code Information:

Administrative Days/Claims

Claims for Admin Days should be billed as indicated below:

- Optum/UHC will authorization Admin days through a Single Case Agreement - accommodation process
- Claims should be submitted on a UB04
- A separate authorization will be required from the IP acute stay
- The Clinical team will load a single case agreement authorization
- Rev code **0199** will be utilized

Encounters/Claims

- UnitedHealthcare recognizes accurate, timely and complete encounter data submissions are evidence that we are fulfilling our responsibilities to New Jersey DHS, allowing use of the data as the foundation for determining premium payments in the future.
- Our claims data is housed in our CSP Facets transaction processing system, which serves as the main data source for encounter data extracts. Based upon adjudicated claims data from CSP Facets, we collect encounter data in HIPAA transaction formats and code sets through our encounter data submission and reporting system, the National Encounter Management Information System (NEMIS). NEMIS processes encounters across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses and provides error correction and resubmission of Medicaid encounters.

What if I disagree with a claim denial or payment amount?

Providers can request a **Formal Claim Appeal** by submitting the request on a Health Care Provider Application to Appeal a Claims Determination form: UHCprovider.com (Provider Forms > DOBI Claims Appeal Form)

Filing time frame for Appeals

- NJ FamilyCare/ Medicaid: Accepted within 90-calendar days from the PRA, EOB, or letter date
- UHC Dual Complete NJ-Y001 (HMO D-SNP): Par providers should follow their contract.
- Non-par providers must be received within 60 calendar days from the initial claim denial date

Submit by mail:

NJ FamilyCare/ Medicaid:
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claim Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

UHC Dual Complete NJ-Y001 (HMO D-SNP) :
UnitedHealthcare Community Plan Grievances and Appeals
Attention: Claim Appeals
P.O. Box 6103
Cypress, CA 90630-9998

Or Online:

UHCprovider.com

Click the Sign In button in the top-right corner. Click Claims & Payments > Look Up a Claim > Act on Claim > Create an appeal.

A determination will be rendered within 30 calendar days

Additional Information

- New and existing Core Medicaid, HIDE SNP, MLTSS and DDD members follow the same claim submission process.
- ***Navigating Optum*** webinar on Provider Express
- Under the Quick Links section on Provider Express > Claim Tips
- National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual
- Billing and rate codes located on njmmis.com rate and code section
- For billing questions call UnitedHealthcare Community Plan,
  1-866-362-3368
- Send paper claims to: **Optum Behavioral Health**
  P.O. Box 30760
  Salt Lake City, Utah 84130-0760

Resources

Providerexpress.com

Provider resource:

- State-Specific News
- Quick Links
- Clinical Resources
- Trainings
- Join Our Network
- Transactions (available to in-network providers only)

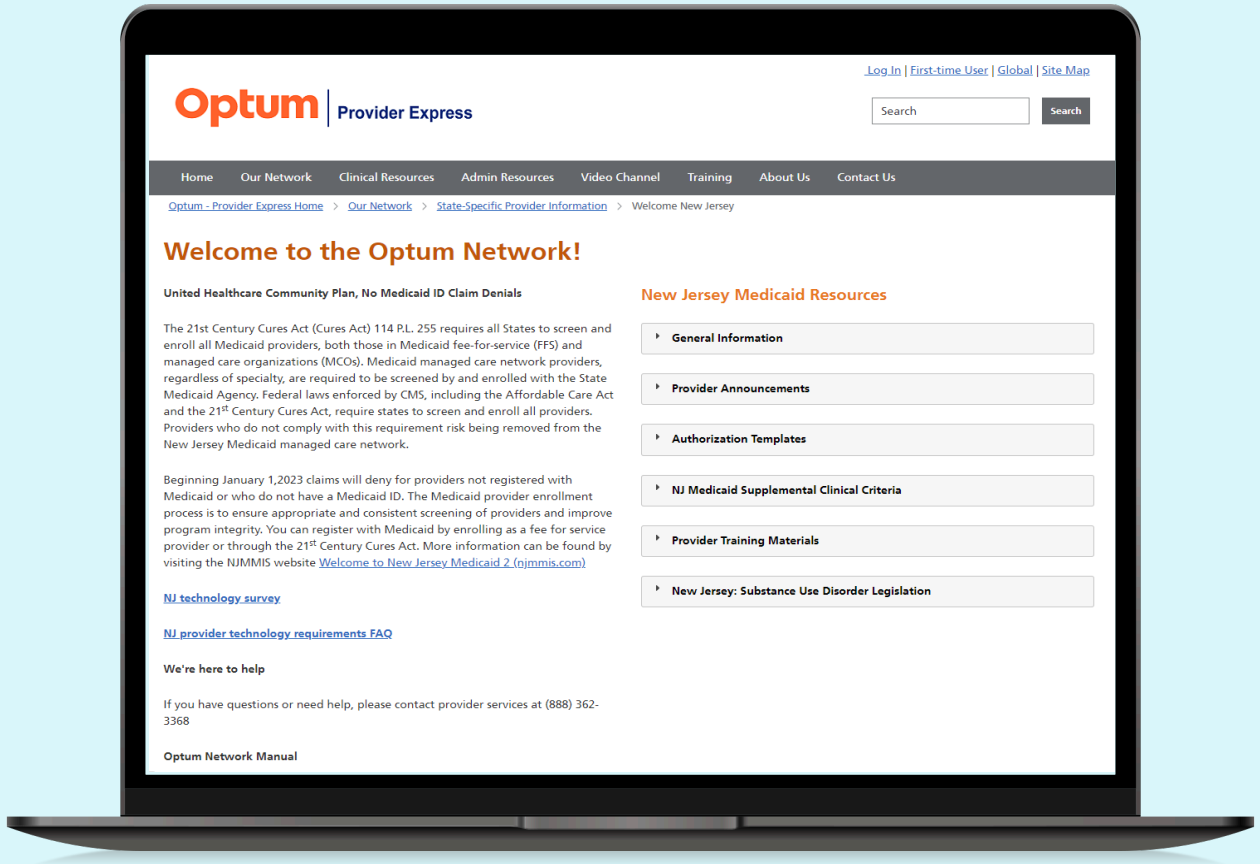
Public Pages

Private pages (in-network providers only)

Navigate to NJ Page via Our Network

[Provider Express Home]

Providerexpress.com New Jersey Page



New Jersey State-Specific Alerts and Information

Product Specific Information – QRGs, provider notifications and Training, Clinical Information

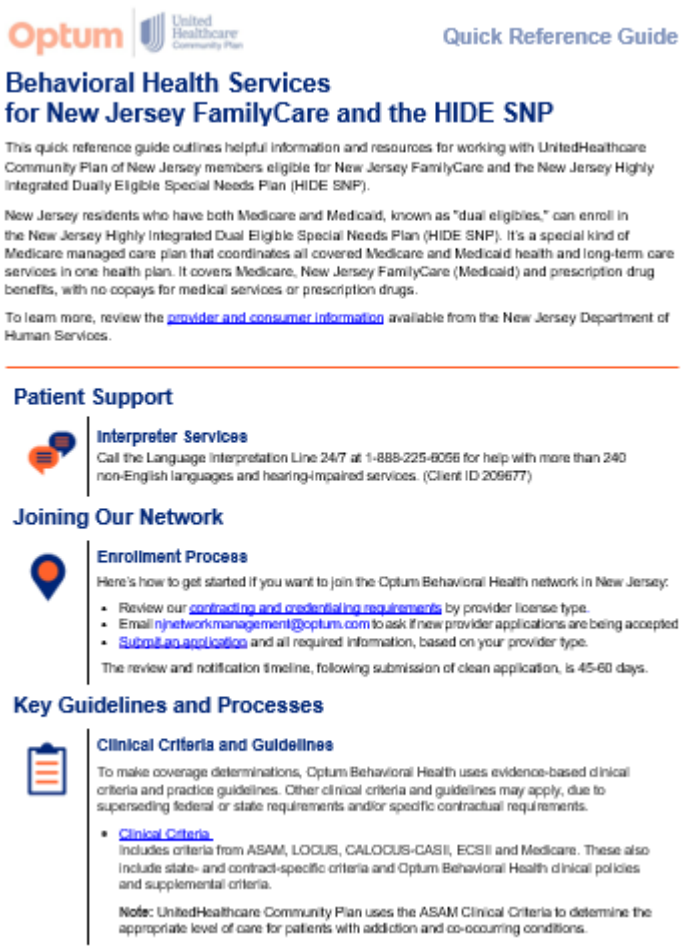
Links to Provider Manuals and Standard Clinical Criteria

Providerexpress.com - Optum - Provider Express

- **Public Pages include general information and other useful resources:**
  - Download standard forms- Optum Forms
  - Provider Manual- New Jersey Provider Network Manual Addendum
  - Clinical Guidelines - Clinical Criteria and Guidelines
  - Training/webinar offerings- Welcome New Jersey

- **Private Pages:**
  - Available only to In-Network Providers
  - Secure and require registration
  - Allows Providers to update information using the “My Practice Info” feature
  - To request a User ID, select the “First-time User” link in the upper right corer of home page
  - For assistance or questions about the registration process, call Provider Express Support Center toll free: **1-866-209-9320** from 8 a.m. – 10 p.m. ET, or chat with tech support online

New Jersey - Quick Reference Guide



Optum | United Healthcare Community Plan — Quick Reference Guide

Behavioral Health Services for New Jersey FamilyCare and the HIDE SNP

This quick reference guide outlines helpful information and resources for working with UnitedHealthcare Community Plan of New Jersey members eligible for New Jersey FamilyCare and the New Jersey Highly Integrated Dually Eligible Special Needs Plan (HIDE SNP).

New Jersey residents who have both Medicare and Medicaid, known as "dual eligibles," can enroll in the New Jersey Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP). It's a special kind of Medicare managed care plan that coordinates all covered Medicare and Medicaid health and long-term care services in one health plan. It covers Medicare, New Jersey FamilyCare (Medicaid) and prescription drug benefits, with no copays for medical services or prescription drugs.

To learn more, review the provider and consumer information available from the New Jersey Department of Human Services.

Patient Support

Interpreter Services

Call the Language Interpretation Line 24/7 at 1-888-225-6056 for help with more than 240 non-English languages and hearing-impaired services. (Client ID 209677)

Joining Our Network

Enrollment Process

Here's how to get started if you want to join the Optum Behavioral Health network in New Jersey:

- Review our contracting and credentialing requirements by provider license type.
- Email njnetworkmanagement@optum.com to ask if new provider applications are being accepted
- Submit an application and all required information, based on your provider type.

The review and notification timeline, following submission of clean application, is 45-60 days.

Key Guidelines and Processes

Clinical Criteria and Guidelines

To make coverage determinations, Optum Behavioral Health uses evidence-based clinical criteria and practice guidelines. Other clinical criteria and guidelines may apply, due to superseding federal or state requirements and/or specific contractual requirements.

- Clinical Criteria
  Includes criteria from ASAM, LOCUS, CALOCUS-CASII, ECSII and Medicare. These also include state- and contract-specific criteria and Optum Behavioral Health clinical policies and supplemental criteria.

  Note: UnitedHealthcare Community Plan uses the ASAM Clinical Criteria to determine the appropriate level of care for patients with addiction and co-occurring conditions.

There are two ways to request authorization for Partial Care and Partial Hospitalization structured day programs:

- **Online:** Complete and submit the NJ Medicaid Partial Care Authorization Template.
- **By phone**: Call **1-888-362-3368** > Enter your TIN# > Select option 3 (intake) > Enter the member's ID# and DOB > Then select the option for mental health.

NJSAMS Authorization Requirement:

Authorization requests for the following services must be submitted via the New Jersey Substance Abuse Monitoring System (NJSAMS) portal.

- ASAM 2WM – Ambulatory Withdrawal Management Without Extended Onsite Monitoring
- ASAM 2.1 – Intensive Outpatient Services
- ASAM 2.5 – Partial Hospitalization Services

Applied Behavior Analysis (ABA) and Developmental Services (DIR)

Providers must complete and submit the ABA Request Form.

Additional Information

For members who have a comorbidity diagnosis and the admission involves both medical and behavioral treatment, you must request prior authorization or complete notification with both Optum Behavioral Health and UnitedHealthcare.

Clinical Appeals

If you disagree with the decision made on a prior authorization request, you can ask us to take another look at it. Send the request to:

New Jersey FamilyCare/Medicaid

- **Online:** UnitedHealthcare Community Plan (Medicaid) Pre-Service Appeals & Grievances
- **By mail:** UnitedHealthcare Community Plan
  Attn: Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
- **By fax:** **Standard appeals** – 801-994-1082
  Expedited appeals – 801-994-1261 (Pre-service and concurrent)

New Jersey HIDE SNP

- **By mail:** UnitedHealthcare Appeals Department
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
- **By fax:** **1-888-389-3254** (Expedited requests only)

Claim Submissions via Electronic Data Interchange (EDI)

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Claim Submissions via Electronic Data Interchange (EDI)

Claims must be submitted to UnitedHealthcare Community Plan within 180 days from the date of service(s). If coordination of benefits – where UnitedHealthcare is considered a secondary payer – is involved, claims should be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service(s), whichever is later.

All claims should be billed using either EDI 837I (Institutional) / UB04 or EDI 837P (Professional)

- Payer ID: 87726

Provider Directory – Behavioral Health provider lookup tool

Find an in-network behavioral/mental health provider near you: NJ-Behavioral-Health-Provider-Search-Instructions.pdf

Behavioral Health provider lookup tool

This step-by-step guide will walk you through the process of finding a Behavioral Health Provider in our online directory.

1. Go to **myuhc.com/communityplan,** scroll down and click on **"Find a Provider"**.

2. Select **"Medical Directory"**.

3. Select **"Medicaid Plans"**.

4. Scroll down and select **"New Jersey"**.

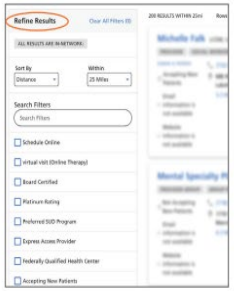
5. Select **"NJ Family Care/LTC"**.

6. Scroll down to "Additional Provider Resources" and click on **"Mental Health Directory"**.

7. Confirm the location and click **"Search"**.

8. Go to the **"Refine Results"** box. Scroll down to select different filters to help you find what you're looking for.

Use the chart on the next page of this guide for help using the search filters.



Continued →

Refine Results | Search filter help

Select "License Type" to click/find:

- ☐ Nurse Masters Level
- ☐ Psychologist
- ☐ Psychiatrist (Physician)
- ☐ Master Level Clinician
- ☐ Physician Assistant

Select "Area of Expertise" to click/find:

- ☐ Outpatient Mental Health Hospital Clinic
- ☐ Outpatient Mental Health Independent Clinic
- ☐ Substance Use Disorder Outpatient (OP) ASAM 1

Select "Treatment Options" to click/find:

- ☐ Opioid Treatment Services (Methadone Maintenance)
- ☐ Adult Mental Health Rehabilitation (AMHR)
- ☐ Medication Monitoring
- ☐ Opioid Treatment Services (Non -Methadone Maintenance)
- ☐ Partial Care Mental Health
- ☐ Autism Treatment Services - Applied Behavioral Analysis (ABA)
- ☐ Autism Treatment Services - Developmental Relationship Based Intervention (DRBI)
- ☐ Medication Assisted Treatment in Physician Office (w/ Navigator)
- ☐ Medication Assisted Treatment in Physician Office (w/o Navigator)
- ☐ Neuropsychological Testing

Select "Substance Use Disorder Programs" to click/find:

- ☐ Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1
- ☐ Substance Use Disorder Long Term Residential (LTR) ASAM 3.5
- ☐ Substance Use Disorder Partial Care (PC) ASAM 2.5
- ☐ Substance Use Disorder Short Term Residential (STR) ASAM 3.7
- ☐ Ambulatory withdrawal management with extended on-site monitoring/Ambulatory Detoxification ASAM 2-WM
- ☐ Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (hospital) ASAM 4-WM
- ☐ Non Medical Detoxification/Non Hospital based withdrawal management ASAM 3.7-WM

Select "Mental Health Programs" to click/find:

- ☐ Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization
- ☐ Inpatient Psychiatric Hospital Care

What to do if you can't find a Behavioral Health provider?

Chat with an advocate through **myuhc.com/communityplan** or the UnitedHealthcare app.

United Healthcare Community Plan

Subject Matter Expert Contact

Overall BH Contact

Stephanie Mulfinger, LCSW, FHELA

Telephone 1-732-623-1044

Stephanie_Mulfinger@uhc.com

NJ Network Manager Contact

njnetworkmanagement@optum.com