carelon Behavioral Health | Wellpoint

New Jersey Medicaid Behavioral Health Integration January 1, 2025 – Phase One Provider Orientation

January 2025

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 (URL placeholder)

Agenda

- Meet our Team
- Medicaid Overview
- Enrollment & Credentialing
- Prior Authorization
- Continuity of Care
- Medical Necessity Appeals
- Claim Submission
- Updating Provider Information
- Provider Orientation
- Resources & Contact Information
- Q&A

Our team

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Director Network Management

Network Contracting
Network Recruitment

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Network Contracting
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Ann Basil, LCSW

Director of Behavioral Health

Case Management
Utilization Management

Medicaid Behavioral Health Integration Overview

Overview

New Jersey is integrating outpatient Behavioral Health services for Medicaid members

Outpatient mental health and substance use services are covered 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).

This Behavioral Health Integration (Phase 1) for all Medicaid members includes the below levels of care and will **go live January 1, 2025**. These services will now be covered for all New Jersey populations.

- Outpatient for mental health and substance use disorder
- Intensive outpatient for substance use disorder
- Partial Care for mental health and substance use disorder
- Ambulatory Withdrawal Management
- Acute Psychiatric Hospitalization/Psychiatric Partial Hospitalization

Phase 2 will include Residential Services and OTPs – Go Live Date TBD by state.

Enrollment & Credentialing

Overview of Enrollment & Credentialing

- Providers must be enrolled with NJ Medicaid via the 21st Century Cures Act Application.
    - You must attach a copy of all current License(s), Registration(s) and Board Certification(s) and complete the conviction/exclusion information and the provider certification on Page 4.
    - Applicants completing this application are under no obligation to accept NJ FamilyCare (NJFC) fee-for-service (FFS) beneficiaries into their professional practice.
- Provider submits request to join the network via the online portal.
- Contracting activities, if needed, are initiated.
- Credentialing activities, if needed, are initiated and occur at the same time as any contracting activities.
- Credentialing performs Primary Source Verification process and provider is presented to National Credentialing Committee for credentialing decisions.
- Letter of decision is sent to provider.
- Provider becomes "in-network" when both contracting and credentialing are fully completed.
- Providers who are already credentialed and are adding a new contract or joining a new group are not subject to additional credentialing. Credentialing only occurs the first time a provider joins a network, and every 36 months from the previous credentialing date.

Overview of our credentialing process

How to apply

- Where can 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 providers can submit their application? Online preferred, fax, and e-mail available as needed.

Requirements for credentialing and listing providers on roster

- Which BH provider types do you require to credential? Credentialing is required for solo and group-based providers who are licensed to practice independently, Blue Cross and Blue Shield Association's as well as licensed freestanding behavioral health facilities.
- Which provider types need to be listed on roster? Facility-based providers
- Which provider types / in what circumstances do providers need to also credential, in addition to being listed on roster? Providers practicing under individual or group contracts require credentialing. However, if they also practice as a facility-based 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 provider type. Groups are contracted but not credentialed. The individuals practicing within the group are credentialed.
- Where can 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 & 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 providers? No additional Wellpoint or Carelon required background checks.

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 vs. do not need to contract the same as for credentialing? Wellpoint contracts at the TIN level. This includes credentialed and non-credentialed providers.
- How long does the contracting process take on average? 45 days

Wellpoint | Credentialing and rostering requirements

Individuals / Group

B: Type 2 NPI/EIN
R: Type 1 NPI

Mary
Fully licensed

James
Licensed under supervision[1]

B: Type 1 NPI/EIN
R: Type 1 NPI of supervisor

Alex
OBAT navigator

B: Type 1 NPI/EIN
R: Type 1 NPI of OBAT prescriber

Sarah
Not licensed

- No credentialing at the group level; only contracting as a group
- All fully licensed practitioners must individually credential
- No rostering required for groups; rostering only required for facilities
- Only fully licensed practitioners shown in network directory

Licensed Facility / Agency

C

B: Type 2 NPI/EIN or Type 1/EIN
R: Type 1 NPI

Mary
Fully licensed

James
Licensed under supervision[1]

B: Type 2 NPI/EIN
R: Type 2 NPI/EIN

Alex
Peers

B: Type 2 NPI/EIN
R: Type 2 NPI/EIN

Sarah
Not licensed

B: Type 2 NPI/EIN
R: Type 2 NPI/EIN

- Providers without license are not listed on roster
- Only facility/agency shown in network directory; Individuals who are listed on roster will show up in Network Directory with their NPI

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)

C Organization credentialed C Individually credentialed R Listed on roster

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 group** on **CMS-1500**
Include the Type 1 NPI of the fully licensed practitioner as "rendering provider"

Billing Independently
- B Type 1 NPI / SSN
- R Type 1 NPI

Billing under Group
- B Type 2 NPI / EIN
- R Type 1 NPI

Mary
Fully licensed[1]
e.g, LPCs, LCSWs, LMFTs, LCADCs and APNs

James
Licensed under supervision[2]
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 Counselling
- 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

- B Type 2 NPI / EIN
- R Type 1 NPI

Mary
Fully licensed[1]
e.g, LPCs, LCSWs, LMFTs, LCADCs and APNs

James
Licensed under supervision[2]
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 Counselling
- 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 andFamily 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

January 2025

Prior Authorization

Services and Prior Authorization

Service	Definition of Service	Auth Required? (In Network)
Outpatient - Mental Health or Substance Abuse	Traditional outpatient services for either mental health or substance use disorder. Services may be provided individually, in group, or in family sessions and may be at a clinic, hospital, or with an independent practitioner. Psychiatric evaluation and/or medication monitoring may be included.	No
Partial Hospitalization (PHP)	Mental health acute partial hospitalization and psychiatric partial hospitalization are structured day programs, managed by hospitals, of varying intensity where members attend Monday through Friday for 5 hours daily. They received individual counseling, group counseling, psycho-education, pre-vocational services, and psychiatric services.	Yes
Partial Care for MH and Partial Care for SUD	Partial care for mental health or substance use disorder are structured day programs where members primarily attend Monday through Friday for 5 hours daily. They received individual counseling, group counseling, psycho-education, pre-vocational services, and psychiatric services. These programs are community-based providers. Partial care for substance use disorder is ASAM level 2.5	Yes
Substance Abuse Intensive Outpatient	Substance use disorder intensive outpatient (IOP) -- Bundled rehabilitative services designed to help clients change behaviors related to alcohol or drug use. Services are provided in a licensed SUD facility. Services include individual counseling,; group SUD counseling; other group counseling; and family counseling delivered at a minimum of three hours per day, fora minimum of three days per week. This level of care meets ASAM level 2.1.	Yes
Ambulatory Withdrawal Management	Withdrawal management services at the ASAM level 2.0 with extended on-site monitoring completed on an outpatient basis. Ambulatory outpatient withdrawal management is defined as an organized service delivered by medical and nursing professionals who provide a range of services including medical and clinical interventions, laboratory testing, the dispensing and/or administration of approved medications provided to treat and monitor clients undergoing withdrawal from drugs or alcohol.	Yes

SUD Authorization Requests via NJSAMS

- Wellpoint currently accepts authorization requests by phone, fax, and web portal. This will continue for all mental health services.

- For substance use levels of care only, effective January 1, 2025, providers will submit authorization requests via NJSAMS for all Phase 1 levels of care. Authorization approvals and denials will be given to providers by phone or fax.

Recall | PA requests for all Phase 1 SUD services will route to MCOs via NJSAMS; maintain status quo submission process for Phase 2 services

Services	Population Type	PA processed by MCO or IME? *(as of Jan '25)*	Providers submit via NJSAMS or MCO portal?
Phase 1 services • Intensive Outpatient • Partial Care • Ambulatory Withdrawal Management *Note: Includes recovery court*	General population	MCO	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP) population	MCO	NJSAMS
Phase 2 services • Short term residential • Long term residential • Residential withdrawal management (ASAM 3.7 WM) *Note: Includes recovery court*	General population	IME	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP) population	MCO	MCO portal

Authorization Grid – Turn-Around Times for Phase 1 Services

Non-Urgent Services – current Turn-Around-Time (TAT) is 14 days – State is updating to 7 days for BH non-urgent services effective 1/1/2025

Urgent Services – For outpatient services newly reclassified as urgent, TAT will be 24 hours during normal business operating hours, and 1 Business Day on weekends.

Urgency Designation:

- Always Urgent: Effective 1/1/2025, the following Phase 1 levels of care will be considered urgent: Acute PHP, SUD Ambulatory Withdrawal Management (ASAM 2.0), SUD Intensive Outpatient (IOP – ASAM 2.1). Additionally, SUD Short Term Residential (ASAM 3.7) and Non-Hospital Detox (ASAM 3.7WM) for MLTSS, DDD, and FIDE DSNP members.

- Sometimes Urgent: Effective 1/1/2025, the following Phase 1 levels of care will be considered urgent IF member is coming to treatment directly from inpatient, ER, or residential: PHP and both MH and SUD Partial Care. Additionally, Adult Mental Health Rebab (AMHR – Psyc Group Homes) and SID Long Term Residential (ASAM 3.5) for MLTSS, DDD, and FIDE DSNP members.

Continuity of Care

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 behavioral health services with an active authorization shall be honored until a new plan of care is established.

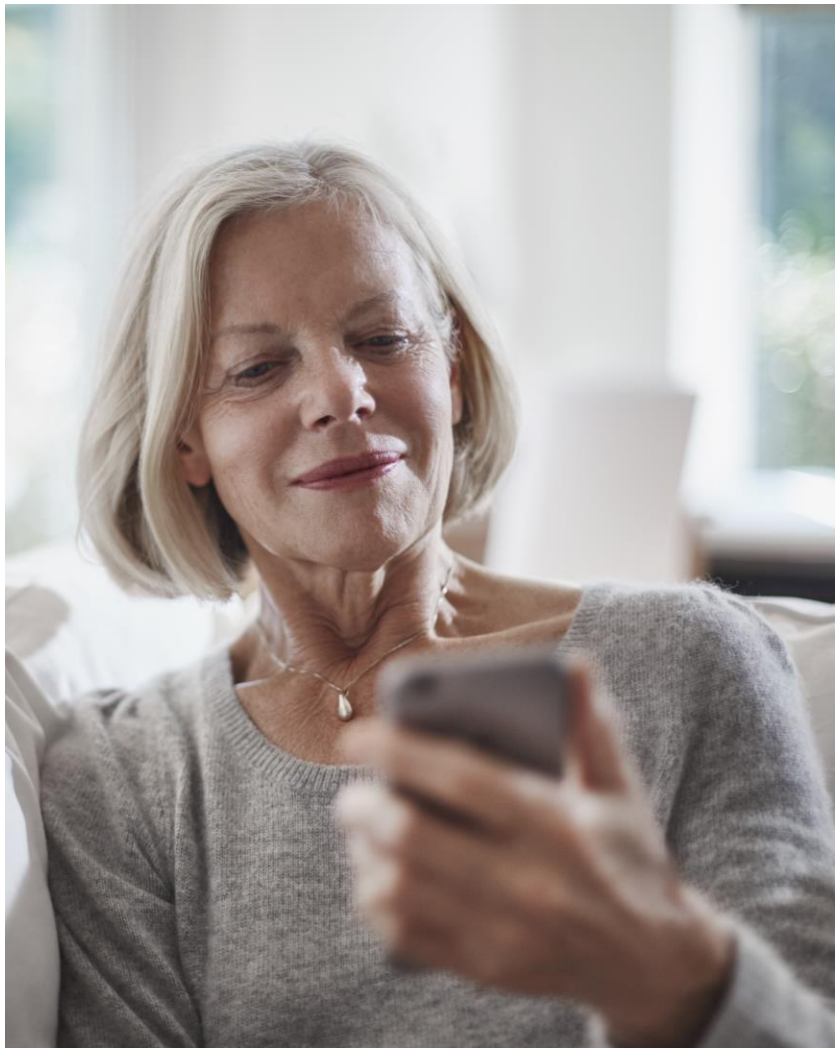
Clinical Criteria

- Wellpoint has a contractual obligation to New Jersey to use American Society of Addiction Medicine (ASAM) criteria for all substance use disorder treatment services.
- Wellpoint uses Milliman Care Guidelines® criteria (MCG) for all mental health treatment services.
- No prior authorization is need for traditional outpatient mental health or substance use disorder.

Important Contractual Information to Know

Any willing provider – according to *Section 4.8.1.P*
Any willing qualified behavioral health provider: The contractor shall be required to contract with any willing qualified BH provider defined by the provider specifications in the BH services dictionary in *Section B.4.4* until specified by DMAHS.

Required to approve when for court-ordered treatment
According to *Section 4.10.G*, the Contractor shall coordinate and reimburse court-ordered medical and behavioral health 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 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.



Important Contractual Information to Know

Prior Auth Waiver, according to *Section 4.4.4.F*:
Effective January 1, 2025, for 90 days, required prior authorization requests for the below listed behavioral health services must be submitted by the provider to the Contractor. The provider shall receive an administrative approval. During the 90-day transition period, no claim edits or denials for lack of service authorization are permitted. The Contractor must honor existing and active authorizations for the full duration authorized.

1. MH Partial Hospitalization
2. MH Partial Care in an outpatient clinic
3. MH Acute Partial Hospitalization
4. SUD Intensive Outpatient services
5. SUD Ambulatory or Residential Withdrawal Management
6. SUD Partial Care

Minimum Auth duration for initial requests – According to section 4.4.4.I
If the Contractor grants an initial authorization for the following services, the Contractor must authorize the below durations at a minimum. Service delivery durations may be shorter than authorized duration, depending on clinical need and provider discretion.

1. 14 days minimum for MH Acute Partial Hospital and Partial Hospital
2. 14 days minimum for MH Partial Care
3. 30 days minimum for SUD Partial Care & Intensive Outpatient
4. 14 days minimum for Short Term Residential services
5. 60 days minimum for Long Term Residential services

Medical Necessity Appeals

Medical Necessity Appeals

An **appeal** is a request for reconsideration of a Utilization Management decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services or reconsideration by an independent review organization administered by the DOBI.

Medical Necessity Appeals can be submitted by a member or a provider on behalf of a member with 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

Timeframes and Levels of submission:

Level	Timeframe for submission	Timeframe for submission with a Continuation of Benefits for existing services
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 ten 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 ten 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 ten calendar days of the date on the Internal Appeal notification letter, or
		  • Within ten calendar days of the date on the External/IURO appeal decision notification letter

How to Submit Appeals

The Member may submit an appeal orally by calling the plan at **833-731-2147 (TTY 711)** Monday through Friday from 8 a.m. to 6 p.m. Eastern time

Providers may submit Appeals in writing along with required medical documentation in the following ways:

- Via Essentials by logging onto the Availity portal at 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

Claim Submission

Claim Submission

There are several ways to submit a Wellpoint claim

Electronic through Availity
PAYER ID: WLPNT
www.Availity.com

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?

Providers who are not yet registered with Availity, can learn more, and sign up today, at no charge by visiting Availity.com.

You 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, access pre-recorded webinars, and download Availity registration guides. If you need further assistance, contact Availity Client Services at 800-282-4548. Assistance is available Monday through Friday 8 AM – 8 PM ET.

Clean Claim Submission

Clean claims are defined as a claim for reimbursement submitted to Wellpoint that contains the required data elements and any attachments requested.

Providers are requested to utilize 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 Claim Data Elements

A clean claim must contain the following information:

Patient demographic information (name, member identification number, address, city, state, and zip code, date of birth, gender)

The insured's information (name, relationship to patient, insurance group name and number).

ICD-10 diagnosis code(s)/revenue codes, date of service, # 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, billing address

Prior authorization number, where applicable

COB information if prior payments were received

Claims – Denied vs Rejected

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

Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information	Goes through the adjudication process but is denied for payment

Claim Denial Appeals

MEDICAID CLAIM DISPUTES:

Providers can submit claim disputes via Availity- www.Availity.com.

For questions on claims submission or other inquiries, **contact Provider Services at 800-454-3730.**

Written Claim 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

Coordination of Benefits

- Federal law requires that Medicaid is 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 noncovered 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 Provider Information

Demographic Updates

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 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 provider directory, you must attest every quarter to the accuracy of your information. Once you attest, the data in CAQH will automatically update Carelon and WellPoint systems.

NJ Medicaid Behavioral Health Integration Provider Orientation

NJ Medicaid Behavioral Health Integration Provider Orientation

Scheduled Provider Orientations

DATE	TIME
Wednesday, November 20	11 AM
Thursday, December 12	3 PM
Monday, December 16	3 PM
Wednesday, December 18	11 AM
Tuesday, January 14	11 AM
Thursday, January 23	2 PM

Click here to register

Resources & Contact Information

Resources & 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.-8 p.m. ET
Phone: 1-800-397-1630

Provider Relations:
provider.relations.NJ@carelon.com

Availity
- www.availity.com
- www.carelonbehavioralhealth.com/providers/resources/provider-portals/availity-essentials

Wellpoint Provider Portal
- www.provider.wellpoint.com/new-jersey-provider/resources/forms

Carelon Behavioral Health Provider Manual
- www.carelonbehavioralhealth.com/providers/resources/provider-handbook

Carelon Administrative Forms: Guides and Resources
- www.carelonbehavioralhealth.com/providers/forms-and-guides

Credentialing Application:
- www.carelonbehavioralhealth.com/providers/join-our-network

Webinar archived and upcoming webinar schedule
- www.carelonbehavioralhealth.com/providers/resources/trainings

Q&A

Appendix