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**Interim Managing Entity (IME)
 Frequently Asked Questions
 7/30/15**

PHASE STRUCTURE OF IME

Phase I – launched July 1, 2015 includes 24/7 availability for callers, screening, referral, and care coordination and will provide limited utilization management activities. Medicaid rates will be increased to match the current state rates for some outpatient and opiate treatment services. Phase I will also include the requirement for prior authorizations of consumer assessments for state and federal block grant funds. Phase I will introduce changes to NJSAMS, including changes in the DASIE, the addition of screening tools, a notes module and a mandatory DSM module.

Phase II - will launch in January 2016 and the IME will use ASAM criteria to approve addiction treatment placements and continuing care stays for individuals being served through IME managed state initiatives and Medicaid covered services and providers. The specifics of Phase II will be available for stakeholders in the fall of 2015.

FUNDING QUESTIONS

1. What is being managed?
 - See the chart below

MANAGED BY THE IME	NOT MANAGED BY THE IME
NJ FamilyCare (Medicaid)	Child Welfare/Department of Children and Families programs
Driving Under the Influence (DUII)	County funds
Medication Assisted Treatment Initiative (MATI)	Department of Corrections Mutual Agreement Program (DOC-MAP)
South Jersey Initiative (SJI)	Drug Court/Administrative Office of the Courts
Substance Abuse Prevention and Treatment Block Grant	Prevention services
	Recovery Centers
	Recovery and Rebuilding Initiative (RRI)
	Screening, Brief Intervention, Referral to Treatment (SBIRT)
	State Parole Board Mutual Agreement Program (SPB- MAP)
	Substance Abuse Initiative (SAI)/Division of Family Development

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2. Will the SSBG funds remain intact until January 2016?
 - Social Service Block Grant funds are NOT included in the IME, nor are Drug Court or county dollars. The IME will manage Substance Abuse Prevention and Treatment Block Grant funds, Medicaid addiction funds, and State addiction funds.
3. Will SSBG funds be removed in a transitional manner or simply not continue with new contracts?
 - SSBG Block Grant funds are NOT included in the IME. For SSBG specific questions please contact renee.burawski@dhs.state.nj.us
4. Will agencies with a calendar year budget stay intact until Calendar Year 2016?
 - Contract conversion to FFS is scheduled for Phase II of the IME roll out on January 1, 2016. The process for the conversion of slot based contracts to FFS has not yet been developed. Providers will be notified when those plans are finalized.
5. If the IME is not managing county or commercial contracts how will I manage my residential capacity?
 - Managing capacity among varied payers is a business practice that agencies will determine individually.
6. FFS fees will be increased. Will they increase for COD enhancements for OTP's from \$256?
 - There is no current plan to increase COD monthly caps
7. Does the IME apply for an independent practitioner who takes Medicaid?
 - No. Independent practitioners will not be managed by the IME.
8. Certain Medicaid plans cover IOP and some don't. How will this be addressed?
 - Currently the Medicaid Alternative Benefit Plan (ABP) includes the IOP services for individuals with substance use disorders but the Medicaid Plan A does not include that benefit. The "true up", which makes all plans have an equal substance use disorder treatment benefit, would address difference. We are currently reviewing the ability to true up. The critical component is the budget authority to make this change.
9. Is outpatient moving to fee-for-service in July?
 - Contracted ambulatory services will not transition to fee-for-service until January 2016.
10. What is the transition plan from contracts?
 - Contracted ambulatory services will transition to fee-for-service in January 2016. Providers with slot-based contracts will need to enroll in the Fee-For-Service network by January 1, 2016, including having a FFS contract by that date (if they do not already have a FFS contract). Current FFS contracts with providers of current slot-based services (except residential) will be modified to include the services that are transitioning to FFS as of January 1, 2016. Residential slot contracts will not move to FFS during SFY16. .
11. We currently have 254 patients in DMHAS slots. We have 200+ that are DMHAS-eligible. These patients could be moved to DMHAS FFS. Will there be agency or state-wide caps on current/new patients and services?

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- When the slots are fully converted to FFS, we envision that there will be no agency limits. However, the available funding will not increase. Therefore, providers could end up serving more people in FFS than they had in slots or they could end up serving less people than they had in slots. Referrals will be based on client choice and capacity reported by agencies into the IME capacity monitoring system.
12. What will be the process for converting current patients in DMHAS slots to FFS or current DMHAS-eligible into FFS? Will there be an electronic process to receive treatment authorizations for a large number of patients?
- We are currently working on the conversion process which is on track for Phase II of the IME implementation on January 1, 2016. We will inform provider agencies of the process when it has been fully developed.
13. My understanding is for current FFS the \$49 rate is for 60 minute sessions. Will this be the same come July 1 or is there any discussion of 45-50 minute sessions at the same \$49 rate?
- It is hard to answer the questions specifically because we need more information about the code and who is being billed, Medicaid or state? However, we understand that there are some discrepancies between Medicaid and State service definitions and requirements. The IME team is working to reconcile these differences. When billing codes, rules, or service definitions are updated providers will be alerted.
14. Is the increase of the Medicaid rates to match the State FFS rates dependent upon the start-up of the IME?
- The increase in select Medicaid rates to the state fee for service rate will be implemented on July 1, 2015.
15. When will the Medicaid non ABP rates be increased?
- The interim rate increase mentioned above is applicable to both the State Plan and Medicaid.
16. Would mental health partial care services be in the same loop as the Medicaid for the addiction treatment regarding management and rates?
- The IME will not be managing mental health services in July. In January the IME will manage Community Support Services (CSS) designed for consumers of mental health services.
17. We are an outpatient mental health agency that treats children and adolescents. The majority of our clients have NJ Family Care and we bill Molina for services rendered. We do not have any contracts or funding. Just so we are clear, in January of 2016 we will require an authorization prior to treating each child?
- The scenario you described will not be managed by the adult IME for behavioral health services. Please contact DCF for any questions about children's services.

INTERIM RATE QUESTIONS

18. My question is in reference to Nursing Assessments. There was talk of a setting a rate for Nursing Assessments required annually for all clients, but was not mentioned in the proposed rates set for July 1, 2015. Will we see a proposed rate for Nursing Assessments in the future

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- The rate chart includes only codes currently billable and of those, only those being increased. Payment for Nursing Assessments is under consideration at NJ FamilyCare and when there is a resolution, providers will be notified.

BILLING QUESTIONS

19. Will billing be automatic from our EHRs to the IME?
 - The IME is not paying any claims so this is not applicable.
20. What is the reconciliation process to identify what has been submitted for payment and what has been paid?
 - Medicaid billing will continue through Molina and State FFS billing will continue to be paid through the DMHAS fiscal agent. Policies and procedures for billing/claiming will remain in place. Providers will be able to reconcile claims through the same process as currently available through Molina and CSC.
21. How will denied claims be handled?
 - Denied claims will be handled per current billing systems procedures.
22. Will there be changes in billing codes that will require agencies to make changes to their current electronic billing systems for submissions to Molina? If there are, software vendors and consultants will need sufficient lead time to program these changes.
 - We are currently examining all codes to attempt to increase consistency between state and Medicaid services and to assure that all applicable codes are available to provider agencies. We will inform provider agencies of any coding changes as soon as possible.
23. Under our current DMHAS slot contract, we have a requirement to collect co-payments (cost-sharing) for patients in DMHAS slots. This is a significant portion of our budget. Will this continue if a patient is being billed through DMHAS FFS?
 - DMHAS has formed a committee of PAC members to explore the issues related to sliding scales and co pays. We will inform provider agencies of any changes to sliding fee scale policy.
24. Will the Medicaid group sizes be changed from a max of 8 to coincide with the DAS slot group sizes?
 - We understand that there is a conflict between the DMHAS regulations and Medicaid regulations in regard to group size. We are working to resolve this issue.
25. If a current ABP Medicaid client is in a group that has more than 8 members, can that client's services be billed to Medicaid? If not what other option could there be to bill?
 - Until the conflict regarding group size is resolved, billing for Medicaid clients must conform to Medicaid regulations.
26. Currently we can only bill Medicaid for 1 service per day, will this be changed since a client is typically seen for an individual on a day they are also attending group?
 - We are reviewing the rule of one Medicaid service per day. We understand that substance abuse services often require more than one service per day and are reviewing the regulation

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- with CMS to explore changing the rule. We will keep providers updated on any changes to these billing practices.
27. Does the 1 billable service per day also pertain to urines, if so will this also be addressed and corrected so the client can be billed for their group and urine on the same day?
 - The one billable service per day refers to a second behavioral health service, not a medical service.
 28. Are the Medicaid rates for the ABP participants effective as of February 1 or July 1?
 - Current ABP rates are effective at the implementation of the ABP. Some rates will change with the implementation of the IME on July 1, 2015.
 29. We currently charge clients for missed sessions (non-grant clients). Can we charge FFS clients the \$23 if they miss an appointment?
 - No. Clients cannot be charged for missed sessions. This applies to both state and Medicaid funding.
 30. Will we be given a certain “allocation” figure, or “matrix’ number of clients that we will be expected to see in Jan. on FFS program?
 - Details of the FFS conversion will be conveyed to all providers at a later date.
 31. We currently have a grant with DAS to provide outpatient drug free counseling. We receive a monthly check from DAS. When will this agency no longer receive this monthly check? Previously, when we have asked this question, State officials have identified (2) different dates. We were told that our check would stop 7/1/2015 and we have also been told the check would stop 1/1/2016. Where can we get a definitive answer?
 - The ambulatory slots will convert to fee for service early in calendar year 2016. There will be multiple communications before and during the process. Be sure to check the website for updated information at <http://www.state.nj.us/humanservices/dmhas/initiatives/managed/>
 32. I am not getting paid at the new rate for the Medicaid ABP clients. I called Molina to speak with the claims department and they are looking into it. They are still paying the individual at 35.64 and not 49.00 they are also still paying the group at 8.00 and not 23.00. Please let me know what I should do at this point I was speaking to Randy ant Molina who told me he would look into it and call me back. He stated the claims were paid at the old rate as it was not a Board certified psychiatrist who saw the client for the individual and the group.
 - All codes have been corrected by Molina so this problem should be resolved.
 33. Is the 90847 HF code not to be used with POS 8 any more? I just received denied claims due to using 8 as my POS.
 - This error was just detected and we have already put the fix in place to add place of service 08 to all these codes.
 34. Clients that have Medicare/ Medicaid have what is called QMB Plus. Wanted to know if we can collect copays from such clients? Typically Medicare pays for the medical visits while methadone is paid by Medicaid.

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- You cannot collect copays on QMB+ clients.

AFFILIATION AGREEMENT AND SCMS ACCOUNT FORM QUESTIONS

35. I have multiple sites. Do I need an Affiliation Agreement for each?

- No, it is only one Affiliation Agreement per agency.

36. What is the SCMS form? Who should fill that out? Should that be included in with the three affiliation agreements?

- The SCMS form is to enable your agency to obtain an account to update the Service Capacity Management System (SCMS), the online database that the IME will use to make referrals. You want to complete that (one per location if you have multiple sites) and email or fax it to the address or number at the bottom of the form. It does not need to be included with the Affiliation Agreement. The agency Executive Director or other authorized representative would complete the form to enable the person in Part B to obtain the SCMS account.

37. An article about IME appeared in the June 19, 2015, issue of NJAMHAA Newswire. The article states that the every provider in the agency should receive "the form" and complete and return it to DMHAS. This was stated in the same paragraph that referred to the Affiliation Agreement, but I don't think that every provider should receive the affiliation agreement. Rather, it would appear that some other form should be given to providers. Please explain exactly what "form" should be completed and returned by each provider. If this is the "Service Capacity Management System (SCMS) Account Request Form," who completes the top portion, and who should complete the bottom portion?

- The Affiliation Agreement is required of any DHS licensed substance abuse treatment agency that accepts clients with Medicaid funding or State funding, whether previously through contract with DMHAS or through the FFS network. Three originals of the affiliation agreement are submitted to DMHAS for processing and execution between DMHAS and UBHC. The third original, once executed, will be sent back to the provider.
[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/UBHC DHS Provider A
ffiliation Agreement.pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/UBHC_DHS_Provider_Affiliation_Agreement.pdf). The SCMS is the online service capacity management system with which the Interim Managing Entity will be able to make referrals to agencies that have an affiliation agreement. Agencies are to update their service capacity status (ie - do you have a bed/space available?) on a daily basis in order to manage these referrals. The SCMS account request form is completed by the agency (part a is the agency head/signatory authorizing the account), and part b is for the person who actually needs the account and will update the system. This form is sent directly to the IME at the email address or fax number on the bottom of the form.
[http://www.state.nj.us/humanservices/dmhas/initiatives/managed/SCMS_Acct_Req_Form.
pdf](http://www.state.nj.us/humanservices/dmhas/initiatives/managed/SCMS_Acct_Req_Form.pdf)

SYSTEM COMMUNICATION QUESTIONS

38. Will the IME be able to receive clinical data in HL7 format from our EHRs?

- No, the IME will not be able to receive clinical data from individual EHRs.

39. Will the IME be able transmit clinical data in HL7 format into our EHRs?

- No, the IME will not be able to transmit clinical data to individual EHRs.

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40. Do I need to give a guarantee from the AM to PM when I update our utilization online? I may get walk-ins during that time.
- The frequency in which a provider agency updates the online utilization management is not being determined by the State or the IME. However, the IME will make referrals based on the capacity indicated in the online system.

REPORTING QUESTIONS

41. What are the reporting responsibilities of the IME and how will those reports be received?
- That has yet to be developed.

REFERRAL QUESTIONS

42. How does the IME impact HIV case management and women's set-aside for OTP's?
- The women's set-aside is still to be determined and HIV will be staying in contracts.
43. IDRC clients get referred directly to providers right now. Will that change?
- In initiatives managed by the IME, assessments and treatment will require prior authorization by the IME to allow for billing for any covered initiative, including DUII. A client can call the IME directly for screening and an authorization for a full assessment or a provider can screen a client and request a prior authorization for a full assessment.
44. What about referrals from hospitals?
- See above
45. What about referrals from jails?
- See above
46. If a client has to be transferred to another LOC outside of our agency, will UBHC be responsible to making the referral and the linkage?
- Licensure regulations do not change with the IME. Agencies are still responsible for referrals and linkages but the IME will be available to assist with that process and complete the service authorizations for continuation of care.
47. Will the client always be on the line when UBHC makes the referral call?
- Whenever possible the IME will provide a warm handoff when making a referral. When the provider agency is not available for a telephone call the IME will be utilizing NJSAMS to make the referral.
48. Will clients identified as Co-occurring under mental health grants require authorization from UBHC?
- The IME is responsible for managing substance abuse treatment services delivered by the substance abuse treatment provider network.
49. Can we direct a client who comes directly to the provider to UBHC for the pre-screening?
- Yes, a provider could do that. But, all of our provider network will receive training on the Immediate Needs Profile and can complete the screening right there at the agency. We would encourage providers to develop the most client centered procedures for screening, assessment and treatment engagement.

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SCREENING/ASSESSMENT/AUTHORIZATION QUESTIONS

50. Will it be a uniform screening and assessment tool statewide?
 - Uniform screening tools will be implemented in Phase I of the IME. We are still exploring assessment tools for possible use in Phase II.
51. If clients are currently in care and are just stepping down in care what do we do?
 - The IME will prior authorize any changes in level of service.
52. What will be the amount of interaction with NCADD for SAI clients eligible for GA? In essence we will be dealing with two ASO's.
 - The IME will not replace the services that NCADD performs for the SAI network.
53. What are the avenues for customer service?
 - Call Center and Care Coordinators will be available for customer service once IME is launched.
54. Client who is totally indigent walks in my door. How will agency "walk in" clients be handled?
 - Agencies can screen walk in clients and then request an assessment authorization from the IME.
55. Screening is done by the IME and the client is sent to me. I do the assessment. Am I paid?
 - Yes.
56. How is the person to get from provider A to provider B if they need a different level of care?
 - The same way it is done today. The IME Care Coordinator can help facilitate that move.
57. In OTP's there are really 3 assessments. Will there be presumptive eligibility for OTP because it is a bit different.
 - We may look at that differently. This is still under discussion.
58. The screening tool is uniform. How long will it take to complete it and then to get the authorization for assessment?
 - We have chosen the UNCOPE and Immediate Needs Profile (INP). Only the INP is a provider requirement and it includes only six questions.
59. Which OP clients will need UBHC authorization?
 - Yes, outpatient services will need authorization. The length of authorizations is under review. We will be setting authorization limits by level of care for the Phase II implementation of the IME.
60. How will authorizations be communicated to payment system?
 - Those mechanisms are being developed with the Medicaid MMIS, Molina, and through NJSAMS.
61. UBHC is an addictions provider. How are you handling referrals to their own program?

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- An independent reviewer will approve all IME self-referrals. Currently UBHC provides a very limited amount of addiction treatment services.
62. What will the timeframes for preauthorization be? Moving to a month would really make things easier all the way around.
- These specifics are currently under review.
63. I am concerned about the implementation of a single statewide assessment tool and its integration with existing EHRs at various agencies. Will NJSAMS also be a separate aspect of assessment and intake? There are many operational, billing level of care approvals with SAI and this system.
- Currently NJSAMS contains an ASI and an ASAM LOCI. Changes are under consideration and the State is working with the NJ Professional Advisory Committee on these tools and processes.
64. When will we be able to obtain prior authorizations for Family Care and Medicaid to bill with the new rates for claims after July 1st? We currently submit bi-weekly Medicaid claims and rely on this money for cash flow.
- We anticipate that the interim rate increases will be available for services delivered beginning on July 1 2015.
65. Will the patient's prior authorization number need to be added to the Medicaid file prior to uploading to Molina (as we do now with Work First NJ SAI)?
- Medicaid authorizations are not required in the Phase I roll out of the IME. We are still working on the prior authorization and billing format both Medicaid and state funds. We will inform provider agencies of the process when it has been fully developed.
66. Will screening instruments be posted for those providers unable to attend the initial group of trainings?
- The power point used for that clinical May training and subsequent trainings will be posted on the website at <http://www.state.nj.us/humanservices/dmhas/initiatives/managed/>.
67. At the June 8th meeting it was not clear specifically how long it would take if we are with a walk-in and wish to complete an assessment right then. How long will it take for the prior auth. Are we talking 20-30 minutes, 5-6 hours, 24-48 hours? I think it makes a big difference when an individual shows up looking for treatment. If they go through an initial screening process and we say okay we will get you back here in 2 days for an assessment you often lose around 30% of those clients who no longer wish to receive services.
- When the individual is eligible for a State Funded Initiative managed by the IME and the network provider can provide the service, the provider requests an authorization for the initial assessment by the IME via telephone or electronically in NJSAMS. If an immediate authorization is needed, provider requests the authorization in NJSAMS & calls the IME 24/7, who will review NJSAMS & if appropriate, secure an immediate authorization.
68. Can you tell me what qualifications the staff person must have to ask the Screening questions?
- No specific credentials needed. Screening tools are specifically designed for use by non-licensed people.

69. The INP is a mandatory field required to access the financial portion (DASIE) and admission field. Is there a workaround for those clients not being managed by the IME (i.e. IDCR, Non-Medicaid self-pay clients, Drug court, etc.)?
- The INP became a required field for all clients as of July 1, 2015. There is no exception for clients in initiatives not managed by the IME.
70. Can you please clarify some information for us? We attempted to secure an assessment authorization for a new intake for our ambulatory DMHAS Slot and was informed this was not required and is not covered under the IME. It was our understanding if a client came in without Medicaid the provider was to call IME and secure an authorization for assessment from them.
- The slots do not need an authorization for assessment.
71. If they are handling the entire Medicaid population, what about existing Medicaid/ABP clients already enrolled in my facility, will the new clients referred by the IME be paid at a higher rate, and the existing clients will be paid at a lower rate?
- The July 1 rate schedule that increases the Medicaid rates to the state rates are the same for Medicaid Plan A and Medicaid ABP. All services delivered July 1 or after to Medicaid enrolled individuals will be paid at the new rate.
72. Is the IME only handling the INITIATIVE programs (3) that were discussed, or the entire Medicaid population, even if they are not part of one of the (3) INITIATIVES?
- The IME is issuing assessment authorizations for the initiatives identified at the training. They are also managing referrals and providing care coordination for the block grant clients and Medicaid clients. In the coming Phase II of the IME, they will be authorizing and managing the treatment for the initiatives identified, Medicaid and any block grant services that are transitioned to fee for services.
73. Our agency is having an issue referring MATI clients to a higher level of care at our agency. Please advise.
- There are three different scenarios for referring MATI clients (or other FFS clients) to parallel care/continuing care services via NJSAMS:
 - 1) Parallel care
 - Client can be referred to either the same or different agency as parallel care (level up or down) from **admission module**.
 - 2) Continuing care
 - Client can be discharged and sent as continuing care to the same or different agency for other level of care from **discharge module**.
 - 3) Referral from LOCI
 - This feature allows clients to be referred to the IME if the agency doesn't provide the level care client needs (or another reason). This feature is from the **LOCI module**. Option of referral from LOCI module cannot be used to send clients as parallel or continuing care. It appears that your agency may be using this functionality for parallel and continuing care. Prior to the IME release (July 1st), there was an option to refer clients to another agency, and post July agency can refer their clients only to IME if they can't serve that level of care at their end.

WAITING LIST QUESTIONS

74. How will agencies manage their waiting lists in conjunction with the IME?
- The IME will have an online capacity management system which they will use to determine capacity and make referrals. The IME will not refer to an agency that indicates their capacity is full if there are other agencies with available treatment capacity. We anticipate that the IME will utilize existing capacity and minimize the need for waiting lists.
75. So agency waiting lists are now going to be State/IME managed?
- The IME will be developing an online capacity management system to track available treatment capacity in the substance use disorder system.

NETWORK MANAGEMENT QUESTIONS

76. Have you thought about what to do with providers that have multiple sites where all the sites aren't in a certain network? Will there be open enrollment before July?
- We do not anticipate an open enrollment prior to July 1. DMHAS and NJ FamilyCare are working with UBHC to utilize the existing provider lists to make a provider data base that can be sorted as needed to make the most appropriate referral.
77. We are a fairly new organization, DAS Licensed but are not yet a FFS provider. Open enrollment is not until this June which normally entails SJI, DUII, Drug Court & MAP. Since SJI and DUII are included in the IME, will there be any change in the process of submitting application for FFS.
- DMHAS reviews provider network capacity via review of utilization management reports and identification of needs in collaboration with our system partners to identify capacity expansion goals for each network. At this time, the DMHAS FFS Initiatives Network is not conducting Open Enrollment for new providers or existing providers during the remainder of SFY15. Announcements of future open enrollment opportunities will be sent directly to eligible licensed providers, therefore, it is important for agencies to maintain current/accurate contact information with the DHS Office of Licensing (OOL). No changes for submitting open enrollment applications for the FFS networks is anticipated.
78. We do have a Medicaid # and an SAI Medicaid # which I understand SAI will not be affected by implementation of IME. Will there be anything else we have to do for the NJ FamilyCare (Medicaid) portion for IME.
- NJ FamilyCare will be included in the IME. Any NJ FamilyCare provider requirements will be distributed to all NJ FamilyCare enrolled providers through NJ FamilyCare.

MISCELLANEOUS QUESTIONS

79. Can we get rid of CIMS?
- Services that are currently contracted in CIMS which are not transitioning to a FFS contracting methodology will remain contracted in CIMS.
80. The Stakeholder Report recommended a 2-year hold harmless period. Will this be implemented?
- No. This was the recommendation from that group but the details of the contract to FFS transition have not been decided by the division.

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81. Do I stop doing NJSAMS now?
- Currently, there are no changes to provider billing or reporting requirements. As the managed care program develops, NJ FamilyCare and DMHAS will be providing agencies with updates and training on any changes. Updates and changes will be communicated at our various stakeholder meetings, as well as through our website at: <http://www.state.nj.us/humanservices/dmhas/initiatives/managed/>.
82. The IME Flow Chart does not include guidance for agency-to-agency referrals. For example, if a client is assessed at one agency and determined to need a referral to another level of care, or is transitioning upon completion to the next level of care – who calls the IME - is it the client, the referring agency, or the receiving agency?
- Treatment authorizations will be provider specific and based on payer source and level of care. To assure access to treatment, the IME will have to issue the correct authorizations for any client transitions. The treating provider will call the IME to initiate the new voucher for treatment at another level of care or at a new provider. The IME will issue the new authorization and provide the client with a warm transfer to a new agency.
83. Where can I find a copy of the “On-line procedure manual hosted by UBHC”?
- This item is one of many under development. When developed it will go on our website with the other managed care items at: <http://www.state.nj.us/humanservices/dmhas/initiatives/managed/>
84. Do you have any material we can share with staff? Procedures and call numbers etc...
- The managed care portion of the DMHAS website has up to date materials on the IME that can be distributed.
85. I know this has been discussed – if we receive request for assessment and person needs a higher level of care who will arrange transport? Where will client wait while these arrangements are being made?
- Assistant Commissioner Kovich sent out a letter regarding the Phases of the IME on April 27, 2015 which is available on the managed care section of the DMHAS website. It indicates that the first phase, July 1, 2015 will not include treatment authorizations. For now, it’s business as usual. The IME can help find empty beds through their bed management system and are a great resource for information but they will never be arranging transportation or moving clients.
86. Will additional clinical trainings be scheduled?
- Yes, additional clinical trainings will be scheduled, but there are no plans to schedule prior to the July 1, 2015 IME start date.
87. Is it just the MATI FFS or MATI contracted clients, or both, who will need IME approval for an assessment?
- Only FFS MATI will require prior authorizations for assessments on July 1, 2015.
88. I made the suggestion that the state (DMHAS/UBHC) develop an approved release of information that all agencies having signed the Affiliation Agreements will sign. Will this be taken into consideration? My concern is that the IME raises a new level of access to client

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records then substance use programs are used to. I think a thorough review regarding language with the states legal entity would protect state funded agencies much better than each individual agency having to develop their own release. I think the language if not the form should be provided or written by the state.

- The State has issued a release of information, which can be found on the managed care portion of the website at:
http://www.state.nj.us/humanservices/dmhas/initiatives/managed/IME_Consent_Form.pdf

89. We have been completing presumptive eligibility through the Department of Health and Human Services to determine if clients are eligible for NJFC/Medicaid since January 2014. As a hospital department, we have been required to do this. At this time, we would be duplicating processes by completing the DASIE to determine eligibility for NJFC/Medicaid coverage. Does completing the DASIE qualify the client for presumptive eligibility?

- Although we are working with our state Medicaid office to remedy this, community Behavioral Health Clinics do not qualify as presumptive eligibility providers. The DASIE does not qualify as a Presumptive Eligibility screening. The DASIE may duplicate some presumptive eligibility questions but it also includes eligibility screening for state only funding.

90. Requesting clarification on whether or not providers are to use the release provided in the link OR are providers to WAIT until DMHAS sends a finalized version? I know that there was some wording that was supposed to be considered for altering that was still in the release in the link.

- Please be advise that the Consent Form is in final format and usable by our system providers. Any revisions required in the future, would be made and the community would be immediately notified.

91. It was my understanding that the service contract signed by providers allowed to interchange information with the IME and DMHAS without a written authorization. Client calling the IME do not sign a written authorization.

- The Affiliation Agreement (“Agreement”) sets out the roles and responsibilities of the NJ DHS/DMHAS, Rutgers UBHC, and the Network Provider with respect to services offered via the IME. To clarify, the Agreement does not serve as a client consent that allows client treatment information to be shared by the parties to the Agreement. A client must personally authorize the release of their treatment information to any entity or individual, including the IME and DHS/DMHAS. Thus, the Agreement requires that Providers obtain a signed consent form from clients allowing client information to be shared so that services can be coordinated by the DHS/DMHAS, Rutgers UBHC (acting as the IME) and the Network Provider. (Agreement at Section I.A.6) To assist providers with obtaining client consent for purposes of the IME, the DMHAS developed an IME Consent Form by which a client authorizes the disclosure of their substance use treatment information between the DHS/DMHAS, IME and their identified Network Provider. With respect to when a client calls the IME, the IME call center does not need to obtain a written consent for purposes of referring clients to a Network Provider. By way of reminder, each Provider is responsible for maintaining client information in accordance with federal and state confidentiality laws and regulations, including HIPAA and 42 C.F.R. Part 2. In light of this query, the DMHAS recommends that Network Providers review their confidentiality procedures and policies to ensure compliance and consult with their legal counsel for guidance. Here’s the link to

To ask a question, please email
MBHOInput@dhs.state.nj.us

access the Consent Form previously distributed.
http://www.state.nj.us/humanservices/dmhas/initiatives/managed/IME_Consent_Form.pdf

Hospital Based Detoxification

92. Are the hospital based Detox providers going to be a resource for UBHC or strictly those in the Fee-for-Service network?
- Sub-acute detoxification services that are paid as a Behavioral Health service will be managed by the IME. Hospital based detoxification that is billed as a medical service will not be managed by the IME and will continue to be managed by the MCOs.
93. Are the hospital based Detox providers required to use NJSAMS for admissions/discharges?
- Only programs licensed by Department of Human Services are required to input information into NJSAMS.
94. Are the hospital based Detox providers required to use Medicaid if it is managed by UBHC?
- Sub-acute detoxification services that are paid as a Behavioral Health service will be managed by the IME. Hospital based detoxification that is billed as a medical service will not be managed by the IME and will continue to be managed by the MCOs.
95. Are the transitions from hospital based Medicaid paid service to STR? Evidenced based?
- The IME will assist in transitions between levels of care that they manage.