NEW JERSEY HUMAN SERVICES

Provider Claims Training

NJ FamilyCare Behavioral Health Integration

OCTOBER 24, 2024

Housekeeping

All attendees will enter the meeting on **mute**

Use the **“raise hand”** function if you wish to speak

This meeting will be recorded to act as an ongoing resource

Submit your **questions using the "Q&A" function** and we will compile them

You can **enable closed captions** at the bottom of the screen

Materials and recording will be published and available on DMAHS website

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Agenda

Welcome and introductory remarks Shanique McGowan, BH Program Manager, DMAHS	9:00–9:10
Overview of Claims Geralyn Molinari, Provider Relations Director, DMAHS Steven Tunney, Director of Clinical Operations, DMAHS	9:10–9:35
MCO Round Robin Aetna, Fidelis Care, Horizon, UHC, Wellpoint	9:35-10:10
Next Steps Jana Lang, BH Program Supervisor, DMAHS	10:10-10:15
Q&A Shanique McGowan, BH Program Manager, DMAHS	10:15-10:30

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NJ FamilyCare has two delivery models

NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes core Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion populations. Medicaid services are provided through **two delivery models**:

Fee For Service (FFS)

- **Providers bill state** Medicaid directly for services
- Currently, **many behavioral health (BH) services,** including mental health (MH) and substance use disorder (SUD)**,** are billed under FFS for the **general population**, but are shifting to managed care
- Offered for **members not enrolled in a managed care organization (MCO)** and members with **presumptive eligibility (PE)**

~5% of NJ FamilyCare members covered under FFS only

Managed care

- Services managed by one of **5 MCOs:** Aetna, Fidelis Care, Horizon, United, Wellpoint
- **Providers bill MCOs** for services; MCOs receive funding from state to **coordinate member care** and **offer special services** in addition to regular NJ FamilyCare benefits
- **MCOs responsible** for provider network management, care coordination and care management, utilization management, quality assurance, etc.

~95% of NJ FamilyCare members enrolled in an MCO

Note: Throughout this presentation, the words Medicaid and NJ FamilyCare may be used interchangeably

Overview of BH Integration

Context

While, physical health is managed by MCOs, many behavioral health (BH) services are still managed through FFS

BH includes mental health (MH) services and substance use disorder (SUD) services

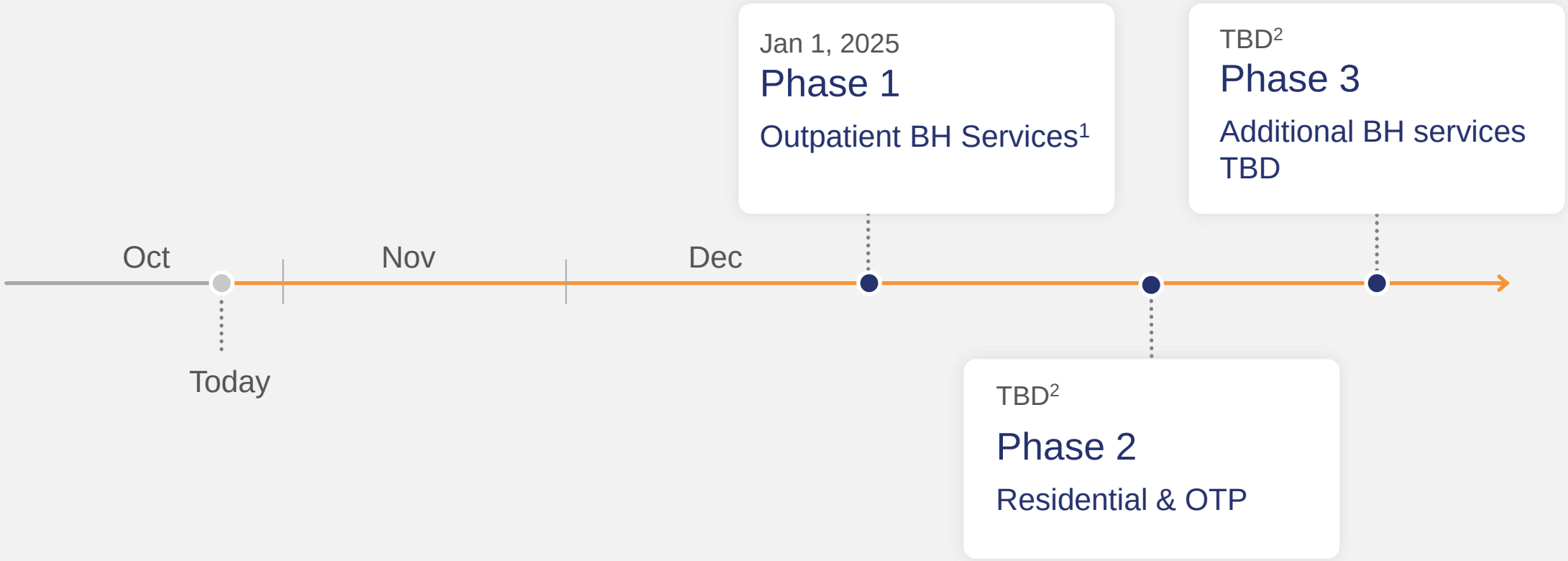
To prioritize whole-person care where all healthcare services across the care continuum are managed under the same entity, NJ is embarking on BH integration by shifting BH services from FFS to managed care

Goals of BH Integration

- **Increase access** to services with a focus on member-centered care
- Integrate behavioral and physical health for **whole person care**, with potential to improve healthcare outcomes.
- Provide appropriate services for members in the **right setting, at the right time**

Less than 2.5 months to Phase 1 go-live

NJ is taking a phased approach to shifting BH services from FFS to be managed by MCOs, with Phase 1 go-live planned for Jan 1, 2025



1. Outpatient BH services are currently covered by managed care for members enrolled in MLTSS / DDD / FIDE-SNP programs and will be integrated for general managed care population during Phase 1; 2. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live based on additional analysis and stakeholder input

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Planned services for each phase of BH integration

Phase 1– Outpatient BH[1] Services

- MH outpatient counseling / psychotherapy
- MH partial hospitalization
- MH partial care in outpatient clinic
- MH outpatient hospital or clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinic
  - Ambulatory withdrawal management
  - Peer support services
  - SUD care management
- SUD partial care

Phase 2 – Residential & OTP

- Adult mental health rehab (AMHR) / MH supervised residential
- SUD short-term residential
- SUD — medically monitored inpatient withdrawal management
- SUD long-term residential
- Opioid treatment programs (OTPs)

Phase 3 – Additional BH Services[2]

Not exhaustive

Scope of services included in phase 3 is **still being confirmed** but services being considered include:

- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes (BHHs)
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM):
  - Program of Assertive Community Treatment (PACT)
  - Children's System of Care (CSOC)
  - Intensive Case Management Services (ICMS)

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Focus today will be submitting managed care claims but first a reminder to check member's coverage

Member's Coverage | Prior Authorization | Service Delivery | Claims Submission

- Check member's insurance coverage
  - Commercial
  - Medicare
  - Medicaid
- Medicaid is the payer of last resort

- Prior Authorization & NJSAMS Training on Nov 21 – *register here*
- PA guidance in upcoming Provider Readiness Packet

- Your domain of expertise

- Focus of today

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Checking members' healthcare coverage and benefits: Three key scenarios

Coordination of benefits required

Scenario 1: Member covered by Commercial Insurance

- Commercial is primary payer until benefits are exhausted

Scenario 2: Member covered by Medicare and Medicaid

- Medicare is the primary payer
- Medicaid is the secondary payer

Medicaid-exclusive claim

Scenario 3: Member covered by Medicaid only

- Medicaid is the sole payer

In all scenarios, Medicaid is the payer of last resort

Scenarios 1 & 2: Providers responsible for coordination of benefits (COB)

Members may be covered by one or more health plans

Commercial

Medicare

Medicaid

Not exhaustive

Commercial / Medicare also cover BH services[1]

Not exhaustive

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Professional Counselors (LPC) & Licensed Clinical Social Worker (LCSW)
- Intensive Outpatient Program provided by the following:
  - Hospital outpatient
  - Federally qualified health centers (FQHCs),
  - Opioid treatment programs (OTPs)

Important to enroll as Medicare provider, if applicable

- Medicare is primary payer, and Medicaid is **secondary payer**
- If member dually eligible, MCO will **not pay the full amount**, only the balance
- Providers can enroll in Medicare online using PECOS[2]
- Contact your Medicare Administrative Contractor (MAC) to help you navigate enrollment

1. Dually Eligible Beneficiaries Receiving Medicare Part B Marriage and Family Therapist Services, Mental Health Counselor Services, and Intensive Outpatient Services Effective January 1, 2024; 2. PECOS = Provider Enrollment, Chain, and Ownership System; A National Provider Number (NPI) is required to enroll in Medicare. If you do not have one, you can apply on the National Plan & Provider Enumeration System (NPPES) website
Note: Refer to DMAHS Coordination of Benefits Guidance for additional detail

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Value of being a Medicare enrolled provider: An example

Member covered by Medicare and MCO Medicaid Plan

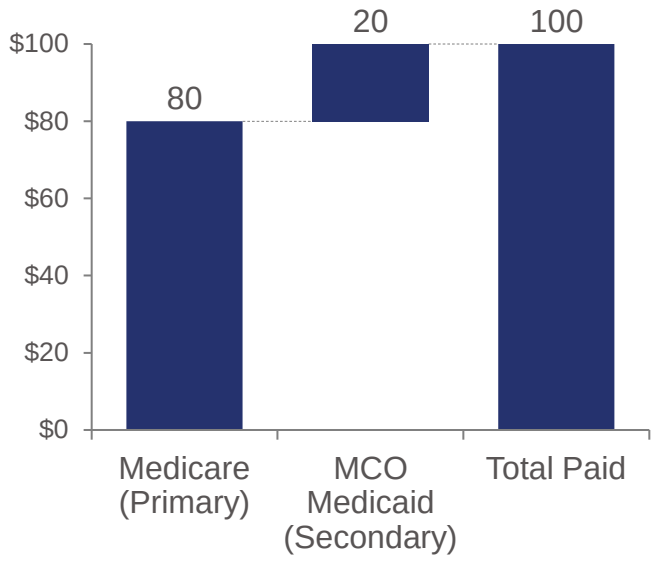
Medicare approved amount for service = $100

Medicare reimbursement = 80%

MCO Medicaid contract rate for service = $100

A Provider enrolled in Medicare and Medicaid – billed Medicare first

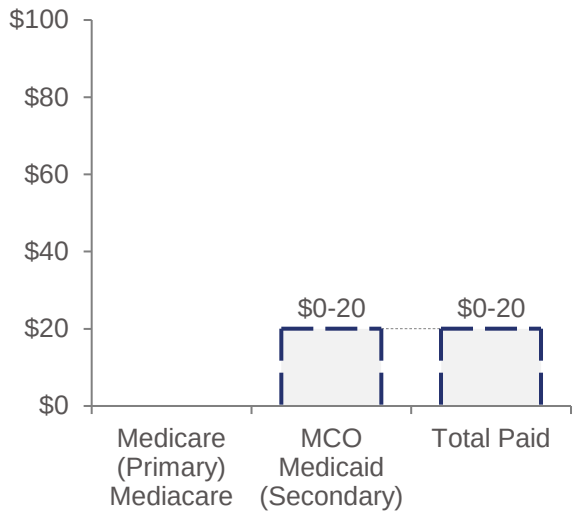
Provider A reimbursement



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

B Provider not-enrolled in Medicare – billed Medicaid only

Provider B reimbursement



- MCO won't pay full amount because Medicare was not billed
- Since provider not enrolled, MCO will typically deny claim

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Claims

A documented request for payment to a Managed Care Organization after providing covered services

Goals

- **Timely and accurate reimbursement:** Ensure prompt and correct payment to healthcare providers while validating the necessity and compliance of services
- **Program integrity:** Detect fraud and monitor expenses to maintain the program's financial sustainability
- **Transparency:** Maintain clear records for accountability and gather data to improve program efficiency and policy decisions

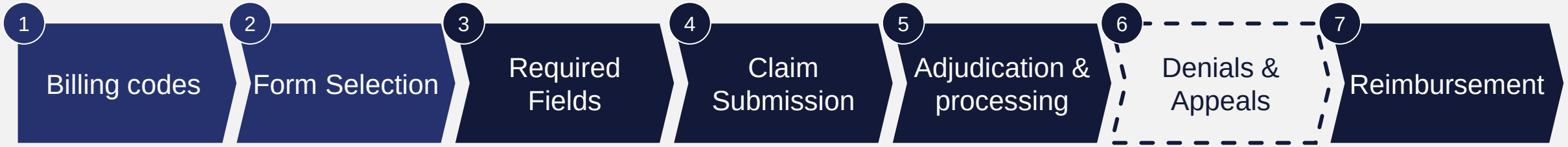
Rate and claims policies to improve provider experience for BH Integration

Introduced FFS rate floor	• All MCOs must pay providers **at or above** FFS rates for BH services • If FFS rates change during existing contract period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS

Shortened BH claims processing times	• Processing timelines must be aligned with MLTSS standards
	  - 15 days for 90% of electronically submitted clean claims
	  - 30 days for 90% of manually submitted clean claims
	  - 45 days for 99.5% of all claims

Reduced minimum weekly payment cadence from 2 weeks to 1 week	• Payments for clean claims must be paid weekly, reduced from bi-weekly
Require 'clean claim' definition in MCO provider manual	• Require MCOs to specify fields that must be completed in UB-04 or CMS 1500 to satisfy the definition of a "clean claim" – *more details to follow*
Mandated claims be covered in MCO BH provider trainings	• Claims must be covered by MCOs in provider trainings - Can be covered in standalone training or as part of broader BH integration provider training

Medicaid claims process: Seven steps for providers



- What are the billing codes for the service delivered?
- Are there other coding requirements? (i.e., modifiers, authorization number)

- Which form do I use? (e.g., CMS1500, UB-04)

- What fields are required to complete my claim? (i.e., "clean claim")

- How do I submit my claim?
- Can I submit my claim manually (i.e., not electronic)?

- How can I track the progress of my claim?
- What is the expected processing time?

- Why might my claim be denied?
- What can I do if my claim is denied?

- How much will I be reimbursed?
- How and when will I receive payment?

Similar across MCOs | MCO variation | As needed

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Medicaid and MCO specific coding requirements for accurate billing

	Diagnosis codes	Procedure codes	Revenue codes	Other codes
	Why is service is needed?	*What services were performed?*	*Where the services were provided?*	*Is service authorized or billable?*
General coding requirements (i.e., same as FFS)	ICD-10-CM codes for primary diagnosis	CPT or HCPCS codes for procedures and services ICD-10-PCS for inpatient hospital procedures	Rev codes for hospitals and facilities to indicate location or department where service performed	Coordination of Benefits (COB) codes to indicate how claim should be processed
MCO Medicaid specific requirements	ICD-10 diagnosis codes must meet MCO Medicaid medical necessity criteria	HCPCS Level II codes required for services not in CPT codes (e.g., ambulance services) Some MCOs **more stringent on modifiers** in specific situations	Modifiers required in specific situations May impose payment caps based on rev code	MCO specific COB process Authorization number: • Covered in State Prior Authorization training

Medicaid follows **National Correct Coding Initiative** (**NCCI) edits** to prevent improper coding and overbilling.

These edits identify improper coding combinations and ensure billing adheres to specific rules

Same CMS 1500 or CMS 1450 ("UB-04") forms used for Medicaid FFS

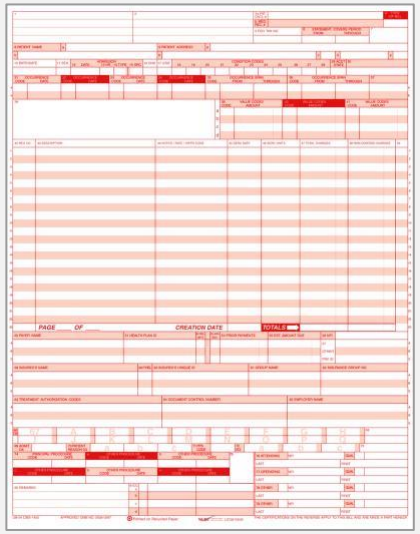
CMS 1500 / 837P[1]

For independent medical professionals (outpatient claims)

Link to form

CMS 1450 ("UB-04") / 837I[2]

For hospitals and facilities (inpatient claims)



Link to form

1. 837P is the standard format electronic equivalent of CMS 1500; 2. 837I is the standard format electronic equivalent of CMS 1450

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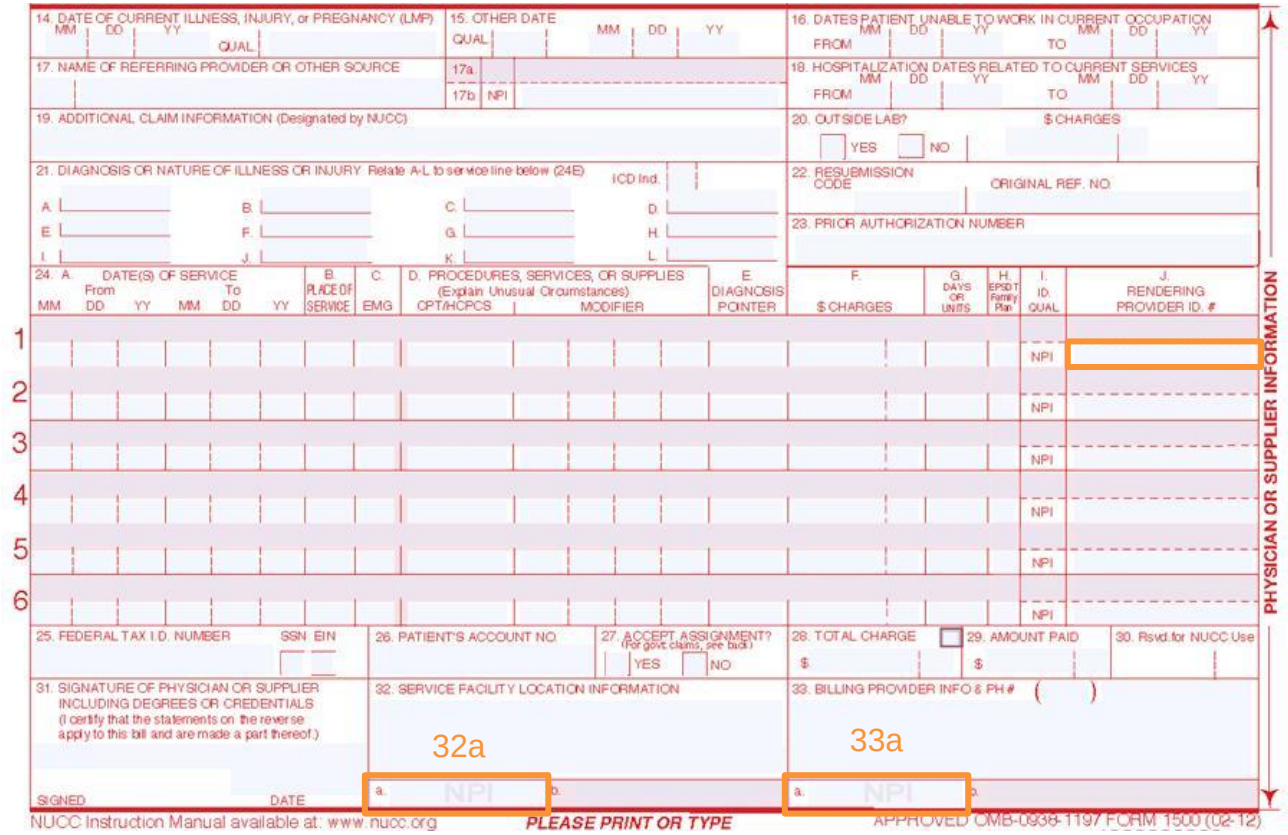
Make sure NPI numbers match guidance from MCO – CMS 1500

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

Three sections to enter NPI:

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

In general, if billing under a group:

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

If billing individually:

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

MCO specific requirements may differ
Details to come

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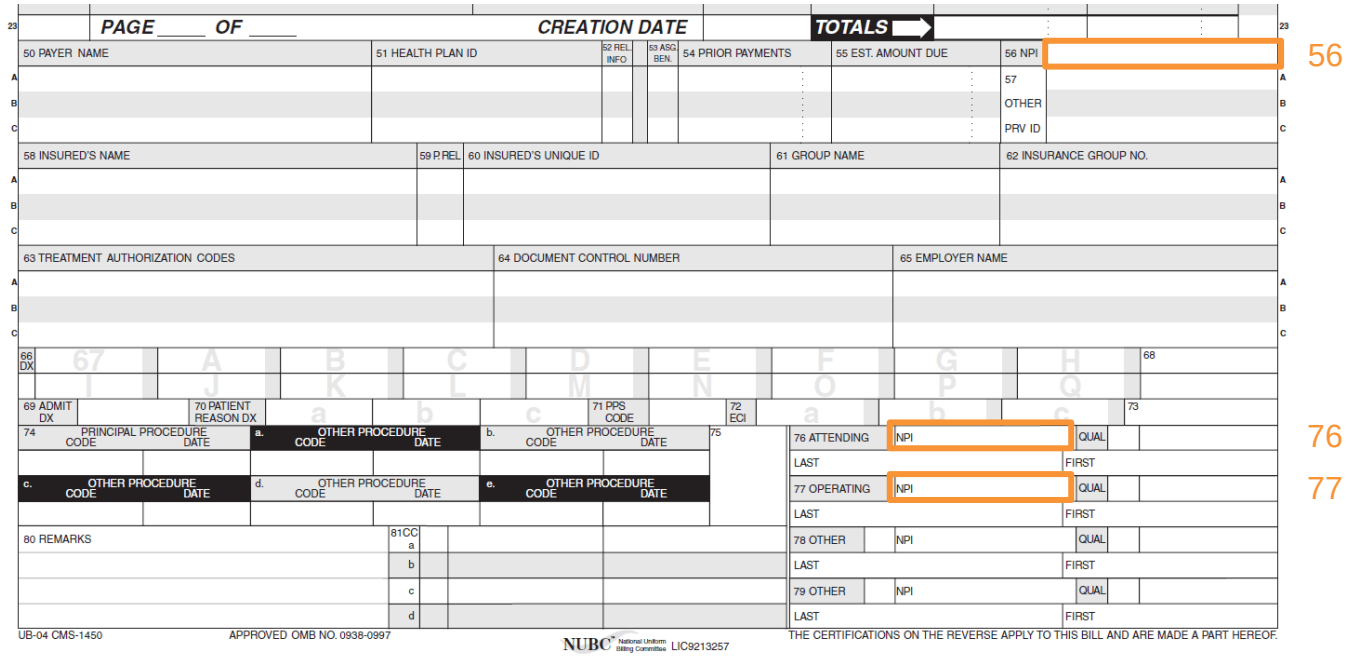
Make sure NPI numbers match guidance from MCO - CMS 1450

Three sections on CMS 1450 ("UB-04") form for NPI numbers



56

76

77

NPIs must match MCO billing requirements

Three sections to enter NPI:

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

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

Billing as a facility:

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

MCO specific requirements may differ
Details to come

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What is a clean claim? – Division of Banking & Insurance (DOBI) definition

"Clean claim" means:

A. Claim is for a **service or supply covered** by the health benefits plan

B. Claim is submitted with **all the information requested** on the claim form or in other instructions - *focus*

C. **Person** to whom service was provided **was covered** on the date of service;

D. The carrier does **not** reasonably believe the claim has been **submitted fraudulently**; and

E. The claim **does not require special treatment**[1]

Providers need to know **exactly which fields are required** for each service by MCO

1. Special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file

State requiring MCOs to provide transparency on required fields in provider manual and trainings

Category	Fields	Aetna	Fidelis Care	Horizon	United	Wellpoint
Patient information	**Demographics:** Address, DOB, phone number, sex, member ID, marital status)					
	Insured's information: Name, relationship to member, phone number, address, date of birth, member ID, sex)					
	Employer or school name					
Provider information	**Referring provider** name and NPI					
	Billing provider name, NPI, and federal tax ID					
	Rendering provider Medicaid ID and NPI					
	Facility information					
Service information	**Illness:** Diagnosis code including procedure, services, or supplies CPT/HCPCS with modifier), dates unable to work					
	Service: Dates, place, units of service					
	Billing information: PA, charges					

Required fields can vary depending on the **type of service** provided and **specific MCO** guidelines

Starting January 1, 2025, each MCO is required to outline the required fields (in CMS 1500 and CMS 1450) for a claim to be considered “clean”:

Provider manual

Provider trainings

Initial claims can be submitted in two ways but electronic is preferred

	Electronic *Submit via provider portals or electronic data interchange*	Paper *Submit by mail only to specified address for each MCO*
Aetna	Availity Payer ID is **46320**	Aetna Better Health of New Jersey P.O. Box 982967 El Paso, TX 79998
Fidelis Care	Fidelis Care Provider Portal or Availity Payer ID is **14163**	Fidelis Care, Claims Department P.O. Box 31224 Tampa, FL 33631-3224
Horizon	Availity or Horizon NJ Health EDI Payer ID is **22326**	Horizon NJ Health Claims Processing Dept.. P.O. Box 24078 Newark, NJ 07101
United	Provider Express or EDI Payer ID is **87726**	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402
Wellpoint	Availity Payer ID is **WLPNT**	New Jersey Claims, Wellpoint P.O. Box 61010 Virginia Beach, VA 23466

Managed care claims must be submitted within 180 days from date of service (DOS)[1]

Benefits of electronic submissions

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

1. If coordination of benefits is involved, where MCO is a secondary payee, most MCOs require COB of claims to be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from dates of services (DOS), whichever is later
Note: Electronic Data Interchange (EDI) facilitates streamlined data exchange between MCOs and providers

Adjudication and processing

Two-types of adjudication

Auto adjudication: goes into pay or deny status automatically.

- Moves to post-adjudication immediately
- Paper / electronic remits are created
- Checks / EFTs are sent to the provider

Manual claims review: Route to a claim's processor for manual review and processing.

Expected decision timelines

State processing timelines for clean claims must be within:

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

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

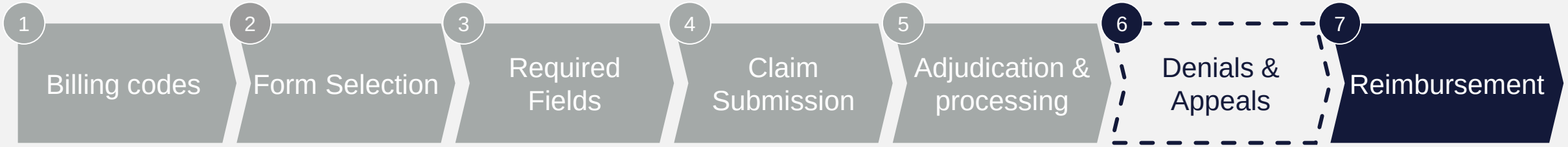
How to check the status of your claim

MCO portal: Some MCOs have a portal to track the status of claims, adjusted claims and appeals

Other MCOs require providers to reach out directly

More details to come from specific MCOs

Last steps: Denials & Appeals, and Reimbursement



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Similar across MCOs | MCO variation | As needed

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What are the top 3 common claims errors you have experienced?

- A Incomplete claim submission
- B Incorrect diagnosis or procedure codes
- C Missing prior authorization
- D Late claim submission
- E Duplicate billing
- F Benefit limit exceeded
- G Services not included in MCO benefit
- H Incorrect claim submission address
- I Invalid provider ID number
- J Incorrect patient Information

Answer in the poll

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If your claim is denied, you have the right to appeal

Right to appeal

- Providers have **right to appeal** denied or underpaid claims if they believe the decision was incorrect
- Appeals must be submitted **within a specified time** after receiving denial, **typically 90-180 days,** depending on MCO
- Each MCO provides specific contact information and forms for submitting appeals
  - Most MCOs use a version of the NJ Healthcare provider appeal form

Steps to appeal

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

Tips for submitting appeals

- Reference denial reason
- Submit documentation to show medical necessity
- Use correct coding (CPT/HCPCS, authorization and rev codes)

1. To be eligible, claims must have completed internal review with MCO and be for a total dispute amount of $1,000 or higher

Reach out to Office of Managed Health Care if you can't reach a resolution

Office of Managed Health Care (OMHC)

- Addresses provider inquiries and/or complaints in relation to MCO:
  - Contracting & credentialing
  - Claims & reimbursement
  - Authorizations
  - Appeals
- Helps bring resolution between provider and MCO

Contact OMHC with details of your claim

- Email: mahs.provider-inquiries@dhs.nj.gov
- Include detail regarding your claim
- If multiple claims are impacted, the information should be summarized using an Excel file
- All information must be sent securely, if it includes Protected Health Information (PHI)

Rates individually negotiated, but must be at or above FFS floor

Each MCO negotiates own rates with providers

MCO reimbursement rates are negotiated between provider and individual MCO

Some MCOs may be willing to provide a fee schedule upon request

- For more information, please reach out to each MCO separately

State requires payment to be at or above Medicaid FFS rates

- All MCOs must pay providers at or above FFS rates
- If FFS rates change during existing contract period, contract rates below FFS floor must be adjusted by effective date indicated by DMAHS
- Medicaid FFS fee schedule can be found here

Receive payments electronically or by check

Electronic: Most MCOs offer faster payments via electronic remittance, such as ACH transfers

Check: Paper checks are an option for those without electronic payment capabilities

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

MCO Round Robin

7 mins x 5 MCOs

- Introduce claims team
- Overview of MCO specific processes
- Quick demo of claims platform / portal
- Share training information / additional resources

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Aetna Better Health of NJ (ABHNJ)

Presenter

Maressa Nordstrom

Behavioral Health Administrator
Senior Clinical Strategist

Aetna | Meet our claims & billing team

Christopher Toland
Senior Claims Manager,
Service Operations

- Management of claims operations and team
- Claims inventory management
- Claims quality oversight

Tish Brown
Claims Supervisor,
Service Operations

- Claims inventory management
- Oversight of claims processing procedures

Liarra Sanchez
Manager,
Network Relations

- Primary point of contact for participating providers
- Network liaison between providers and internal departments
- Provides Network orientation and ongoing Provider education

Aetna | Our claims process

Required fields

- Information detailed on upcoming slide

Claims submission

- Providers can submit claims electronically or via mail
  - Electronic submission via Availity Provider Portal
  - By mail: P.O. Box 982967 El Paso, TX 79998
- Include Payor ID **46320**

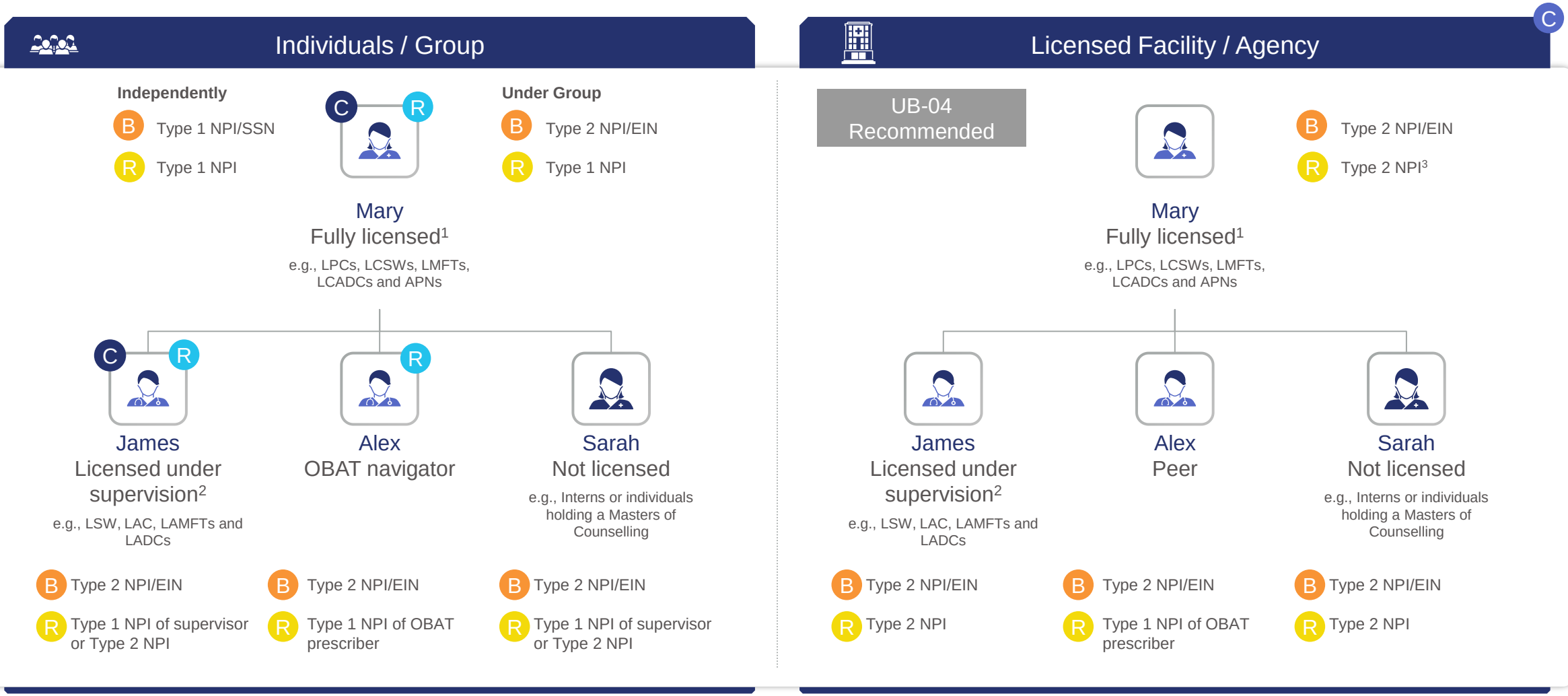
Adjudication & processing

- Accepted claims are auto-adjudicated in Aetna's QNXT system
  - Claims that fail adjudication, are manually reviewed
  - Claim is moved from pay/deny status
- Fully processed claim is finalized, remit is created, and payment is sent to the provider.
- To check the status of a claim, review in the Availity provider portal, or call Provider Services at (855) 232-3596

Denials & Appeals

- If a claim denies, providers have **60 calendar days** from the remittance notice to appeal the decision
- Providers can submit an appeal by:
  - Availity Provider Portal
  - Phone- (855) 232-3596
  - Fax – (844) 321-9566
  - Mail – PO Box 81040, 5801 Postal Road, Cleveland, OH 44181

Aetna | Billing NPI requirements



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 contract allow for Type 1 NPI providers to bill as rendering on facility claims. Check your specific contract

B Billing provider
R Rendering provider
C Organization credentialed
C Individually credentialed
R Listed on roster

Aetna | Billing Required Fields

Individuals / Group

CMS-1500 Required Fields

- Type of Health Insurance (Item 1);
- Subscriber's/patient's plan ID # (Item 1a);
- Patient's name (Item 2);
- Patient's date of birth and sex (Item 3);
- Subscriber's name (Item 4);
- Patient's address (street or P.O. Box, city, ZIP code) (Item 5);
- Patient's relationship to subscriber (Item 6);
- Whether patient's condition is related to employment, auto accident, or other accident (Item 10);
- Subscriber's policy number (Item 11);
- Subscriber's birth date and sex (Item 11a);
- Insurance Plan name (Item 11c);
- Disclosure of any other health benefit plans (Item 11d);
- Patient's or authorized person's signature or notation that the signature is on file with the physician or provider (Item 12);
- Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (Item 13);
- Date of current illness, injury, or pregnancy (Item 14);
- Other Date (Item 15);
- Name of referring provider or other source (Item 17);
- Referring provider NPI number (Item 17b);
- Diagnosis codes or nature of illness or injury (Item 21);
- Treatment Authorization Number (Item 23);
- Date(s) of service (Item 24A);
- Place of service codes (Item 24B);
- EMG – emergency indicator (Item 24C);
- Procedure/modifier code (Item 24D);
- DX Pointer – diagnosis code (Item 24E);
- Charge for each listed service (Item 24F);
- Number of days or units (Item 24G);
- Rendering provider NPI (Item 24J);
- Physician's or provider's federal taxpayer ID number (Item 25);
- Total charge (Item 28);
- Signature of physician or provider that rendered service, including indication of professional license (Item 31);
- Name and address of facility where services rendered (Item 32);
- The service facility NPI (Item 32a);
- Physician's or provider's billing name and address (Item 33);
- Main or billing Type 1 NPI number (Item 33a).

Licensed Facility / Agency

C

CMS-1450 (UB-04) Required Fields

- Rendering Provider's name, address and telephone number (Item 1);
- Pay-to Provider's name, address and telephone number (Item 2);
- Patient control number (Item 3a);
- Type of bill code (Item 4);
- Provider's federal tax ID number (Item 5);
- Statement period (beginning and ending date of claim period) (Item 6);
- Patient's name (Item 8b);
- Patient's address (Item 9);
- Patient's date of birth (Item 10);
- Patient's sex (Item 11);
- Date of admission (Item 12);
- Admission hour (Item 13);
- Type of admission (Item 14)
- Source of admission code (Item 15);
- Discharge hour - (Inpatient Only) (Item 16);
- Patient-status-at-discharge code (Item 17);
- Revenue code (Item 42);
- Revenue/service description (Item 43);
- HCPCS/Rates (current CPT or HCPCS codes are required) (Item 44);
- Service date (Item 45)
- Units of service (Item 46);
- Total charge (Item 47);
- Payer Identification Name (Item 50);
- Main NPI number (Item 56);
- Subscriber's name (Item 58);
- Patient's relationship to subscriber (Item 59);
- Insured's unique ID (Item 60);
- Treatment Authorization Code (Item 63);
- Diagnosis qualifier (Item 66);
- Principal diagnosis code (Item 67);
- Admit diagnosis (Item 69);
- Provider name and identifiers (Item 76-79).

B Billing provider

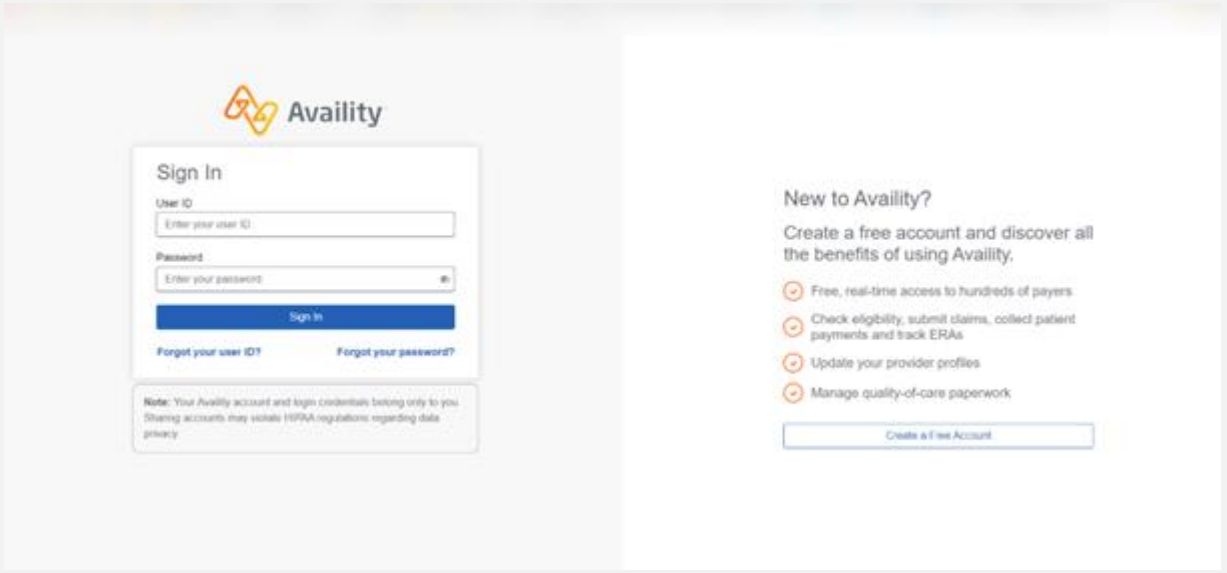
R Rendering provider

C Organization credentialed

C Individually credentialed

R Listed on roster

Aetna
Claims portal demo



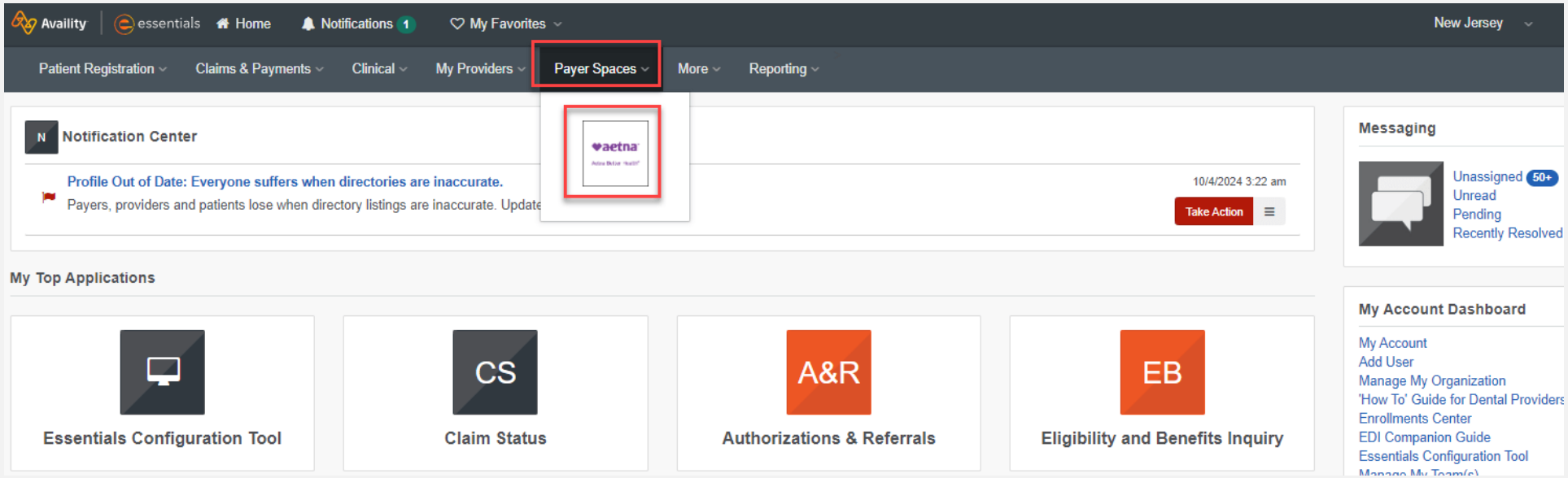
NEW JERSEY HUMAN SERVICES

1

Submit claims using Aetna Better Health of NJ Portal: [Access Availity Here]

2

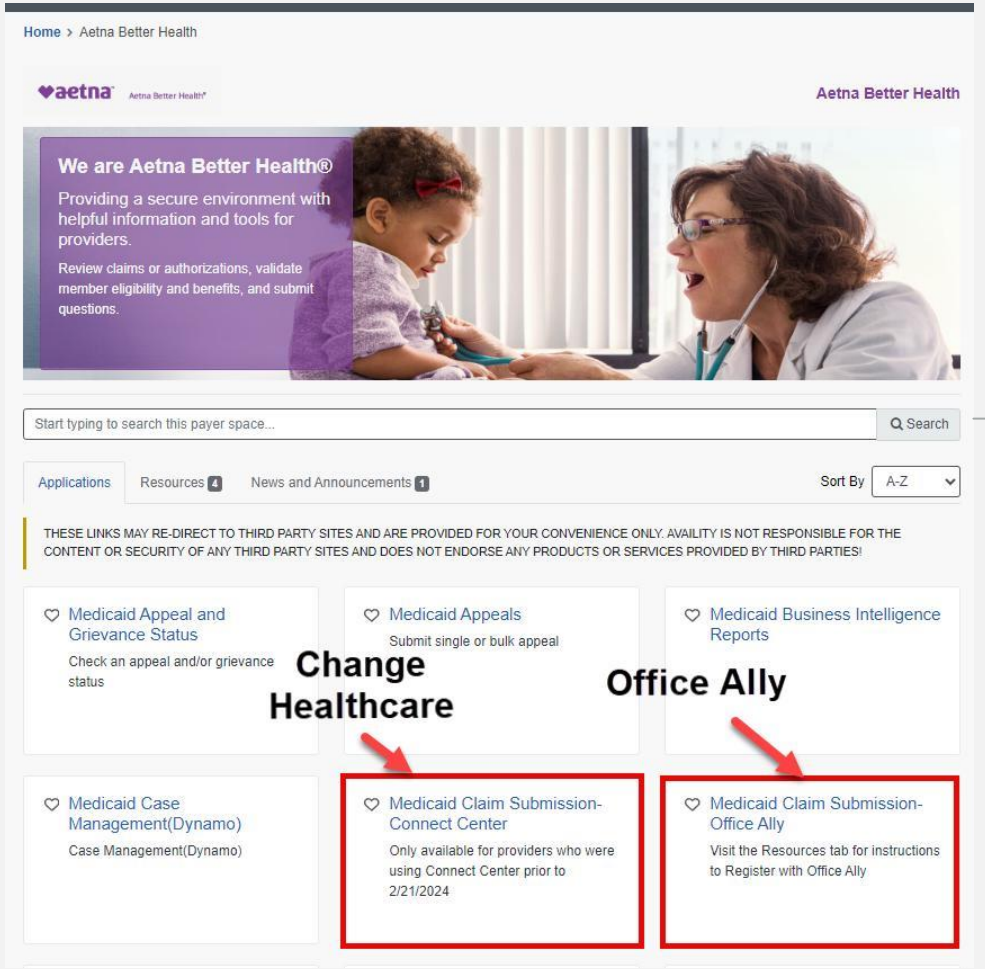
Once provider is logged into Availity they can go to NJ and then the payer spaces and select “Aetna Better Health”.



NEW JERSEY HUMAN SERVICES

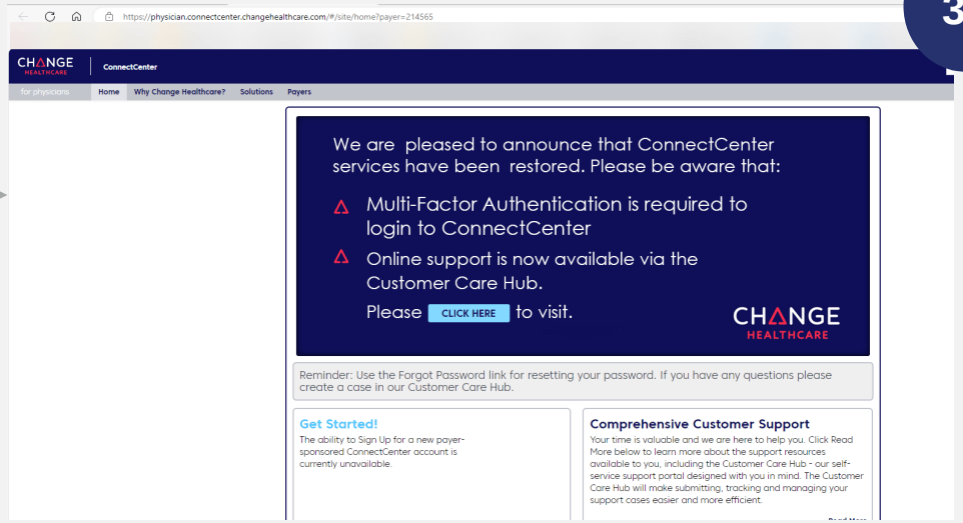
3

Once the provider is in the payer space, select either Change Healthcare **OR** Office Ally.



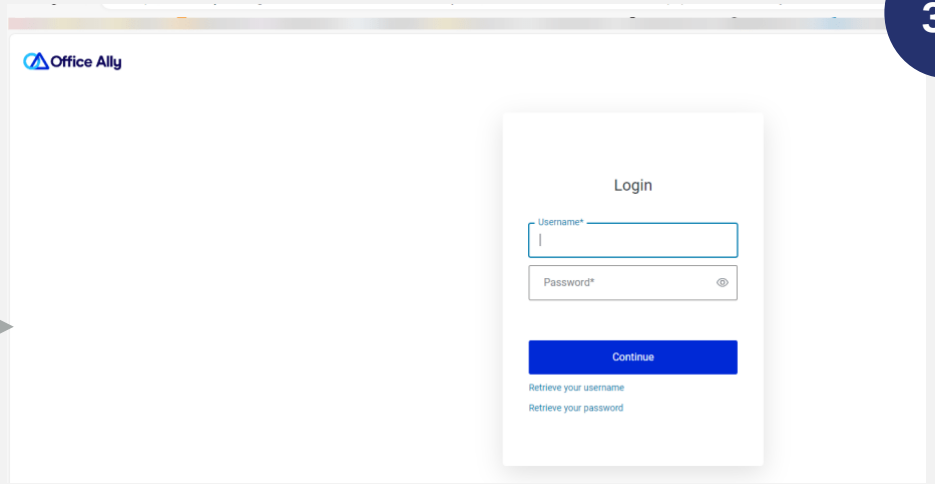
Change Healthcare website log in

3a



Office Ally website log in

3b



NEW JERSEY HUMAN SERVICES

Aetna| Upcoming trainings and resources

Upcoming trainings

When	Training Topic	Target audience	Link
Nov 6 12p- 1p	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	FFS BH providers joining managed care	Register
Nov 6 1p- 2p	BH/ABA Provider Training Traditional Overview for BH providers new to ABHNJ	BH/ABA Providers New to ABHNJ	Register
Nov 20 12p- 1p	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	FFS BH providers joining managed care	Register
Dec 11 12p- 1p	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	FFS BH providers joining managed care	Register
Jan 15 12p- 1p	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	FFS BH providers joining managed care	Register
Nov 20 1p- 2p	BH/ABA Provider Training Traditional Overview for BH providers new to ABHNJ	BH/ABA Providers New to ABHNJ	Register

Additional resources

For further information on submitting claims with us, please contact:

Liarra Sanchez, Manager, Network Relations
609-455-8997
SanchezL7@Aetna.com

Links:

- Access Availity Claims Portal Here
- ABHNJ Provider Manual
- MCO Quick Reference Guide
- New Provider Orientation
- ABHNJ Provider Website

NEW JERSEY HUMAN SERVICES

FIDELIS CARE®

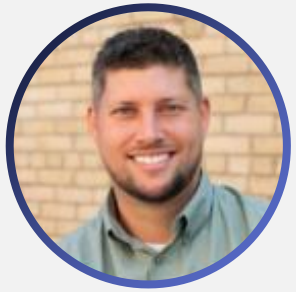
Presenter

Stuart Dubin

Vice President, Operations

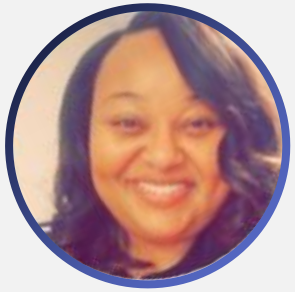
NEW JERSEY HUMAN SERVICES

Fidelis Care | Meet our claims & billing team



Christopher Anderson
Director, Business Operations

- Claims and Business Operations Oversight



Keyana Brown
Director, Business Operations

- Market Business Operations Oversight

Diana Crews
Director, Claims Operations

- Claims Processing Oversight

Fidelis Care | Our claims process

Required fields

Proper identifiers:

- Member Info
  - Name, DOB, address, Fidelis Care ID #
- Provider Info
  - Name, TIN, NPI
  - Member DOS (Date of Service)
  - Rendering Provider
  - Billing Provider
  - Place of Service
  - ICD-10 Diagnosis Codes

Claims submission

- Claims can be submitted electronically through provider's own clearing house or on the Fidelis Care portal for PAR Providers.
- Questions with claims submissions can be directed to **EDIBA@centene.com**

Adjudication & processing

Systems will double check all identifiers:

- Provider Information
- Member Information
- Member Benefits
- Bill type
- Service Type
  - Service Billed
  - Date of service
  - Diagnosis Codes
  - CPT/Rev code billed
  - Quantity Billed

Denials & Appeals

Disputes for payment policy related issues must be submitted to Fidelis Care in writing within **90 days** of the date of denial on the EOP; or via the Fidelis Care portal for PAR Providers.

Information on disputes and appeals can be found on p.6 of the Quick Reference Guide, found on the plan website.

Fidelis Care | Billing requirements

Individuals / Group

Independently

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

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

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

C

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

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Fully licensed[1]

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

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Licensed under supervision[2]

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

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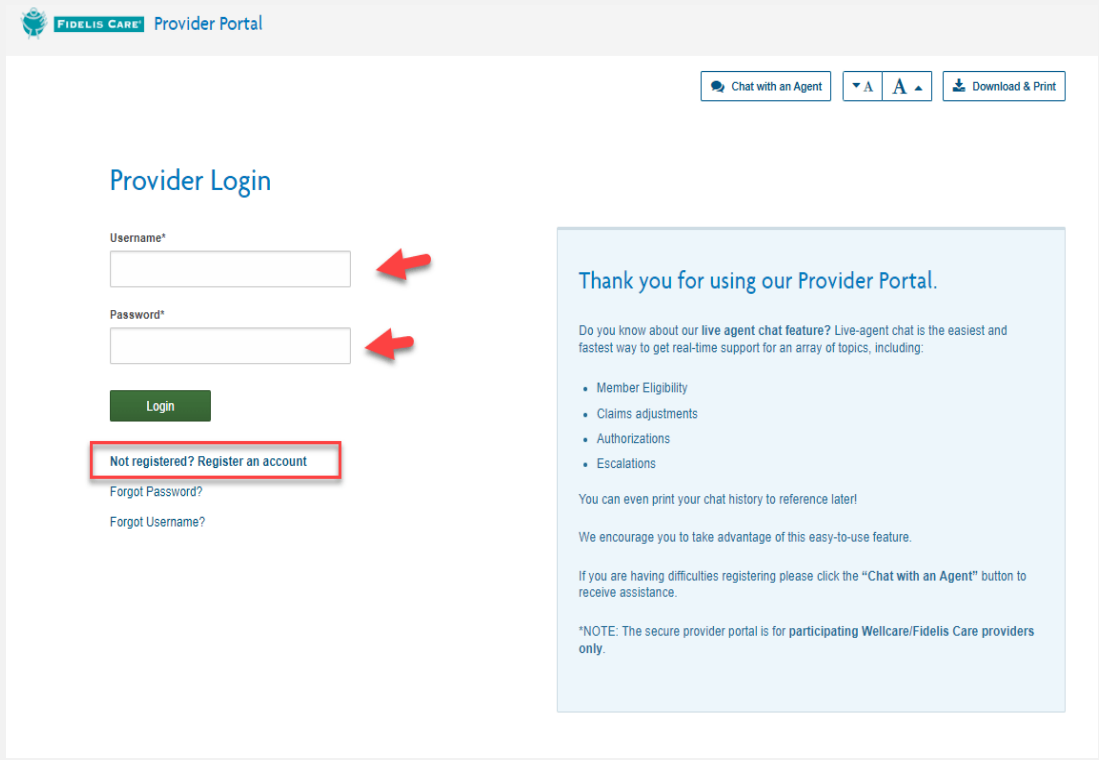
- B Type 2 NPI/EIN
- R Type 1 NPI of supervisor

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)

B Billing provider | R Rendering provider | C Organization credentialed | C Individually credentialed | R Listed on roster

Fidelis Care Claims portal demo

Fidelis Care portal Login

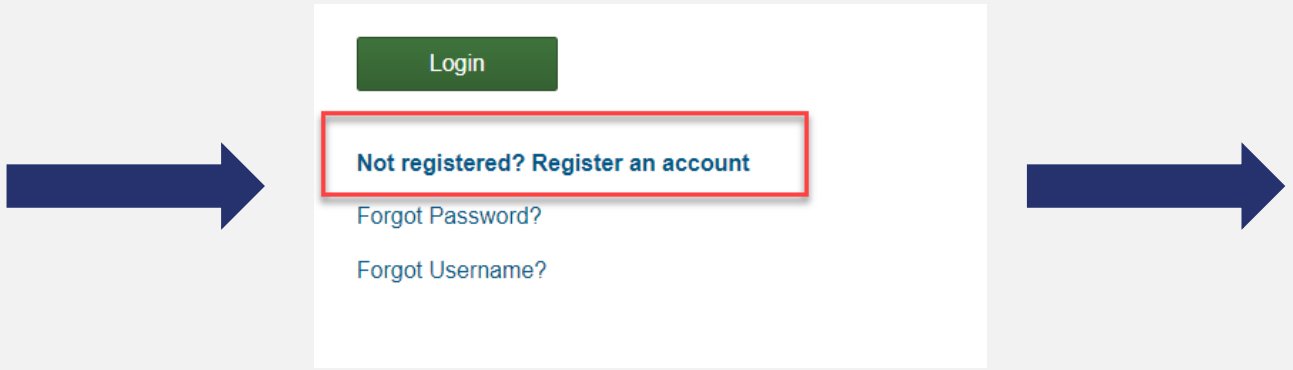


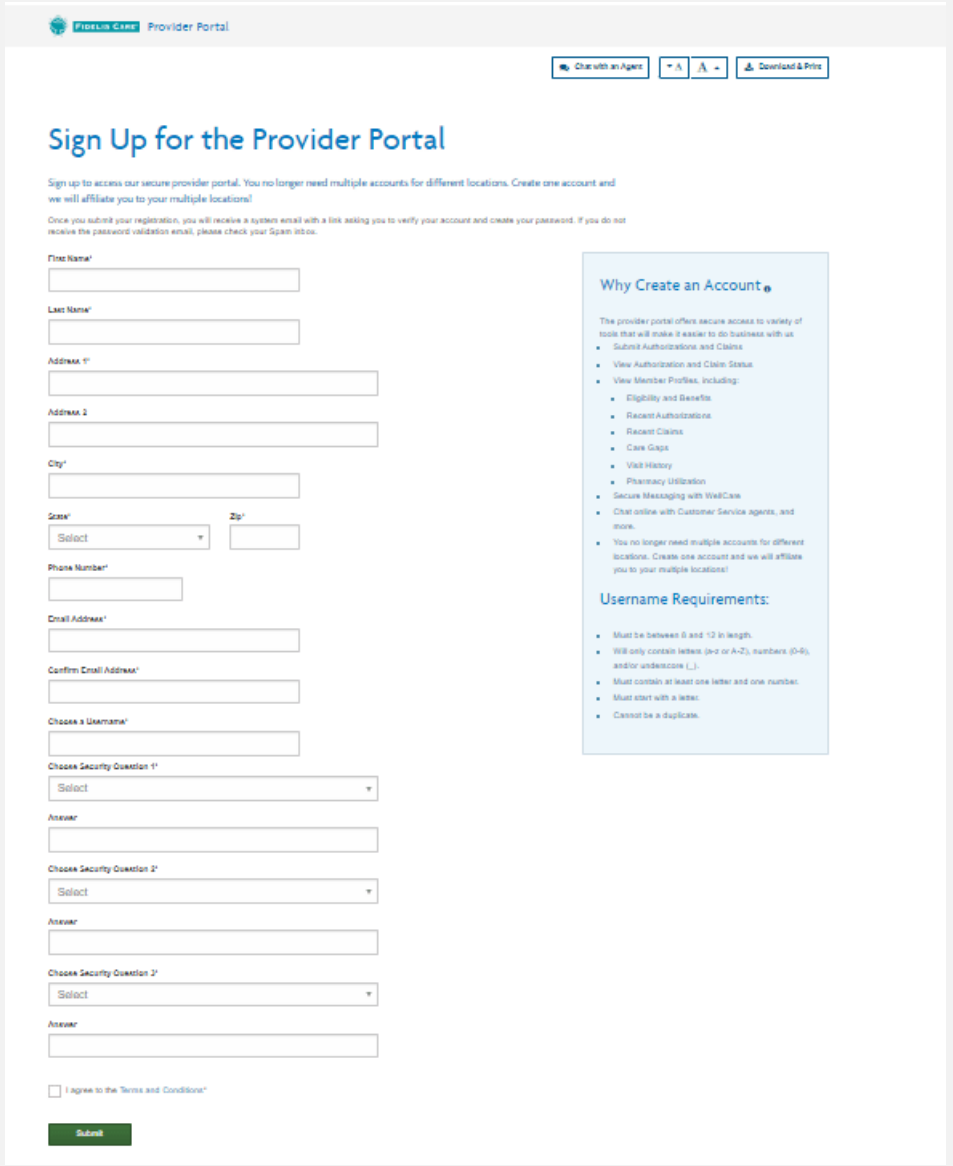
Full Claims Submission training video

(Additional Provider Portal Overview Training Guides)

NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal



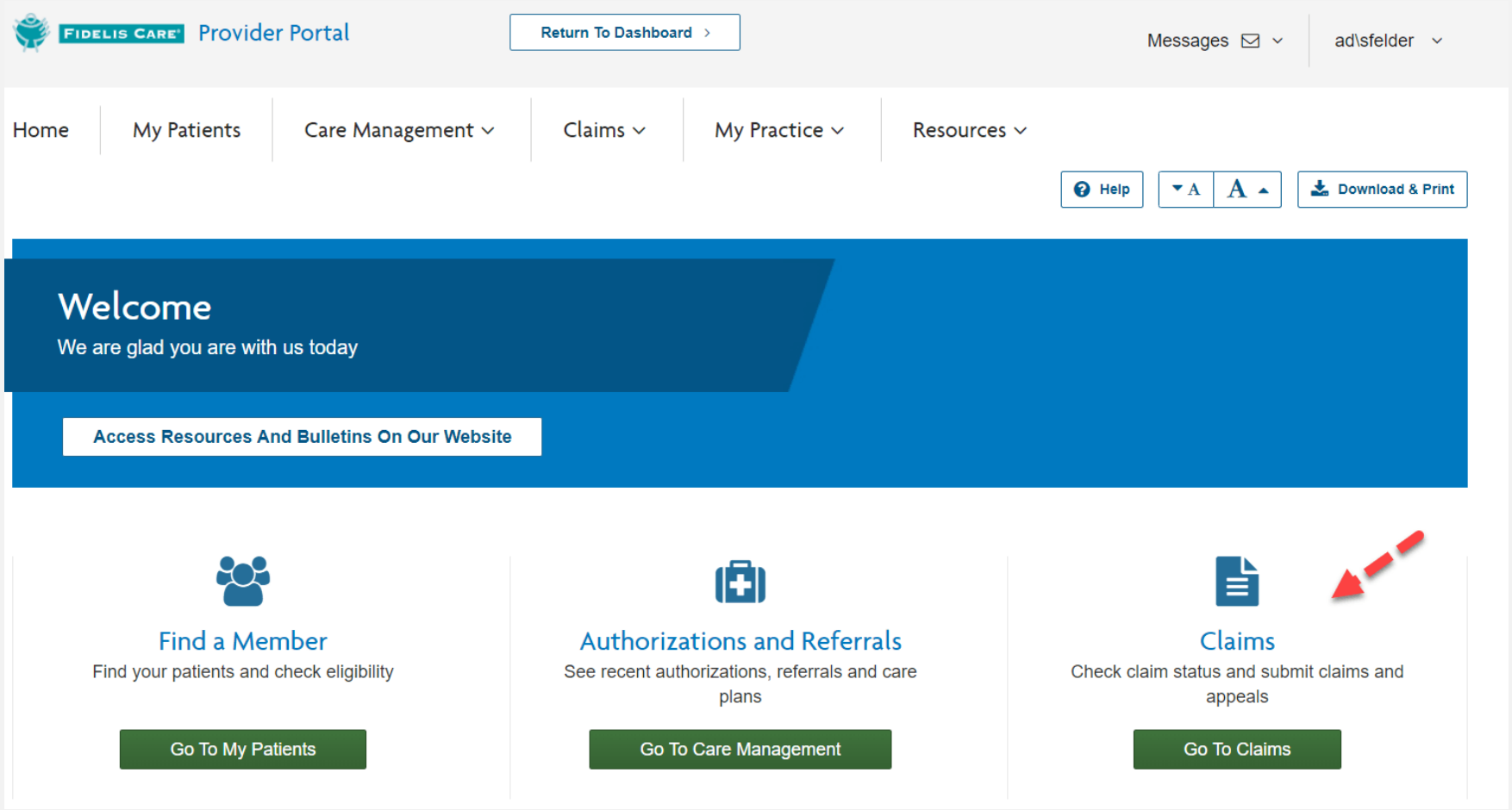


Fidelis Care Portal Process

- If provider does not have a portal login, they can click the “NOT REGISTERED” link as shown above and it will take them to the Sign Up page for the portal.
- Once the page is completed and submitted, they will get an email to verify the email address entered.
- Once this is completed, they will need to reach out to their portal admin (in their office) or their Provider Rep to assign their username to the TIN.

NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal

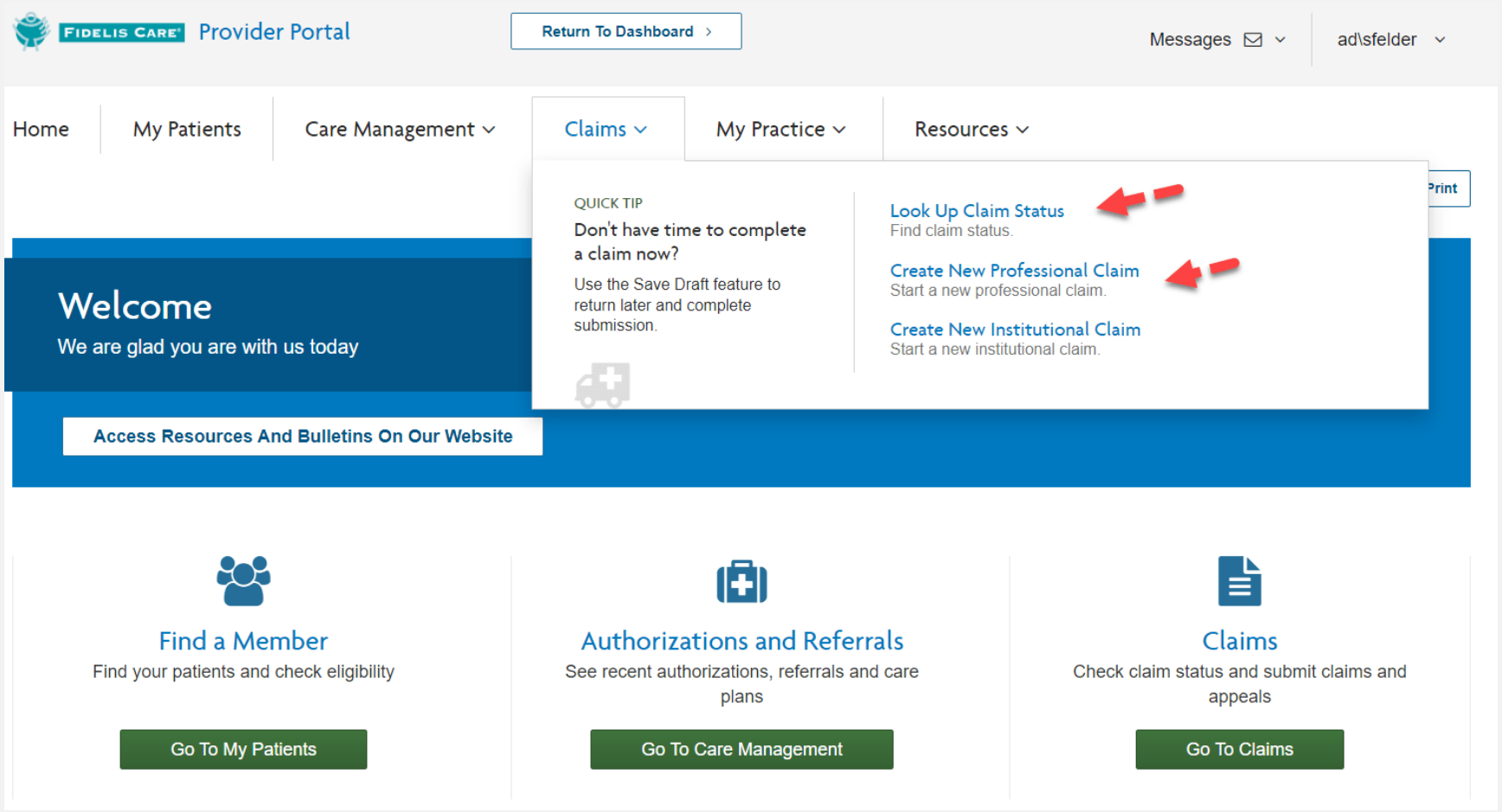


You can select "Claims" at the bottom of the home page

NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal

OR by hovering over the top tool bar



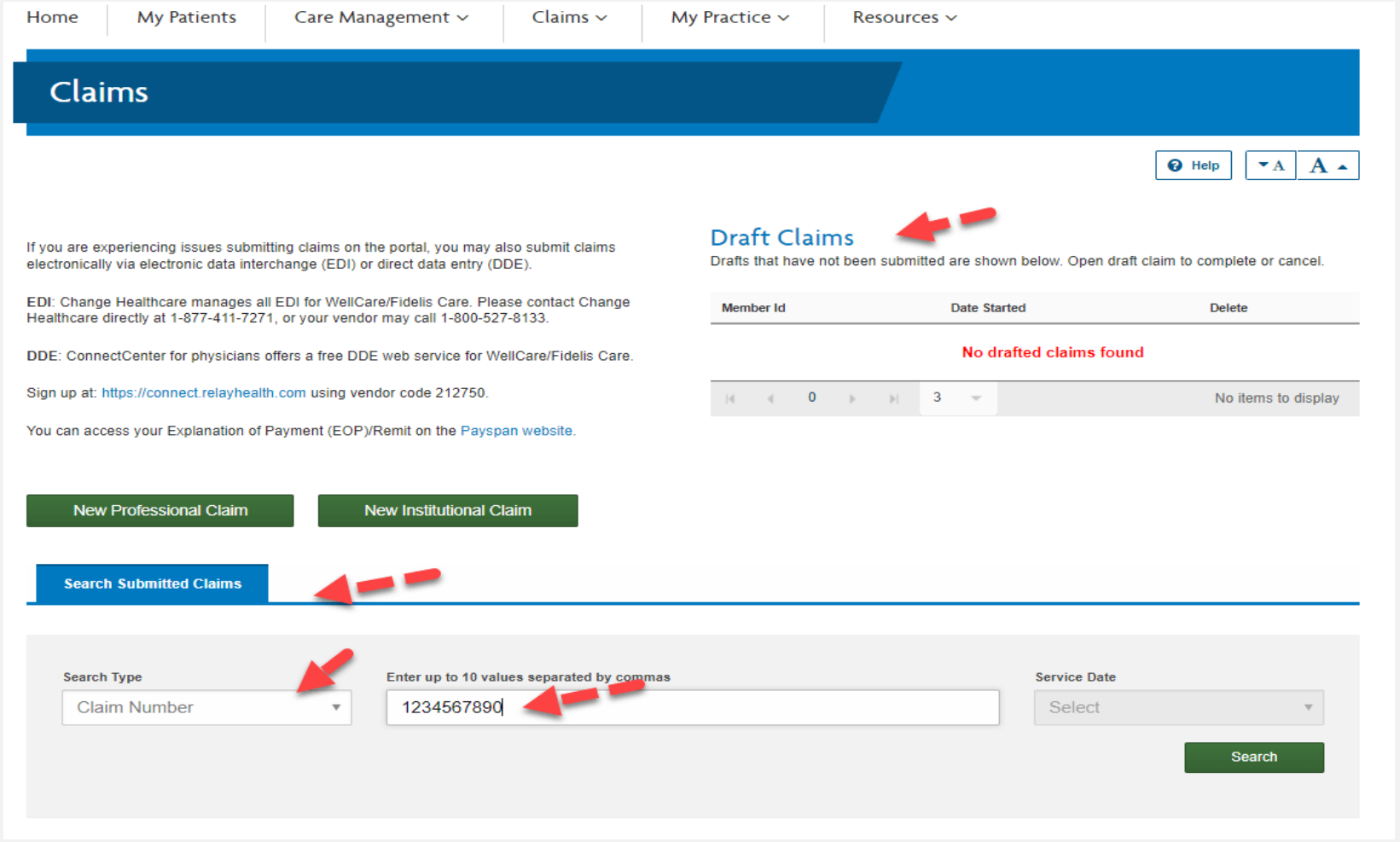
Fidelis Care NJ | Claims Portal

Check claim Status

Use drop down to select Search Type

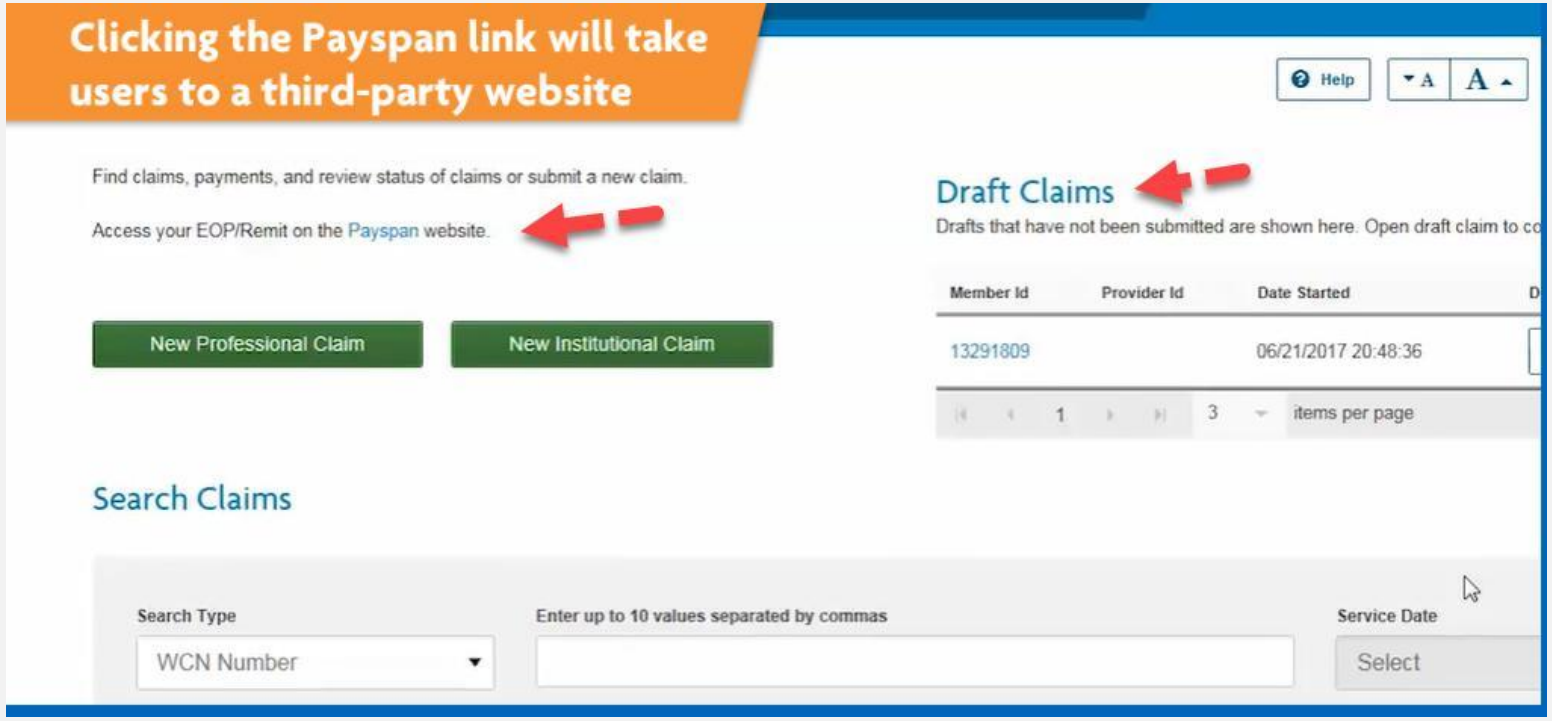
Search Type Criteria:

- Fidelis Care Claim Numbers are 10 digits long
- You can also search by Member ID and Date of service.



NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Claims Portal



Link to the Payspan website for easy access of EOP/Remits. They can also access DRAFT claims

NEW JERSEY HUMAN SERVICES

Fidelis Care NJ | Upcoming trainings and resources

Upcoming trainings

Nov 7 10:00 AM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)
Nov 26 4:00 PM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)
Dec 5 9:00 AM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)
Dec 16 3:00 PM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)
Jan 7 10:00 AM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)
Jan 30 3:30 PM	Behavioral Health Integration Overview	Par & Non Par BH Providers	(Join Meeting)

Additional resources

For claims, provider can:

- Refer to our Provider Resource Guide or Quick Reference Guide
- Call **1-888-453-2534** or visit https://www.fideliscarenj.com/contact-us.html

Fidelis Care NJ BH Team for escalation:

- Provider Network Specialist: Melanny.Zerna@fideliscarenj.com
- Contract Negotiator II: Evelyn.Mora@fideliscarenj.com
- Contract Negotiator I: Michael.Czajkowski@fideliscarenj.com
- Snr Dir, Population Health & Clinical Ops: Lisa.Dolmatz@fideliscarenj.com
- Manager, Behavioral Health: David.Houston@fideliscarenj.com

Links:

- Fidelis Care Provider Manual
- Fidelis Care Quick Reference Guide
- New Provider Portal Training
- Behavioral Health Virtual Provider Training
- Provider Portal

Presenter

Edward Elles

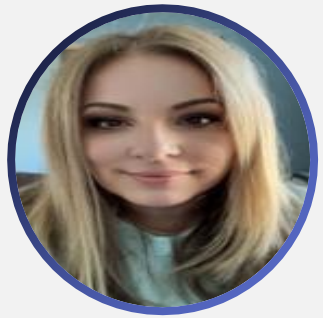
Director of Behavioral Health

Horizon NJ Health | Meet our claims team

General Practice (GP) operations

Michael Healey
Director

- Responsible for the ownership of projects and daily operations

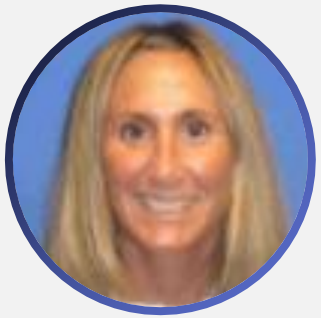


Jennifer McGinley
Manager

- Responsible for the management of projects and daily operations

Michelle Ray
Business Analyst III

- Responsible for analysis and resolution of system-related contract/pricing discrepancies



Toni Gorski
Claims Business Tech Analyst

- Responsible for gathering data for analytic reporting purposes

Reynelda Boggs
Provider Resolution Analyst II

- Responsible for coordinating the resolution of complex claims issues

Gina Swezda
Provider Resolution Analyst II

- Responsible for coordinating the resolution of complex claims issues

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Our claims process

Required fields

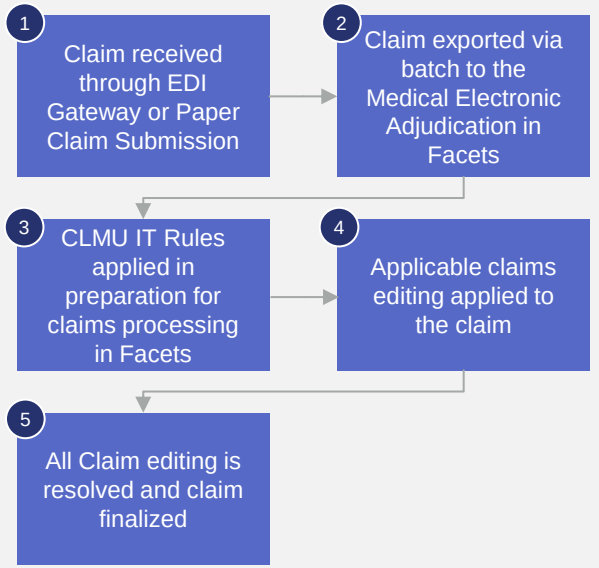
- Key required fields include:
  - Horizon NJ Health Member ID (YHZ#), Name, DOB
  - Provider Name, TIN, Rendering NPI
  - DOS, Service, Diagnosis, Units
- Refer to **full list of required fields** for CMS 1500 and UB-04 - *see later slide*

Claims submission

- Submit claims **within 180 days** from Date of Service or Date of Discharge
- **Electronic[1]:**
  - Horizon NJ Health EDI Gateway through direct submission through clearinghouse / vendor using payor ID **22326**
  - Availity Essentials
- **Paper:**
  - Horizon NJ Health, Claims Processing Department, PO BOX 24078, Newark, NJ 07101-0406

Adjudication & processing

- Horizon NJ Health will pay clean claims as follows:
  - within **15 days** - for electronic
  - within **30 days** - for paper



Denials & Appeals

- To submit a claim dispute/inquiry:
  - Please contact Provider Services at **1-800-682-9091** or;
  - Submit a Claim Investigation inquiry via **Availity Essentials**
- To submit a claim appeal to dispute the amount you have been reimbursed, send a HCAPPA form **within 90 days of denial** and any supporting documentation to us using one of:
  - Horizon NJ Health, Claims Appeals, PO Box 63000, Newark, NJ 07101-8064 or;
  - Fax: 1-973-522-4678

1. Hospitals, physicians and health care professionals should send EDI claims

NEW JERSEY HUMAN SERVICES

Horizon NJ Health | Billing NPI requirements

Individuals / Group

Independently

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

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
(Supervised billing is not permitted)

- B: Supervised billing is not permitted
- R: Supervised billing is not permitted

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
(Supervised billing is not permitted)

- B: Supervised billing is not permitted
- R: Supervised billing is not permitted

Licensed Facility / Agency

C

Facility
Fully licensed

e.g., OTP Clinics, Outpatient/Substance Use Disorder Facilities, Freestanding Psychiatric Hospitals

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

James
Licensed under supervision[2]

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

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

Alex
OBAT navigator or Peer

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

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

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

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), Psychiatrists, Psychologist, and Advanced Practicing Nurse (Psychiatric Nurses); 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) - (Supervised billing is not permitted)

B Billing provider | R Rendering provider | C Organization credentialed | C Individually credentialed

Horizon NJ Health | Billing required fields – CMS 1500 & UB-04

Ref doc

Claim Form Required Fields

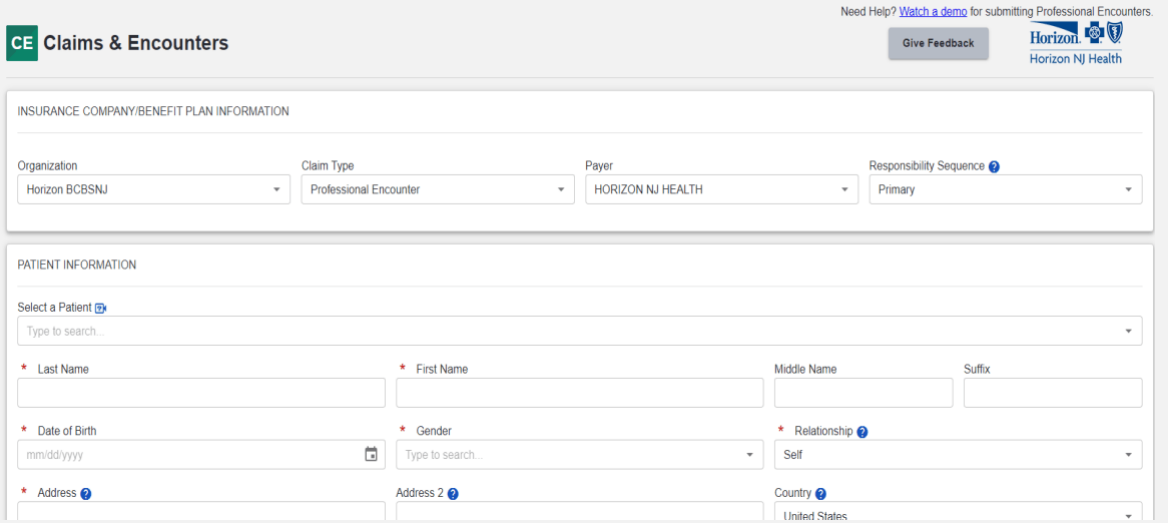
CMS 1500 required fields

1a. Insured's ID #	Horizon NJ Health ID (YHZ #)
2. Patient's Nam	
3. Patients DOB	
3. Patients SEX	
4. Insured's Name	Required if Patient relationship is not Self or blank
5. Patient's Address	
21. Diagnosis	
22 b. Original Ref No	Required if 22 a re-submission Code is 7 or 8
24 a. DOS	at least 1 line is required
24 b. Place of Service	at least 1 line is required
24 d. Procedure /CPT code	at least 1 line is required
24 e. Diagnosis pointer	at least 1 line is required
24 f. Charges	at least 1 line is required
24 g. Days/Units	at least 1 line is required
24 j. Rendering Provider ID	at least 1 line is required
25. Federal TIN SSN or EIN	
26. Patient Account No	
28. Total Charge	
31. Clinical Signature Date	
33. Billed By	
33 a. NPI	

CMS 1450 ('UB-04') required fields

1. Provider Name and Address	
3 a. Patient control number	
3 b. Medical record number	
4. Type of Bill	
5. Fed. Tax No	
6. Statement Period	
8. Patient Full Name	
9. Patient Full Address	
10. Patient Birthdate	
11. Patient Sex	
12. Admission Date	Required on Inpatient bill type
13. Admission Hr	
14. Admission Type	
15. Admission Source	Required except on bill type 014
17. Discharge Status	
39 - 41. Value Code	Required on bill types 032x, 033x, 034x, and 072x or; bill types 013x, 022x, 023x, 083x, and 085x when submitted with Rev 540 and HCPCS A0426-A0434
42. Revenue Codes	At least 1 line is required
43. NDC Code / Units	Required on Inpatient bill types with Rev 631-637 and Procedure code beginning with "J" or "Q"
45. Service Date	Required on Outpatient bill types
46. Service Units	
47. Total Charges	
50. Payer name	
51. Health Plan ID	Horizon NJ Health ID (YHZ #)
52. Release of Info Indicator	Required if Box 50 is populated
56. NPI	
58. Insured's Name	Required if Box 59 is not "18"
59. Patient's Relationship to Insured	
64. Document Control Number	Required if Frequency code is "7 "or "8"
67. Principal Diagnosis Code	
69. Admitting Diagnosis Code	Required on Inpatient bill types
71. DRG	Required on bill type 011x
74. Principal Procedure Code/Date	Required when Rev 099, 360-362, 367, 369, 370, 374, 379, 490, 499, 710, or 719 submitted
76. Attending Provider Name / NPI	

Horizon NJ Health Claims portal demo

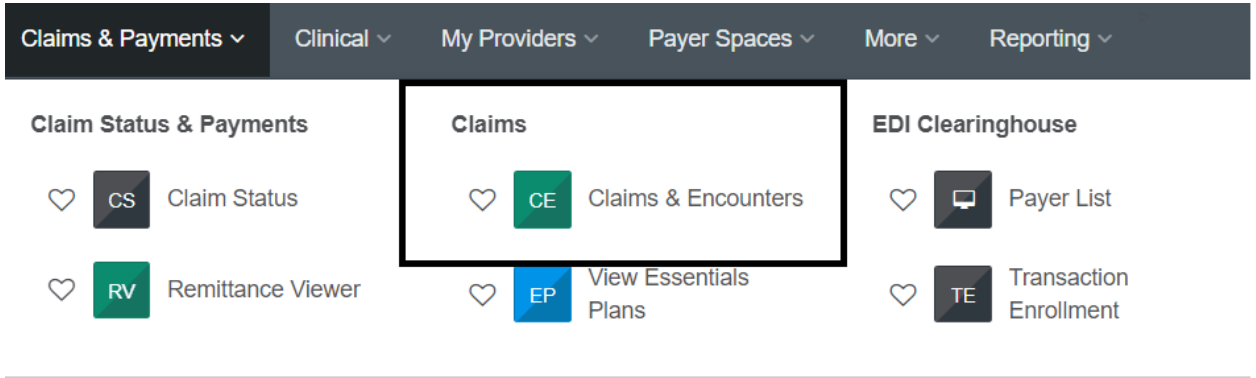


Submit claims using HNJH Portal
https://www.availity.com/

Watch a demo (requires registration)

NEW JERSEY HUMAN SERVICES

Availity Demo

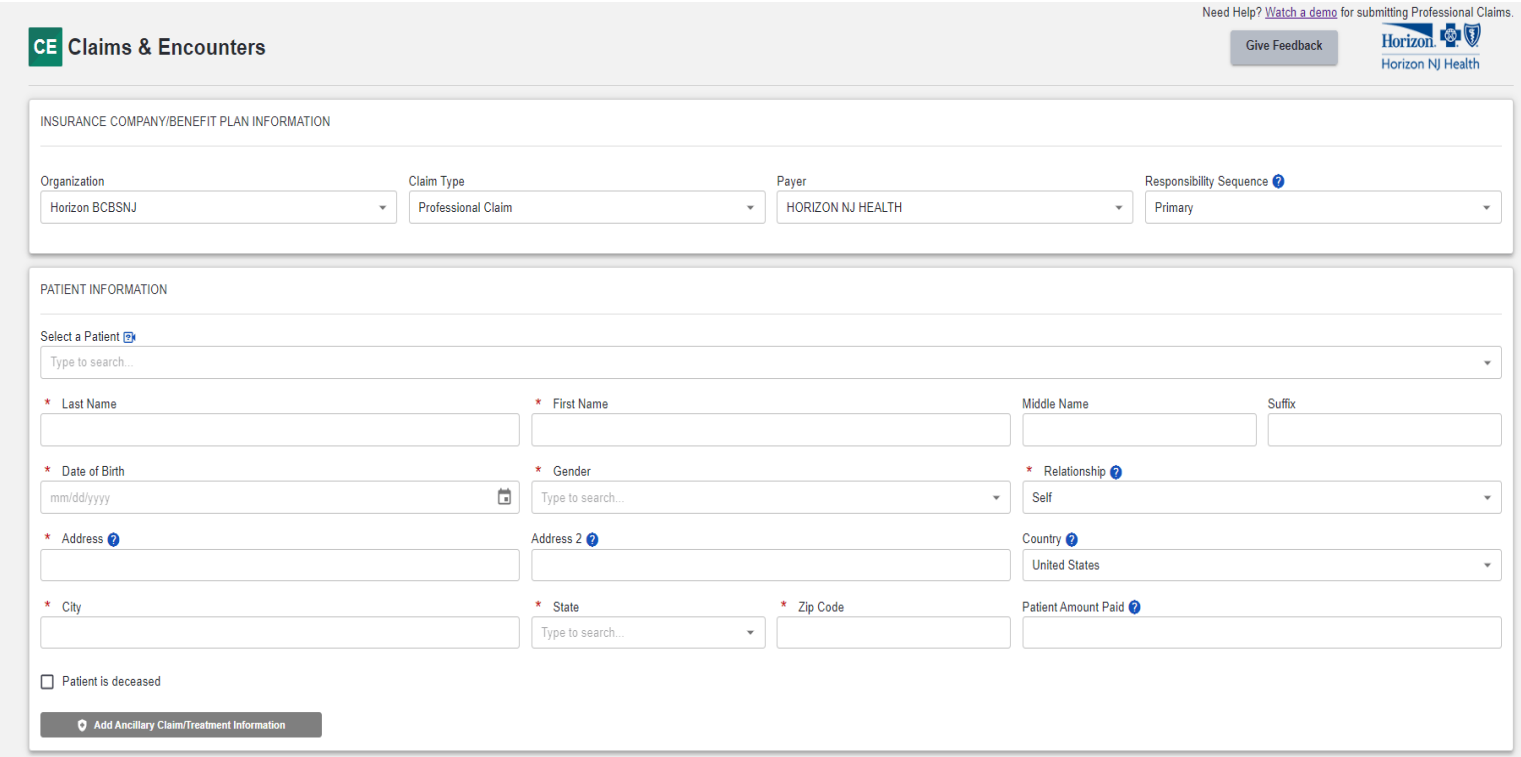


Availity Demo

Step 1

Plan and Patient Information

The user will fill out the insurance information as well as the type of claim they are filing (professional claims are the only claim option available). Next, they will fill out the patient information.



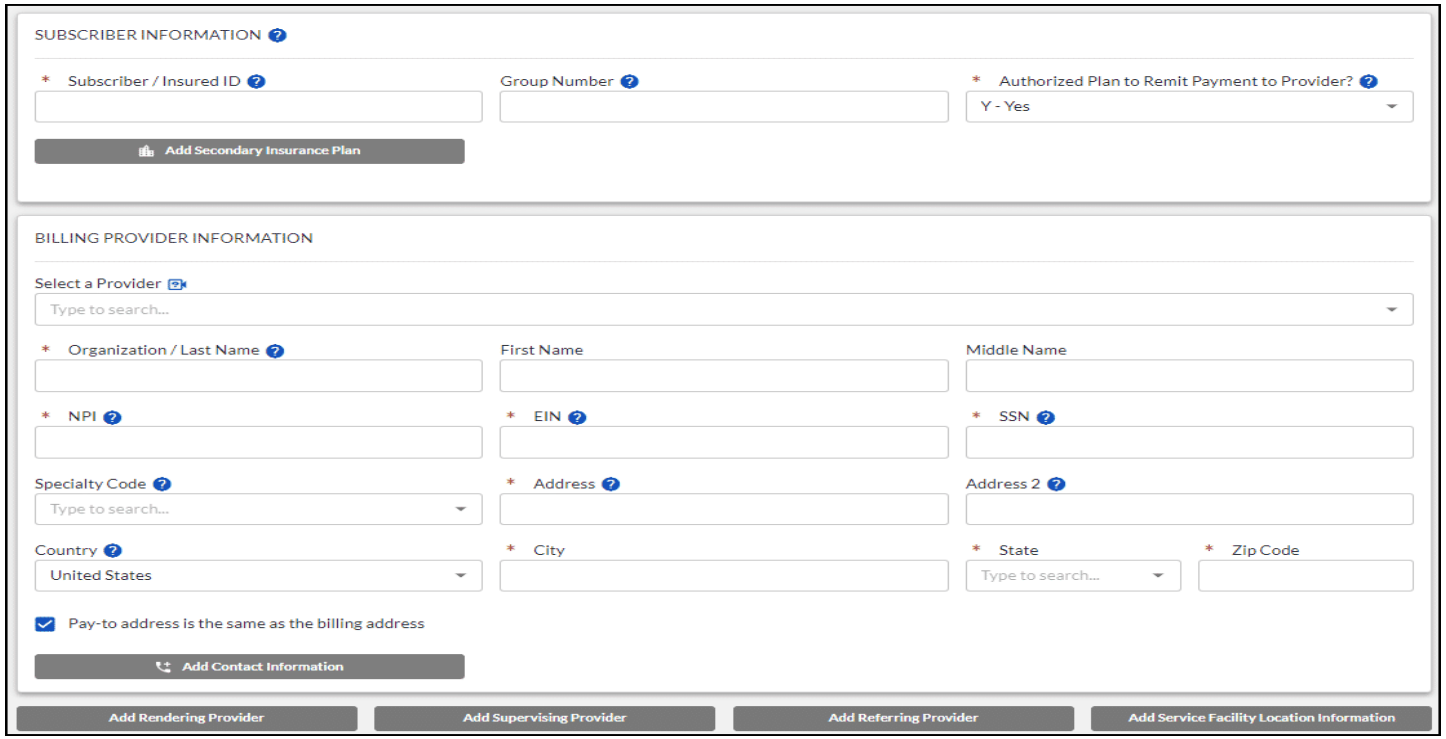
NEW JERSEY HUMAN SERVICES

Availity Demo

Step 2

Subscriber and Provider Information

Next, they will add the subscriber information and the provider information. They will be able to select the providers under their organization from the drop-down menu. They also have the option of adding rendering, supervising, referring providers as well as servicing facility. Please click “Add Rendering Provider” which is the dark gray box on the bottom right corner of this screenshot.



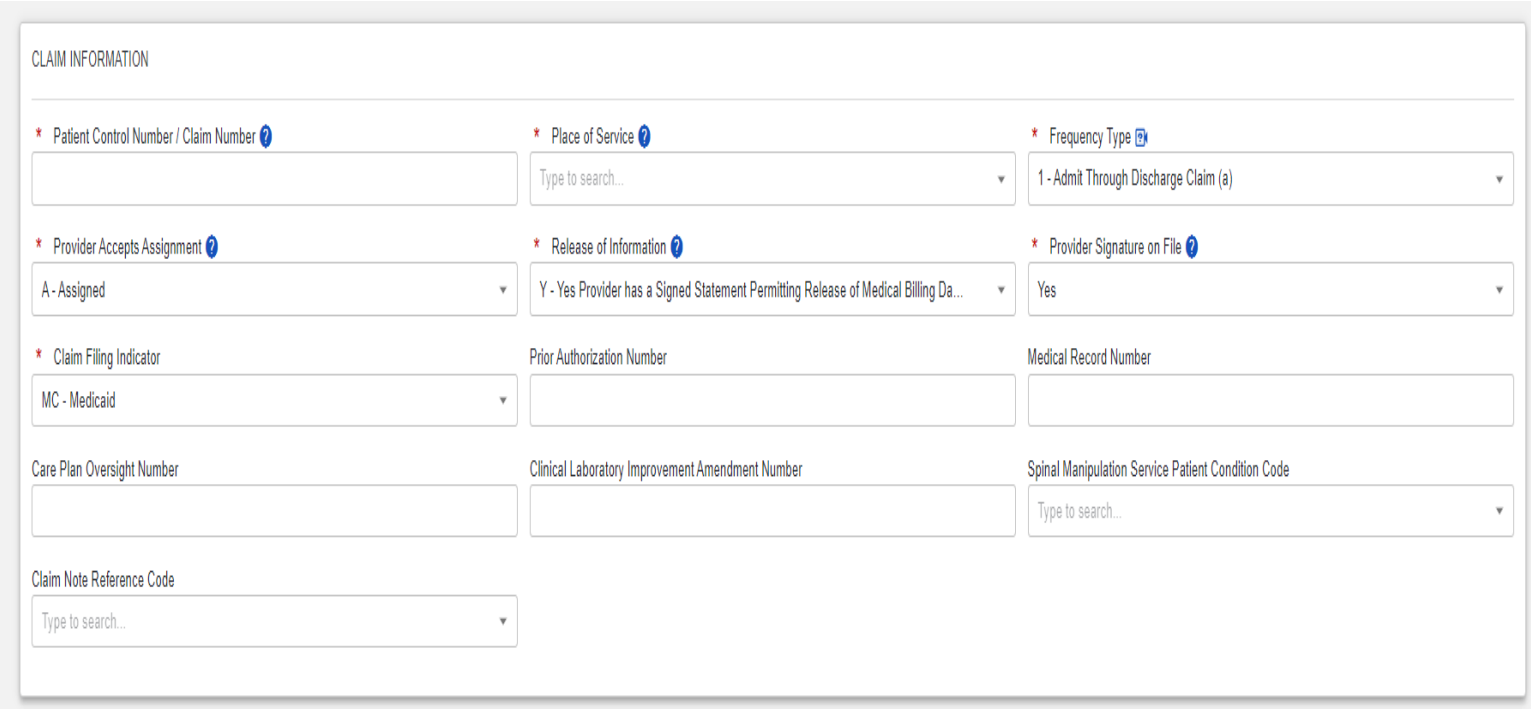
NEW JERSEY HUMAN SERVICES

Availity Demo

Step 3

Claim Information and Diagnosis Codes

Additional claim information will be entered here. You can see fields for Patient Account Number, Place of Service, Assignment of Benefits, Diagnosis Codes and more.



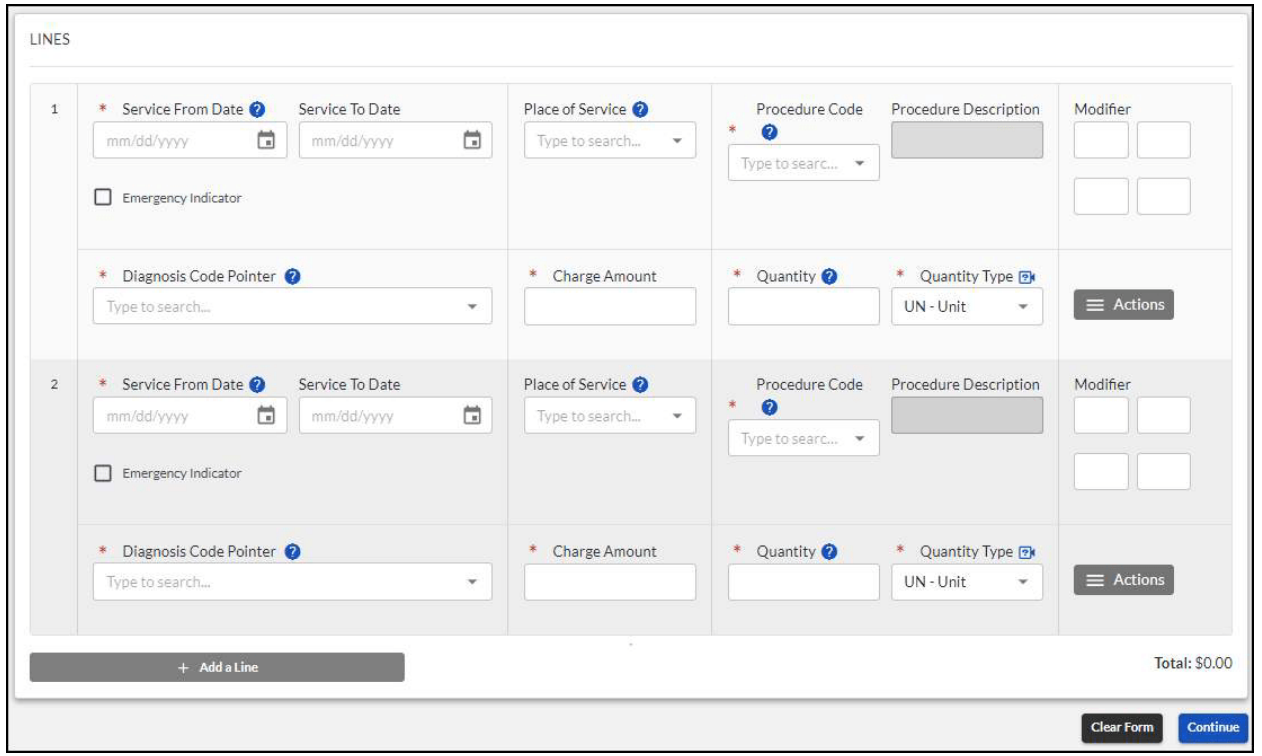
NEW JERSEY HUMAN SERVICES

Availity Demo

Step 4

Line Detail Information

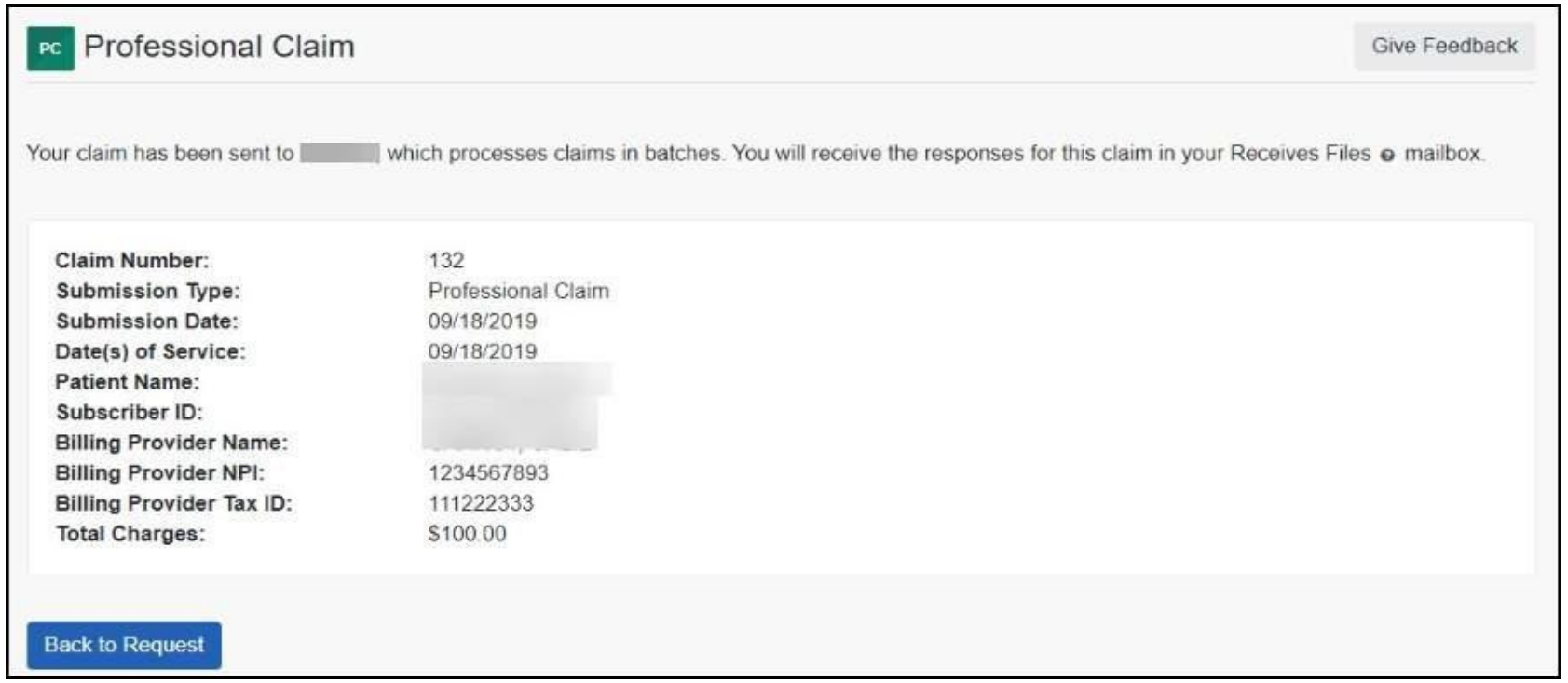
Here the provider will enter the service line information including procedure codes, dates of service, modifiers and charges. When all lines are completed, they can submit their claim.



Availity Demo

Results

The user will receive confirmation that their claim was submitted successfully.



Horizon NJ Health| Upcoming trainings and resources

Upcoming trainings

Behavioral Health Integration Credentialing and Contracting Process
Overview of covered benefits, credentialing process, Horizon NJ Health participation

Behavioral Health Integration Training
Overview of covered benefits, claims submissions and other helpful resources

When	Training Topic	Target Audience	Link
10/29/2024; 10:00am	Behavioral Health Integration Credentialing and Contracting Process	Professional	Register
		Ancillary	Register
11/7/2024; 2:00pm	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register
11/19/2024; 11:00am	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register
12/11/2024; 11:00am	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register
12/17/2024; 1:00pm	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register
1/8/2025; 10:00am	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register
1/16/2025; 3:00pm	Behavioral Health Integration Training	Professional	Register
		Ancillary	Register

Additional resources

For further information, please contact:

BHMedicaid_@horizonblue.com

Links:

- Claims Submission Link
- Claims Policies and Procedures
- HNJH Provider Manual
- HNJH Quick Reference Guide
- New Provider Orientation

United Healthcare

Presenter

Scheanell Holland

NJ Network Manager

NEW JERSEY HUMAN SERVICES

UnitedHealthcare | Meet our claims & billing team

Lisa Bahr
Director Claims

Wendy Salas
Associate Director Claims

Wesley Lopez Mckenzie
Manager Claims

Leigh Huffman
Sr. Claims Business Processor Consultant

UnitedHealthcare | Our claims process

Required fields | Claims submission | Adjudication & processing | Denials & Appeals

Required but not limited to the following:

- Member's name's
- Identification Number
- Date of birth
- Providers Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- Taxonomy code
- Complete diagnosis (ICD-10-CM)
- Value code
- Rate code
- Revenue code
- Modifiers
- Date of service
- Duration / units

Electronic Submission

- Electronic Data Interchange (EDI)
  - All claims should be billed using either EDI 837I (Institutional) / UB04 or EDI 837P (Professional)
  - Payer ID: 87726
- Provider Express.com
  - Outpatient, clinicians and groups billed on 1500 form

Paper Submission

- Original 1500 version 02/122 (formerly CMS-1500)
- UnitedHealthcare Community Plan P.O. Box 5250, Kingston, NY 12402

- Claim received by UHC
- Routed to the appropriate claim platform
- Clean claims may:
  - auto adjudicate; or
  - route to a claim's processor for manual review and processing
- Claim status can be checked via the Provider Express Portal- Claim Inquiries & Claim Adjustments (video)
- Claims must be submitted within **180 days** from the date of service
- If coordination of benefits UHC secondary payer – 60 days from the date of the primary insurer's EOB or 180 days from the date of service whichever is later

- Online via UHCprovider.com
- Mail

Filing time frame for Appeals

- NJ FamilyCare/ Medicaid: Within 90 days from the determination date
- UHC Dual Complete NJ-Y001 (HMO D-SNP):
- Par providers should follow contract
- Non-par providers must be received within 60 days.

Most common denial reasons:

- **CO256** - Provider not contracted with UHCCPNJ
- **OA18** - Duplicate Claim submitted and previously processed
- **OA23** - Coordination of Benefits

UnitedHealthcare | Billing requirements

Individuals / Group

Independently

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

Under Group

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

Mary
Fully licensed[1]

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

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

James
Licensed under supervision[2]

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

- B Type 2 NPI/EIN
- R Type 1 NPI of OBAT prescriber

Alex
OBAT navigator or Peer

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

Sarah
Not licensed

e.g., Interns or individuals holding a Masters of Counselling

Licensed Facility / Agency

C

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

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Fully licensed[1]

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

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

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

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- R Type 2 NPI

Alex
Peer

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

Sarah
Not licensed

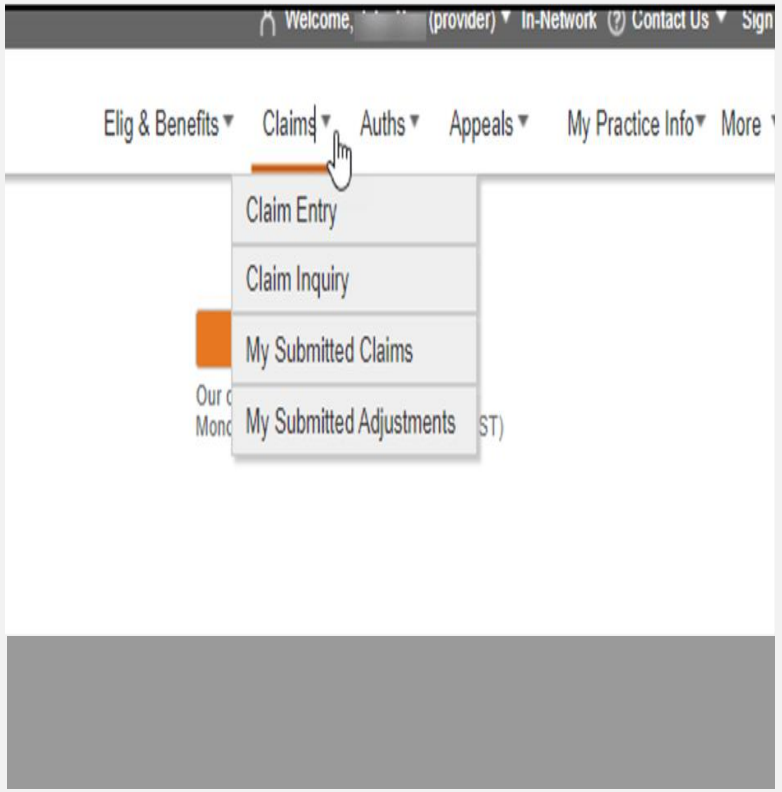
e.g., Interns or individuals holding a Masters of Counselling

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

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 | C Organization credentialed | C Individually credentialed | R Listed on roster

UnitedHealthcare Claims portal demo



Submit claims using Providerexpress.com
[Claim Entry on Provider Express]

NEW JERSEY HUMAN SERVICES

UnitedHealthcare | Upcoming trainings and resources

Upcoming training

When	Link	Training Topic	Audience
2024 • Nov 6, 10:00-11:00am • Nov 19, 1:00-2:00pm • Dec 3, 2:00-3:00 pm • Dec 19, 11:00-12:00pm • **2025** • Jan 7, 10:00-11:00am • Jan 15, 2:00- 3:00pm	 Register Register Register Register Register Register	**Provider Orientation** Topics include NJ behavioral health benefit design, credentialing, clinical and utilization requirements, case management, billing & claims, appeals, Provider portals	Behavioral health providers

Additional resources

For further information on submitting claims with us, please contact:

- Claims Provider Service line: **1-888-362-3368**

Links:

- Claims Submission Portal: Optum - Provider Express Home
- Provider Manual: New Jersey Medicaid Provider Network Manual Addendum (providerexpress.com)
- Quick Reference Guide: Behavioral Health Quick Reference Guide (providerexpress.com)
- New Provider Orientation: NJ Medicaid Mental Health and Substance Abuse Provider Training 2024 (providerexpress.com)
- Claim Adjustment Reason Codes (CARC)- https://x12.org/codes/claim-adjustment-group-codes
- Remittance Advice Remark Codes (RARC)- https://x12.org/codes/remittance-advice-remark-codes

Wellpoint

Presenter

Rhonnda Talton

Provider Network Manager, Sr.

NEW JERSEY HUMAN SERVICES

Wellpoint | Meet our claims & billing team

Jason Friedman
Director, Provider Solutions

Eyreny Mekhaiel
GBD State Operations Director

Michael Giaimo
Business Change Manager, Sr.

Wellpoint | Our claims process

Required fields

- Claims must include:
  - member information
  - CPT-4, HCPCS or rev codes
  - ICD-10 Diagnosis codes
  - rendering provider NPI
  - tax ID
  - authorization #
  - NDC#
  - itemized invoices
  - other pertinent information

Claims submission

- Claims are submitted via www.Availity.com
- Claim can be mailed to:
  - Wellpoint NJ Claims Dept, PO Box 61010, Virginia Beach, NJ 23466-1010

Adjudication & processing

- Claims can be tracked via Availity.
- Claims are processed within 15 days.

Denials & Appeals

- A claim might be denied for member termination, no authorization, incorrect billing codes, missing NDC#, or COB
- Providers can appeal the claim via:
  - Availity
  - Written letter (same address as submission).

Wellpoint | Billing requirements

Individuals / Group

Independently

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

Under Group

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

Mary
Fully licensed[1]

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

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Licensed Facility / Agency

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B Billing provider | R Rendering provider | C Organization credentialed | C Individually credentialed | R Listed on roster

Wellpoint Claims portal demo

Availity®

Submit claims using Availity

NEW JERSEY HUMAN SERVICES

Wellpoint | Upcoming trainings and resources

Upcoming trainings

Date	Time	Topic	Link
November 20	11 AM	NJ Medicaid Carve-in Provider Orientation	Register
December 12	3 PM		
December 16	3 PM		
December 18	11 AM		
January 14	11 AM		
January 23	2 PM		

Additional resources

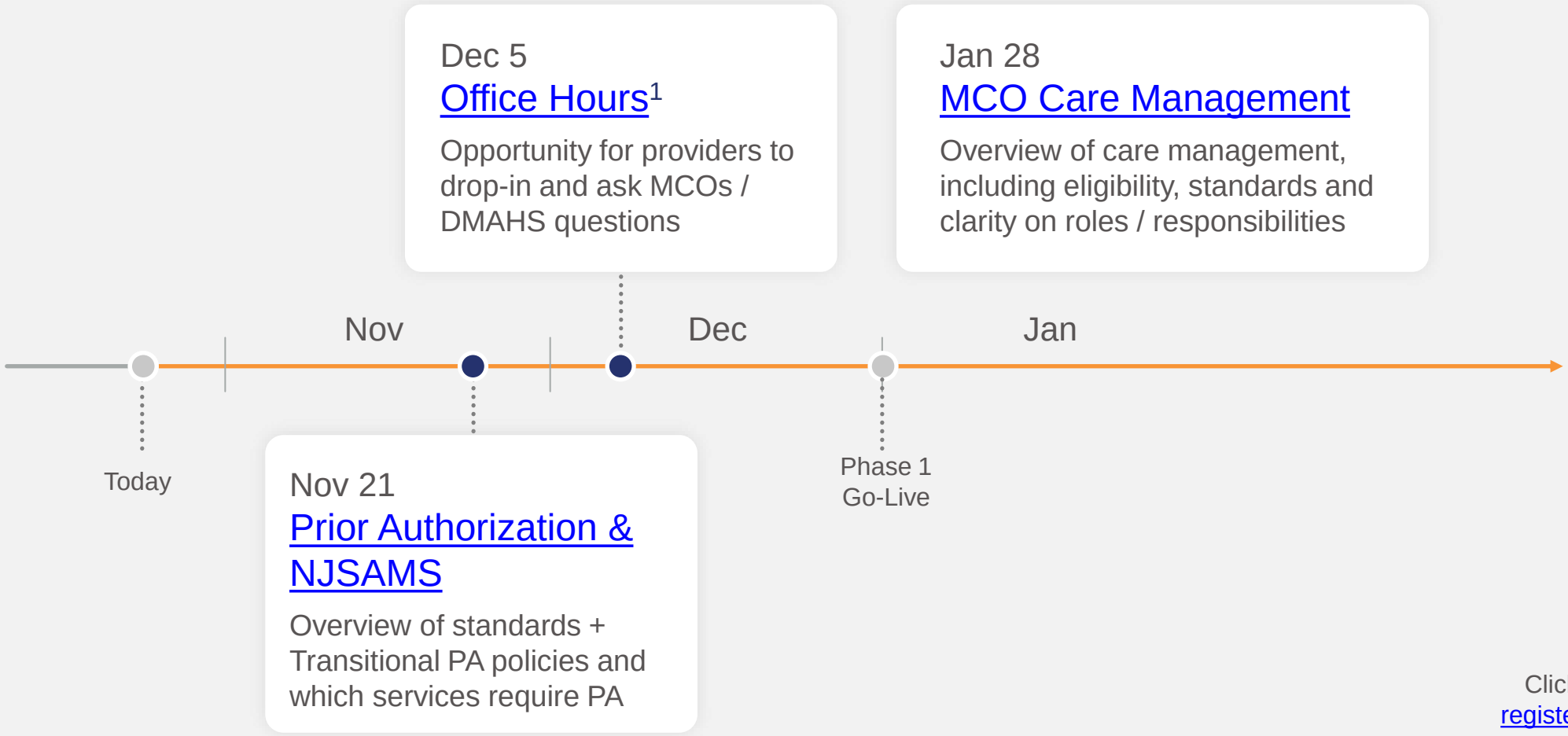
For further information on submitting claims with us, please contact:

Availity Support
1-800-AVAILITY (1-800-282-4548)
Create a Case / Chat with Support

Links:

- Claims Submission Portal
- Wellpoint Provider Manual
- Wellpoint Quick Reference Guide
- Wellpoint BH Quick Reference Guide
- New Provider Orientation

Register for upcoming DMAHS sessions



Click on link to register for training

1. DMAHS in the process of determining appropriate format – hybrid, in person or online

NEW JERSEY HUMAN SERVICES

Next steps and key contact information

Next steps

1. Review DMAHS Claims guidance included in provider readiness packet
2. Reach out to DMAHS if you have any general claims questions
3. Reach out to MCOs if you have questions which are specific to their requirements and / or processes

Contact information

DMAHS for general claims questions

Dmahs.behavioralhealth@dhs.nj.gov

Behavioral Health Integration Stakeholder Information

MCOs for specific questions

Refer to contact information in each MCOs round robin presentations

Q&A

DMAHS or MCO claims questions


NEW JERSEY
HUMAN SERVICES

Appendix

Common Provider Errors

Fidelis Care

Horizon

United Health Care

Wellpoint

NEW JERSEY HUMAN SERVICES

Common Provider Errors

Common provider errors leading to denials (I/II)

#	Error	How to avoid
A	Incomplete claim submission	• Use a **checklist** to ensure all required fields are completed • Implement **Electronic Health Record (EHR)** system that flags incomplete sections
B	Incorrect diagnosis or procedure codes	• **Double-check coding** before submission. • Use **coding software** or **cross-referencing tools** that align diagnosis with procedure codes
C	Missing prior authorization	• Ensure all services that require prior authorization are pre-approved. • Utilize **automated tracking systems** to manage and confirm authorizations
D	Late claim submission	• Set **internal deadlines** well ahead of official submission deadlines. • Use **reminders** or automated billing systems to track submission timelines and avoid delays.
E	Duplicate billing	• Implement billing software that **flags duplicate claims** before submission • Establish a **review process** to ensure each service is only billed once

Common provider errors leading to denials (II/II)

#	Error	How to avoid
F	Benefit limit exceeded	• Check **patient benefit limits** before delivering the service • Use billing software that alerts staff when a benefit is close to being exhausted
G	Services not included in MCO benefit	• Review the **patient's benefit plan** to confirm coverage • Know the **out-of-network claim process** for the MCO if applicable
H	Incorrect claim submission address	• Regularly **update records** with the correct submission address for all MCOs • Use **address validation tools** in the billing system to confirm the address before submission
I	Invalid provider ID number	• Keep a **centralized and regularly updated record** of provider IDs • Use **validation checks** in the billing system to alert staff if an invalid ID is entered
J	Incorrect patient information	• Verify **patient demographics** at every visit to ensure accuracy • Use **EHR systems** to access most current patient information and prevent manual errors

Fidelis Care

Fidelis Care | Billing requirements – Notes

Individuals / Group

Notes on filling out CMS 1500

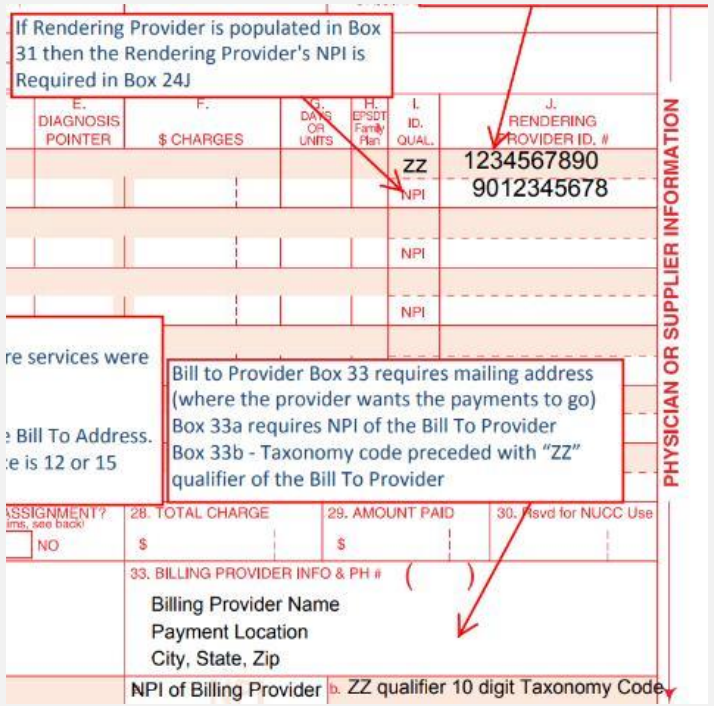
- Rendering Provider NPI should be entered in box 24J
  - You do not have to enter NPI in box 24J if box 31 and 33 are the same
- Box 31 is for Rendering Provider's signature: Last Name, First Name
- Box 32 Address MUST be physical address where services were rendered.
  - Address can NEVER be a POC Box
  - Address is required when different from the Bill To Address
  - Address is not required if the place of service is 12 or 15 (Home or Mobile Unit)
- Box 33 is Bill to Provider: requires mailing address (where provider wants the payments to go)
- Box 33a requires NPI of the Bill to Provider
- Box 33b is for Taxonomy code preceded with "ZZ" qualifier of the Bill to Provider

Licensed Facility / Agency

C

Notes on filling out CMS 1500

- Rendering Provider NPI should be entered in box 24J, this will differ from billing NPI in box 33.



B Billing provider

R Rendering provider

C Organization credentialed

C Individually credentialed

R Listed on roster

Horizon

Horizon NJ Health | Clearinghouses affiliated with Horizon

837GPP

Partner Name	Sender ID	Event Type
CLAIMMD Professional	NJHP001	837GPP
CLAIMMD Professional	NJHP001	837GPP
CORTEX EDI Professional	NJHP004	837GPP
TRANSACT-EDI INC Professional	NJHP007	837GPP
WAYSTAR INC Professional	NJHP009	837GPP
OFFICE ALLY INC Professional	NJHP011	837GPP
AVAILITY LLC Professional	NJHP015	837GPP
TPS Professional	NJHP018	837GPP
FINTHRIVE Professional	NJHP022	837GPP
ABILITY Professional	NJHP024	837GPP
AVAILITY LLC PORTAL	NJHP028	837GPP
NJH VVC HOLDING CORP	NJHP048	837GPP
NJH CARECLOUD INC	NJHP050	837GPP
NJH QUADAX INC	NJHP062	837GPP

837GPI

Partner Name	Sender ID	Event Type
WAYSTAR INC Institutional	NJHP010	837GPI
TPS Institutional	NJHP019	837GPI
FINTHRIVE Institutional	NJHP023	837GPI
ABILITY Institutional	NJHP025	837GPI
NJH VVC HOLDING CORP	NJHP049	837GPI

Ref doc

EDI
aringhouses for 83

Horizon NJ Health | Billing requirements – Notes (I/II)

Individuals / Group

Notes

- Professional claims must be submitted on a **CMS 1500** form include the rendering and billing NPI as well as the EIN.
- Claims for the newly carved in services should be submitted to Horizon NJ Health for dates of service beginning 1/1/2025
- Claims for newly carved in services will follow the same procedures as for services already covered by Horizon NJ Health
- Providers are encouraged to submit claims electronically.
- Horizon NJ Health's payer ID: **22326**
- Horizon NJ Health will pay clean claims as follows:
  - Electronic Claims will pay within 15 days
  - Paper Claims will pay within 30 days
- HNJH members do not have copayments and/or coinsurance

Licensed Facility / Agency

C

Notes

- Facility/clinic claims must be submitted on a **CMS 1500** form unless your contract states otherwise. The claim must include the facility/clinic EIN and NPI in both the billing and rendering fields
- Claims for the newly carved in services should be submitted to Horizon NJ Health for dates of service beginning 1/1/2025
- Claims for newly carved in services will follow the same procedures as for services already covered by Horizon NJ Health
- Providers are encouraged to submit claims electronically.
- Horizon NJ Health's payer ID: **22326**
- Horizon NJ Health will pay clean claims as follows:
  - Electronic Claims will pay within 15 days
  - Paper Claims will pay within 30 days
- HNJH members do not have copayments and/or coinsurance

Horizon NJ Health | Billing requirements – Notes (II/II)

Individuals / Group

Notes

- Claims must be submitted within **180 calendar days** of the date of service
- HNJH claims must be submitted through **Availity Essentials** or **Horizon NJ Health EDI**
- HNJH claims must include your taxonomy code. For CMS-1500 professional claims:
- The taxonomy code should be identified with the qualifier “ZZ” in the shaded portion of box 24i
  - The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level
  - Claims that do not contain these codes cannot be processed
  - Additional information is available on the HNJH’s Provider Administrative Manual, Section 9.2.3

Electronic Funds Transfer

- Register and view details on EFT at the following link
- https://www.horizonnjhealth.com/for-providers/resources/edi-eft-transactions/electronic-funds-transfer-eft

Licensed Facility / Agency

C

Notes

- Claims must be submitted within **180 calendar days** of the date of service
- HNJH claims must be submitted through **Availity Essentials** or **Horizon NJ Health EDI**
- HNJH claims must include your taxonomy code. For CMS-1500 professional claims:
  - The taxonomy code should be identified with the qualifier “ZZ” in the shaded portion of box 24i
  - The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level
  - Claims that do not contain these codes cannot be processed
  - Additional information is available on the HNJH’s Provider Administrative Manual, Section 9.2.3

Electronic Funds Transfer

- Register and view details on EFT at the following link:
- https://www.horizonnjhealth.com/for-providers/resources/edi-eft-transactions/electronic-funds-transfer-eft

Horizon NJ Health Payer ID: 22326

NEW JERSEY HUMAN SERVICES

United Health Care

UnitedHealthcare | Billing requirements – Notes

Individuals / Group

Notes

Applies to:

- Individually credentialed rendering / billing individually
- Group credentialed rendering / billing under group
- Group credentialed non-rostered rendering / billing under group

Billing for non-rostered group entity

- Claims are for services listed on your group contracted fee schedule
  - Group/agency name (Box 31)
  - The NPI number (Box 24J)
  - The group/agency name, address, and phone number (Box 33)
  - 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

Filing claims:

- Outpatient claims must be billed on 1500 form
- National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual National Uniform Claim Committee - 1500 Instructions (nucc.org)

Licensed Facility / Agency

C

Notes

Applies to:

- Facility credentialed rendering / billing under facility
- Agency / clinic credentialed rendering / billing under agency / clinic
- Agency / clinic credentialed licensed rostered rendering / billing under agency /clinic

Billing for facilities/agencies:

- Inpatient claims must be billed on a UB-04
- Centers for Medicare & Medicaid Services (CMS) 1450 UB-04 Claim Form Institutional paper claim form (CMS-1450) | CMS

Clean Claim Definition – for all provider types

- A claim with no defect or impropriety (including any lack of any required substantiating documentation) or 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

B Billing provider

R Rendering provider

C Organization credentialed

C Individually credentialed

R Listed on roster

Wellpoint

Wellpoint | Billing requirements – Notes

Individuals / Group

Notes

- Solo providers and Provider Groups submit claims with the Provider name, tax identification number, and rendering NPI number.
- Provider fills out the HCFA 1500 for office visits and OP services.
- Provider submits form in Availity
- Electronic claims are processed within 15 days
- Paper claims are processed within 30 days

Licensed Facility / Agency

C

Notes

- Facilities/Agencies bill under the tax identification number and facility/agency NPI number.
- Provider fills CMS 1450 form for IP services
- Provider submits form in Availity
- Electronic claims are processed within 15 days
- Paper claims are processed within 30 days

B Billing provider

R Rendering provider

C Organization credentialed

C Individually credentialed

R Listed on roster