



New Jersey Medicaid Behavioral Health Integration January 1, 2027 — Phase two Care provider orientation

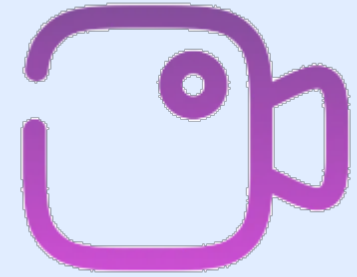
Before we start



All participants are **muted** upon entry and throughout the duration of this session.



Q&A session will occur at the end of this presentation. If you need to ask a question, require clarification or make a comment, please use the Chat feature within Webex.



This presentation will be **recorded and shared** with all registrants. Presentation slides and recording will be posted [here](#).

Agenda

- Meet our team
- Medicaid overview
- Enrollment and credentialing
- Prior authorization
- Continuity of care
- Medical necessity appeals
- Claim submission
- Updating care provider information
- Care provider orientation
- Resources and contact information
- Q&A



Our team



Maribel Rivera-Grant

Director Network Management

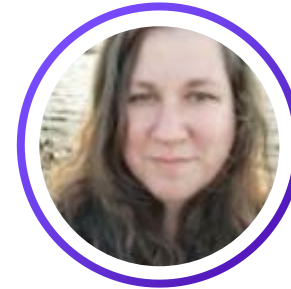
Network Contracting
Network Recruitment



Rhonnda Talton

Provider Network Manager Sr.

Network Contracting
Network Recruitment



Erin Blackwood

Credentialing Manager, CPCS

Network Credentialing
Network Recredentialing



Amy Daversa

Credentialing Director

Network Credentialing
Network Recredentialing



Ann Basil, LCSW

Director of Behavioral Health

Case Management
Utilization Management

Overview of behavioral health phase 2 integration

As phase 2 of the behavioral health (BH) integration, New Jersey is integrating substance use disorder residential treatment services and opioid treatment programs (OTPs) for NJ Family Care, effective January 1, 2027. This will move coverage of these services from FFS Medicaid to Wellpoint for NJ Family Care members, and includes the following services:

- SUD Short-term Residential — ASAM 3.7
- SUD Medically-monitored Inpatient Withdrawal Management (non-hospital) — ASAM 3.7WM
- SUD Long-term Residential — ASAM 3.5
- Opioid treatment programs (OTPs)

Please note that these services are already covered by Wellpoint for members of Managed Long-Term Services and Supports (MLTSS), Division of Developmental Disabilities (DDD), and Fully-Integrated Dual Eligible Special Needs Plans (FIDE SNP).

Enrollment and credentialing

Overview of enrollment and credentialing

- Care providers must be enrolled with Medicaid via the [21st Century Cures Act Application](#).
- Care provider submits a request to join the network via the online website at <https://Availity.com/>.
- Contracting activities, if needed, are initiated.
- Credentialing activities, if needed, are initiated and occur at the same time as any contracting activities.
- Credentialing performs the Primary Source Verification process, and the care provider is presented to the National Credentialing Committee for credentialing decisions.
- A letter of decision is sent to the care provider.
- Care provider becomes "in-network" when both contracting and credentialing are fully completed.
- Care providers who are already credentialed and are adding a new contract or joining a new group are not subject to additional credentialing. Credentialing occurs only the first time a care provider joins a network and every 36 months thereafter.



Medicaid behavioral health integration overview

Overview of our credentialing process

How to apply

- Where can care providers access your credentialing application? www.carelonbehavioralhealth.com/providers/join-our-network
- How long does it take to credential with you on average? Our average is aligned with the state guidance.
- What are the ways that care providers can submit their application? Online preferred, fax, and email available as needed.

Requirements for credentialing and listing care providers on the roster

- Which BH care provider types do you require to credential? Credentialing is required for solo and group-based care providers who are licensed to practice independently, Blue Cross and Blue Shield Association's as well as licensed freestanding behavioral health facilities.
- Which care provider types need to be listed on the roster? Facility-based providers
- Which care provider types/in what circumstances do care providers need to also credential, in addition to being listed on the roster? Care providers practicing under individual or group contracts are required to be credentialed. However, if they also practice as a facility-based care provider in a different setting, they will need to be credentialed and rostered.
- Do your individual and/or group/facility applications differ, and if so, how? Yes, the questions/requirements are applicable to the care provider type. Groups are contracted but not credentialed. The people practicing within the group are credentialed.
- Where can care providers/administrators access your roster template? Roster templates can be found on our website under forms and guides: www.carelonbehavioralhealth.com/providers/forms-and-guides.

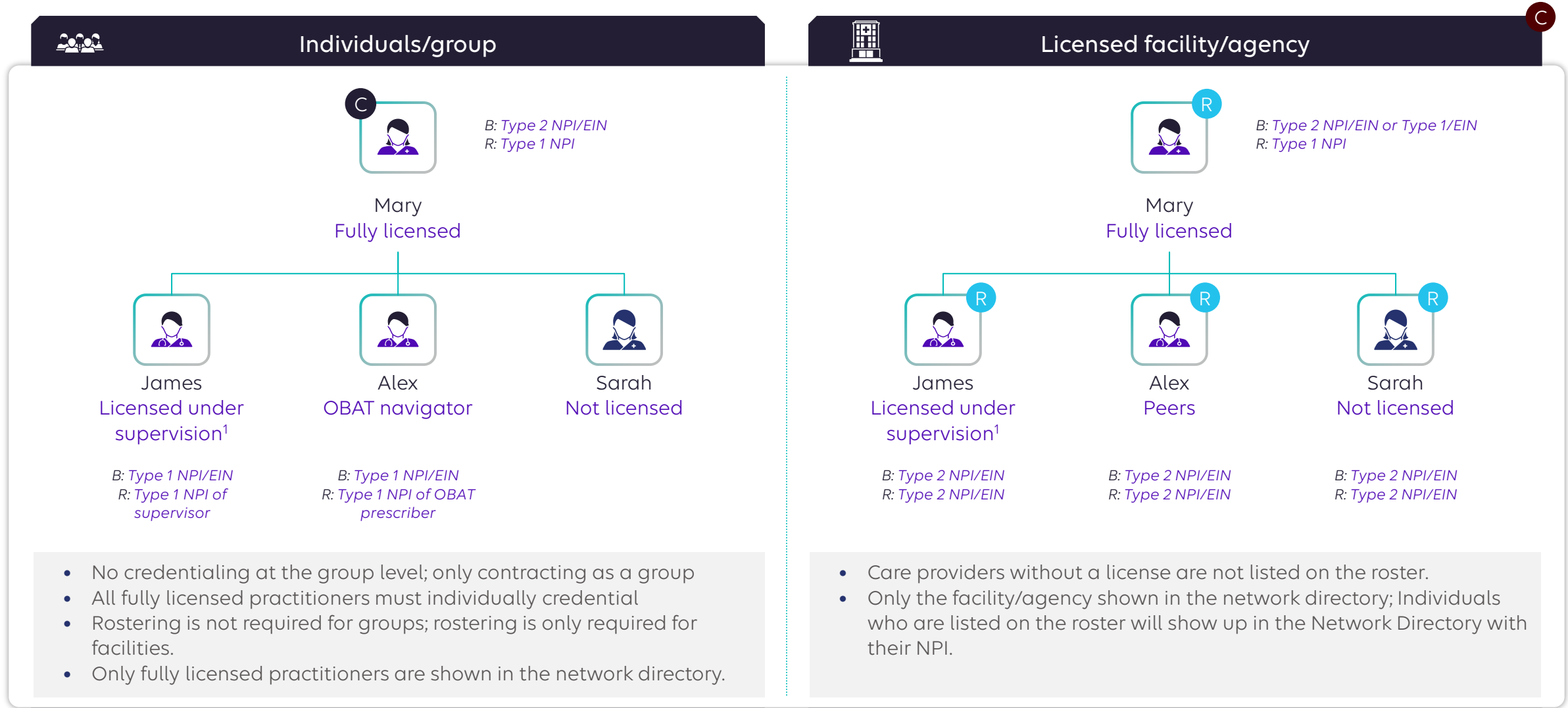
Documentation and background checks

- What additional documentation do you require over and above state standards, if any? None, credentialing requirements align with state and NCQA standards.
- Do you require background checks? If so, for which care providers? No additional Wellpoint or Carelon Behavioral Health background checks are required.

Contracting

- Do you conduct contracting during or after credentialing? Contracting is executed in parallel with the credentialing process.
- Are your requirements for which provider types do versus do not need to contract the same as for credentialing? Wellpoint contracts at the TIN level. This includes credentialed and non-credentialed care providers.
- How long does the contracting process take on average? 45 days

Wellpoint | Credentialing and rostering requirements



1. For BH this includes Licensed Social Workers (LSW), Licensed Associate Counselors (LAC), and Licensed Associate Marriage and Family Therapists (LAMFT), Licensed Alcohol Drug Counselor Assistant (LADC-A)

Wellpoint | Review billing NPI requirements

Specific items to check:

- Is supervised billing allowed for interns and other non-licensed individuals?
- Should licensed facilities/agencies use Type 2 or Type 1 NPI for rendering provider? Is this different for OBAT Navigator and peer services?



Individuals/group

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

Billing Independently

B Type 1 NPI / SSN

R Type 1 NPI



Mary
Fully licensed¹

e.g., LPCs, LCSWs, LMFTs,
LCADCs and APNs



James
Licensed under
supervision²

e.g., LSW, LAC, LAMFTs and
LADCs



Alex
OBAT navigator
or Peer

B Type 2 NPI / EIN

R Type 1 NPI of OBAT
prescriber / supervisor

Billing under Group

B Type 2 NPI / EIN

R Type 1 NPI



Sarah
Not licensed
e.g., Interns or individuals
holding a Masters of
Counseling

B Type 2 NPI / EIN

R Type 1 NPI of supervisor



Licensed facility/agency

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



Mary
Fully licensed¹
e.g., LPCs, LCSWs, LMFTs,
LCADCs and APNs

B Type 2 NPI / EIN

R Type 1 NPI



James
Licensed under
supervision²
e.g., LSW, LAC, LAMFTs and
LADCs

B Type 2 NPI / EIN

R Type 1 NPI of supervisor



Alex
OBAT navigator
or Peer

B Type 2 NPI / EIN

R Type 1 NPI of OBAT
prescriber / supervisor



Sarah
Not licensed
e.g., Interns or individuals
holding a Masters of
Counseling

B Type 2 NPI / EIN

R Type 1 NPI of supervisor

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); 3. Some facility contracts allow for Type 1 NPI providers to bill as rendering on facility claims. Check your specific contract

B Billing
provider

R Rendering
provider

Prior authorization

Phase 2 services and prior authorization

Service	ASAM level and billing code(s)	Authorization required? (in network)
SUD Short-term Residential	ASAM level 3.7 — H0018_HF (STR), H0018_HV (room and board), H0018_HF_U1 (with methadone MAT), H0018_HF_U2 (with non-methadone MAT)	Yes
SUD Medically-monitored Inpatient Withdrawal Management (non-hospital)	ASAM level 3.7WM — H0010_HF and H0010_HV (room and board)	Yes
SUD Long-term Residential	ASAM level 3.5 — H0019_HF (LTR), H0019_HV (room and board), H0019_HF_U1 (with methadone MAT), H0019_HF_U2 (with non-methadone MAT), and H0019_HF_U3 (with admin of buprenorphine or related products)	Yes
Opioid Treatment Programs (OTPs)	Medically administered treatment (MAT) is a service offered at a licensed outpatient facility which provides Methadone, Suboxone or other approved opioid agonist treatment medication, to an individual to alleviate the adverse medical, psychological, or physical effects related with opioid addiction. This care meets the ASAM Criteria for Opiate Maintenance Therapy.	No (but IOP does require authorization)

Authorization grid — turn-around times for phase 2 services

- Non-urgent services — Turn-around-time (TAT) is seven days
- Urgent services — TAT is 24 hours
 - **Phase 2 services and urgency designations:**
 - Short-term residential — Urgent
 - Medically-monitored withdrawal management — Urgent
 - Long-term residential— Non-urgent (care provider may request it to be urgent for initial authorization if member is being admitted directly from inpatient, ER, or residential).
 - Opioid treatment programs — No authorization required.

All SUD authorizations must be requested via NJSAMS

Continuity of care and Clinical Criteria

Continuity of care:

- Wellpoint adheres to the New Jersey Department of Human Services guidelines regarding continuity of care.
- When a member enrolls with Wellpoint, approved BH services with an active authorization shall be honored until a new plan of care is established. Wellpoint does not have access to authorization information from FFS Medicaid or other MCOs, so this must be provided when requesting prior authorization.

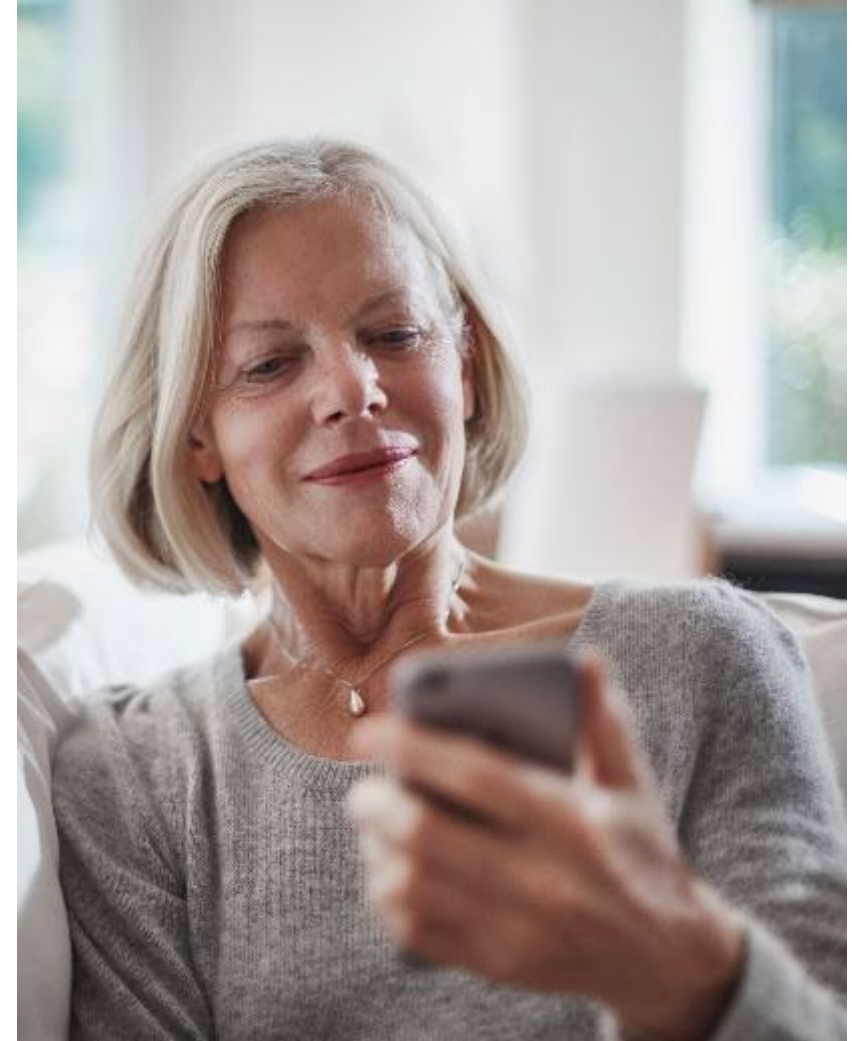
Clinical Criteria:

- Wellpoint has a contractual obligation to New Jersey to use American Society of Addiction Medicine (ASAM) criteria for all substance use disorder treatment services.
- No prior authorization is need for opioid treatment services (OTPs), but intensive outpatient treatment (IOP) does require authorization.

Important contractual information to know

Recovery Court

According to Section 4.10.G, the contractor shall coordinate and reimburse court-ordered medical and BH services (except sexual abuse evaluations) as determined and requested by the court. It is the responsibility of the contractor to inform the courts about the availability of its care providers. If the court orders a non-contractor source to provide the treatment or evaluation, the contractor shall be liable for the cost and will reimburse the non-contracted source at no less than the Medicaid rate.



Medical necessity appeals

Medical necessity appeals

An **appeal** is a request for reconsideration of a utilization management decision resulting in not being approved, concluded, or other limitation in the coverage of and access to healthcare services, or reconsideration by an independent review organization administered by the DOBI.

Medically necessary appeals can be submitted by a member or a care provider on behalf of a member **with the member's written consent**.

Expedited appeals: A request to change an adverse determination for urgent care. An urgent care request is any request for medical care or treatment, with respect to which the application of the time period for making an appeal determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Priority type	Resolution timeframes
Expedited appeal	72 hours
Standard appeal	30 calendar days

Medical necessity appeals (cont.)

Timeframes and levels of submission:

Level	Timeframe for submission	Timeframe for submission with a Continuation of Benefits for existing services
An internal appeal is the first level of appeal	60 calendar days from date on initial notification/denial letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the notification letter, whichever is later.
External/IURO appeal conducted by an 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.
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 1-2 calendar days of the date on the External/IURO appeal decision notification letter.

How to submit an appeal

- Members may submit an appeal by calling the plan at **833-731-2147 (TTY 711)**, Monday through Friday from 8 a.m. to 6 p.m. ET.
- Care providers may submit appeals in writing, along with required medical documentation, in the following ways:
 - Via Availity Essentials by logging onto the Availity Essentials website at <https://Availity.com>:
 - From the Patient Registration tab, select **Authorizations & Referrals** and **Auth/Referral Inquiry**. Locate the prior authorization you want to appeal and select **Request Appeal** from the case overview.
- By mail: Wellpoint Appeals, P.O. Box 62429, Virginia Beach, VA 23466-2429

Claims submission

Claims submission

There are several ways to submit a claim:

- Electronically through the Availity Essentials platform:
 - <https://Availity.com/>
 - PAYER ID: WLPNT
- Paper:
 - Wellpoint New Jersey Claims Department
P.O Box 61010
Virginia Beach, VA 23466-1010

Claims must be submitted within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services.

New to Availity?

Care providers who are not yet registered with Availity Essentials can learn more and sign up today at no charge by visiting <https://Availity.com>.

Care providers can also visit the **Register and Get Started with Availity Essentials page** to learn more. Here, you can register for live webinars to guide you through registering an account and organization with Availity Essentials, access pre-recorded webinars, and download Availity Essentials registration guides. If you need further assistance, contact Availity Client Services at **800-282-4548**. Assistance is available Monday through Friday, 8 a.m. — 8 p.m. ET.

Clean claims submission

Clean claims are defined as submitted reimbursement claims that contain the required data elements and any requested attachments.

Care providers are requested to use industry-standard, compliant codes on all claim submissions.

Services should be billed CPT,[®] codes, HCPCS codes, and/or revenue codes to support the services or procedures rendered.

Clean claims data elements

A clean claim must contain the following information:

- Patient demographic information, including name, member identification number, address, city, state, and zip code, date of birth, and gender.
- The insured's information, including name, relationship to patient, insurance group name, and number.
- ICD-10-CM diagnosis code(s)/revenue codes, date of service, number of days and/or units, itemized bills and total charges, and place of service, CPT-4/HCPCS/DRG codes.
- National Drug Code (NDC) unit price, quantity, and composite measure per drug.
- Group name and rendering provider's federal tax ID, NPI, and billing address.
- Prior authorization number, where applicable.
- COB information if prior payments were received.

Claims — denied versus rejected

There are two notifications your office may receive in response to a claim submission:

Rejected	Denied
A rejected claim does not enter the adjudicated system due to missing or incorrect information.	A denied claim goes through the adjudication system but is denied for payment.

Claim denial appeals

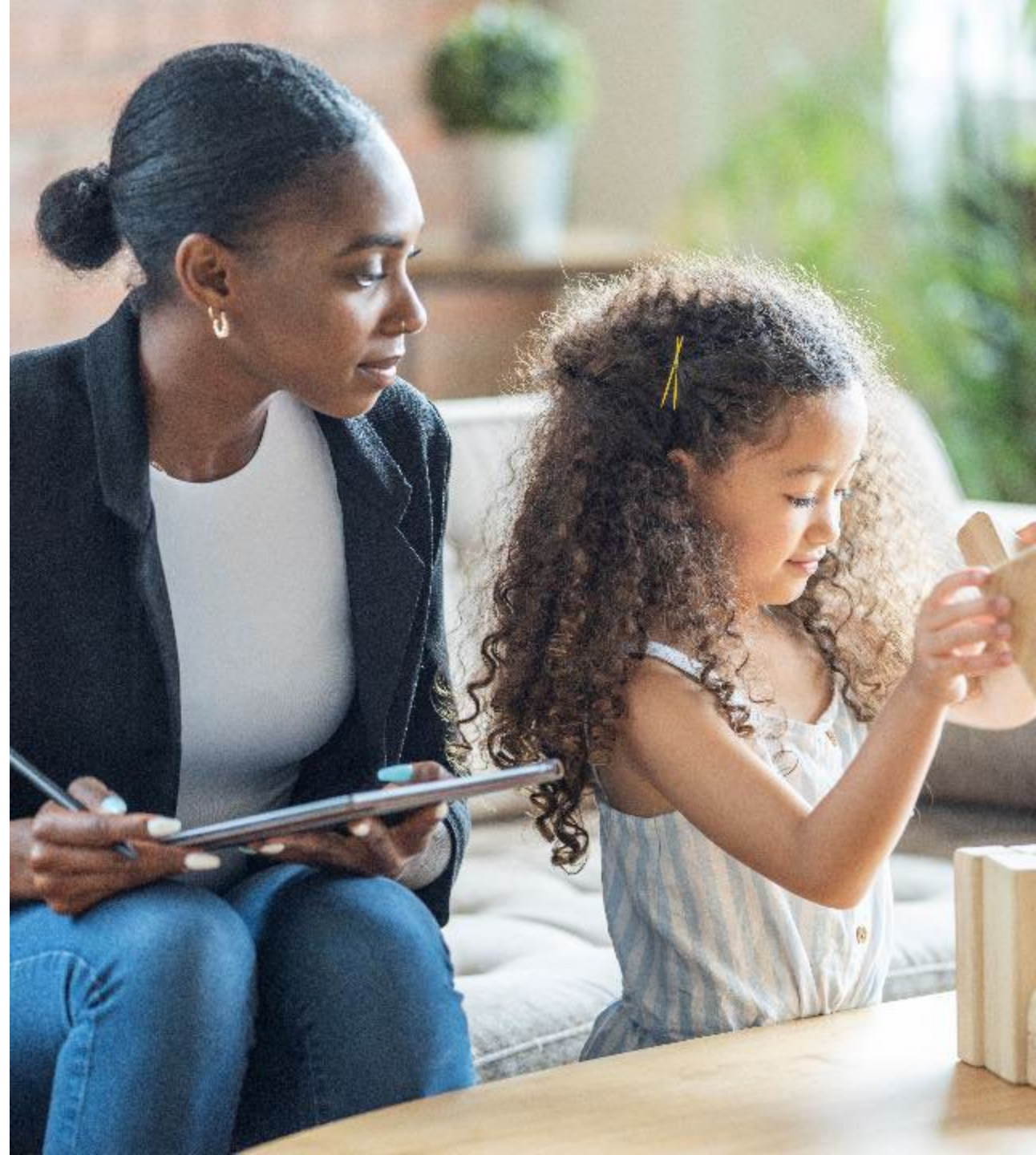
Medicaid claim disputes:

- Care providers can submit claim disputes via Availity Essentials: <https://Availity.com>.
- Written claims appeal:
 - Payment Dispute Unit Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010
- **FIDE SNP:**
- Customer Service: **844-765-5160**
Medicare Payment Dispute Unit
P.O. Box 110
145 S. Pioneer Road
Fond du Lac, WI 54935
- For questions on claims submission or other inquiries, **contact Provider Services at 800-454-3730.**

Coordination of benefits

- Federal law requires that Medicaid be the payer of last resort.
- You must bill the member's primary insurance first and provide the EOP from the primary carrier with each claim submission to Wellpoint.
- If the member's primary insurance benefit has been exhausted for a service or the service is determined to be a non-covered benefit by the primary insurer, Wellpoint will not require subsequent EOPs from the other payer for the remainder of the calendar year.
- You may not balance bill a Medicaid member.

There are no changes in the billing process for NJ Medicaid Non MLTSS-non DDD



Updating care provider information

Care provider demographic information

- All provider demographic information should be updated through the provider's CAQH profile:
<https://proview.caqh.org/Login/Index?ReturnUrl=%2f>
- If a provider does not use CAQH, the updates can be made through the Carelon Behavioral Health provider portal:
www.carelonbehavioralhealth.com/providers/resources/provider-portals
- If you are an individual practitioner, we encourage you to register and participate with CAQH Proview. To remain active in the Carelon Behavioral Health care provider directory, you must attest every quarter to the accuracy of your information. Once you attest, the data in CAQH will automatically update Carelon Behavioral Health and Wellpoint systems.



NJ Medicaid Behavioral Health Integration care provider orientation

NJ Medicaid Behavioral Health Integration care provider orientation

Scheduled care provider orientations

Date	Time
Wednesday, October 8	11 a.m.
Wednesday, October 29	11 a.m.
Wednesday, November 5	11 a.m.
Wednesday, November 19	11 a.m.
Wednesday, December 3	11 a.m.
Wednesday, December 10	11 a.m.



[Select to register](#)



Resources and contact information

Resources and contact information

Wellpoint

Clinical contact:

- Director of Behavioral Health,
Ann Basil, LCSW
- Ann.Basil@wellpoint.com

Carelon Behavioral Health:

- National Provider Service Line
Monday through Friday, 8 a.m. to 8
p.m. ET
- Phone: 800-397-1630

Provider Relations:

- provider.relations.NJ@carelon.com

Availity Essentials:

- <https://www.Availity.com>
- www.carelonbehavioralhealth.com/providers/resources/provider-portals/availability-essentials

Wellpoint care provider website:

- www.provider.wellpoint.com/new-jersey-provider/resources/forms

Carelon Behavioral Health Provider Manual:

- www.carelonbehavioralhealth.com/providers/resources/provider-handbook

Carelon Behavioral Health administrative forms: Guides and resources

- www.carelonbehavioralhealth.com/providers/forms-and-guides

Carelon Behavioral Health credentialing application:

- www.carelonbehavioralhealth.com/providers/join-our-network

Webinar archived and upcoming webinar schedule:

- www.carelonbehavioralhealth.com/providers/resources/trainings

Q&A

