



Provider Prior Authorization Training

NJ FamilyCare Behavioral Health Integration

NOVEMBER 21, 2024

Housekeeping



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



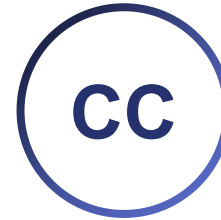
Use the “**raise hand**” function if you wish to speak



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



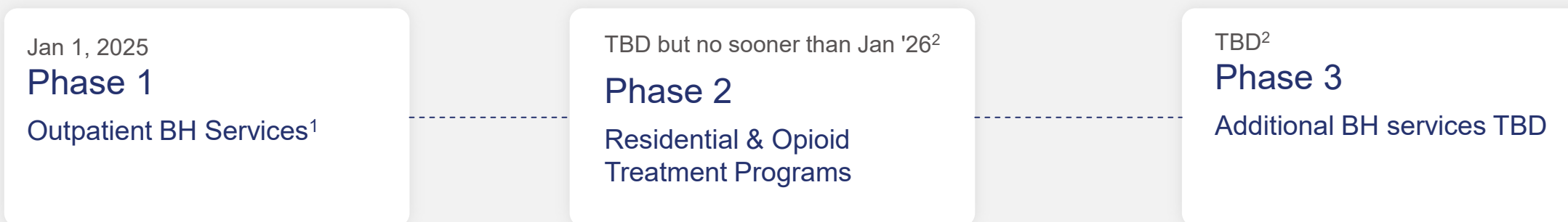
Materials and recording will be published and available on DMAHS website

Agenda

Welcome Megan Lisch, Center for Healthcare Strategies	9:00–9:05
Overview of BH Integration Shanique McGowan, BH Program Manager, DMAHS	9:05–9:10
Overview of PA and key standards Shanique McGowan, BH Program Manager, DMAHS	9:10–9:35
MH PA deep-dive Aetna, Fidelis Care, Horizon, UHC, Wellpoint	9:35–10:05
Additional resources and contacts Shanique McGowan, BH Program Manager, DMAHS	10:00–10:05
SUD PA deep-dive Vicki Fresolone, Manager of Integrated Services, DMHAS Nitin Garg, Director of IT, DMHAS Chandra Akenapalli, DMHAS	10:05–10:30

Reminder | BH Integration Overview

- NJ FamilyCare has two payment models: Fee For Service (FFS) and Managed care
- While physical health (PH) is billed to managed care organizations (MCOs), behavioral health (BH) services for the general population are currently billed FFS
- NJ is moving select BH services from FFS to managed care, meaning PH and BH services will be managed by a single entity
- Goals: (1) increase **access**, (2) focus on **whole person care**, and (3) provide the **right services**, in the **right setting**, at the **right time**
- 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

Planned services for each phase of BH integration

Phase 1– Outpatient BH¹ 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 Services²

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)

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

Five learning goals for today

By the end of today's training, you will:

- ☆ Be aware of recent **policy changes** improving the prior authorization (PA) process under managed care
- ☆ Understand the **high-level process** for submitting PA requests under managed care
- ☆ Know how to submit PA requests for **mental health** services
- ☆ Know how to use **NJSAMS** to submit PA requests for **substance use disorder (SUD)** services
- ☆ Identify **key contacts** and **resources** for ongoing support and information

Prior Authorization

Like FFS, providers are required to obtain approval from MCOs before delivering and being reimbursed for **certain services**

Goals

- ☆ **Medical necessity:** PA helps verify that the proposed treatment or medication is medically necessary and appropriate for the member's condition
- ☆ **Member safety:** PA ensures that prescribed treatments and medications are safe and effective for the member
- ☆ **Cost effectiveness:** PA helps guide the use of treatments that are both evidence-based and cost-effective, maximizing access to quality care for all member

Three key types of PA requests



Initial authorization

A PA requested **before** the start of a service or treatment



Concurrent / Extension authorization

A PA requested for the **continuation or extension** of a service already underway



Retroactive authorization

A PA that is submitted **post service** delivery and backdated to the first day of service

Intended for specific, exceptional circumstances¹

1. It is the responsibility of the provider to ensure authorization is obtained prior to service delivery

Recent policy changes improve PA process under managed care (I/II)

Transitional



Transfer all active PAs to MCOs

- All active authorizations with end dates after January 1, 2025, will be automatically transferred to MCOs



Auto-approval during transition

- MCOs required to auto-approve all services for the first 90 days of transition (until March 31, 2025)



Exempt services

- No prior authorization permitted for **mental health (MH)** and **substance use disorder (SUD) outpatient counseling and psychotherapy**



Urgency designation

- Designated certain services as urgent (e.g., SUD IOP)



Reduced turnaround times

- Reduced turnaround times for behavioral health services, including 24 hours for all urgent services – *more detail to come*

Recent policy changes improve PA process under managed care (II/II)



Retroactive authorization

- MCOs must allow submissions of authorizations within 5 days of service initiation; retroactive authorizations can only be denied for lack of medical necessity or eligibility



Minimum durations

- Set minimum durations to ensure adequate time for providers to complete assessments – [more detail to come](#)



Standardized required fields

- Standardized required fields for MH and SUD PA across MCOs – [more detail to come](#)



NJSAMS for SUD PA

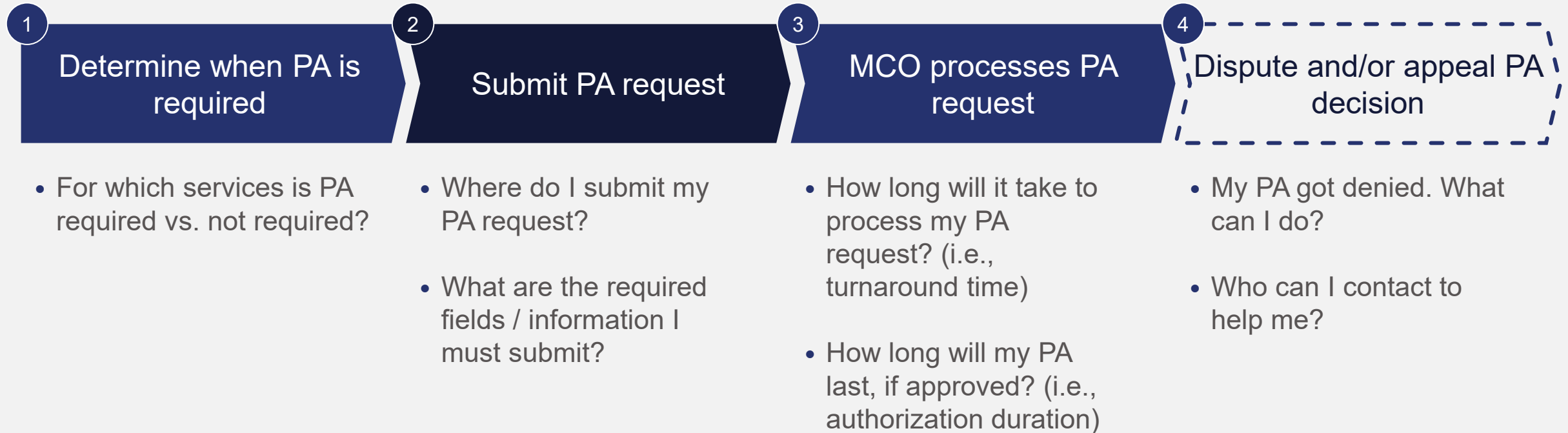
- Require MCOs to accept NJSAMS for all SUD PA requests to remove duplication in provider data entry – [more detail to come](#)



ASAM trainings

- Instituting annual training requirements on ASAM for MCO staff reviewing SUD PA requests, as well as inter-rater reliability testing to ensure consistent application of criteria across MCO UM staff

Four key steps in managed care PA



Similar across
MCOs

MCO variation

As needed

Phase 1 service PA requirements

✕ PA not required

MH

- Outpatient counselling and psychotherapy

SUD

- Outpatient counselling and psychotherapy



PA required

MH

- Partial Care (PC)
- Partial Hospital (PH)

SUD

- Partial Care (PC)
- Intensive Outpatient (IOP)
- Ambulatory Withdrawal Management (AWM)¹

1. Not required for Horizon

Auto-approved Phase 1 services

Purpose of submitting "administrative" (auto-approved) PA request is for MCO visibility and documentation

Until March 31, 2025



All MH and SUD services for the first 90 days of integration

Ongoing – for participating providers



All court ordered MH and SUD services



For ambulatory withdrawal management, auto-approval of 5 days for alcohol, opioids, and benzodiazepines use disorders

Summary of where to submit MH PA requests

Provider Portal
Preferred method

Call or Fax
Available if needed

Aetna	Availity Portal	Phone: 1-855-232-3586 (follow prompts to BH) Fax: 1-844-404-3972 (include PA form)
Fidelis Care	Fidelis Care Provider Portal	Phone: 1-888-453-2534 Fax: 1-888-339-2677 for Outpatient and 1-855-703-8082 for Inpatient
Horizon	Availity Portal	Phone: 1-800-682-9094 Fax: 1-732-938-1375 or 1-855-241-8895 for Outpatient
United	Provider Express	Phone: 1-888-362-3368 (Enter TIN#, select option 3, enter member ID, select option for MH)
Wellpoint	Availity Portal	Phone: 1-833-731-2149 (Provider Services) Fax: 1-844-451-2794 for Inpatient Medicaid and Urgent Services; 1-844-442-8007 for OP Medicaid ¹

For members with presumptive eligibility, MH PA gets submitted to the county [Medical Assistance Customer Centers \(MACC\)](#) offices.

SUD PA requests

In general, SUD PA requests for Phase 1 services are to be submitted in NJSAMS

(more detail to come)

1. Medicare lines also available: Outpatient Medicare – 844-430-1703 and Inpatient Medicare and Urgent Services – 844-430-1702

Required fields for complete MH PA request

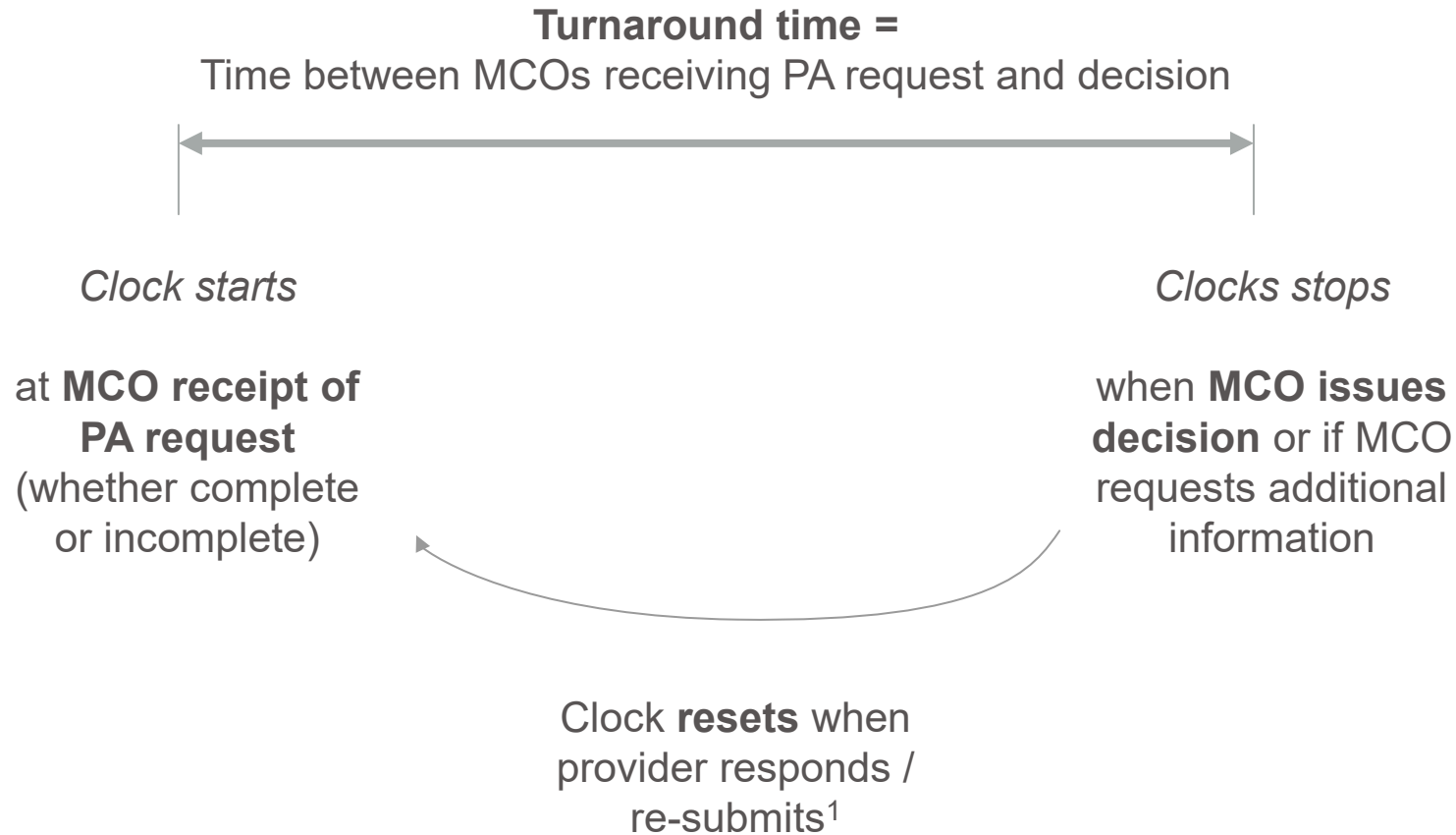
Note: Required fields for complete SUD PA will be shared later in presentation

Category	Required fields
General information	<ul style="list-style-type: none"> • Non-urgent vs. urgent (& clinical reason for urgency) • Type of request (initial vs. extension, renewal, or amendment)
Patient information	<ul style="list-style-type: none"> • Name, phone #/address, DOB, member ID and Medicaid #
Provider information	<ul style="list-style-type: none"> • For both requesting provider/facility and servicing provider or facility: <ul style="list-style-type: none"> - Name, NPI, Specialty, Contact info (phone, address, email), TIN - PAR vs. OON
Services requested	<ul style="list-style-type: none"> • Plan of care • CPT or HCPCS code(s) and units • MH treatment requested with frequency / length, start / end date • Diagnosis description (ICD) & code • Checkmark for level of care required
Clinical documentation	<ul style="list-style-type: none"> • Brief clinical history • Present clinical status (incl. presenting symptoms, medications used/medication plan) • Risk of harm to self or others • Criteria / level of care utilized in past 12 months • Discharge plan (incl. planned discharge level of care, barriers to discharge, expected discharge date)

The State of New Jersey has established a policy requiring MCOs to standardize these fields as the minimum necessary for a complete PA request

MCOs may request additional information or fields but a PA request will be deemed complete as long as these required fields are accurately submitted

Turnaround time starts at PA receipt and ends when MCO issues decision



Urgent PA Example:

- Provider submits incomplete PA for MH acute partial hospital on Tues at 12pm – **0 hrs**
- MCO requests additional information at 5pm (*clock stops*) – **5 hrs**
- Provider submits amendment on Thurs at 9am (*clock resets*) – **0 hrs**
 - MCO has until 9am Fri to make decision (24 hour turnaround)
- Makes decision on Fri at 6pm (*clock stops*) – **9hrs**

Total turnaround time = **9hrs**

(Yellow = elapsed turnaround time)

¹For urgent requests, the clock resets upon MCO receipt of additional information according to prescribed timelines, but with a new turnaround time cap of 48 hours from time of additional information receipt

Maximum turnaround time of a PA request depends on urgency designation



Urgent

For outpatient services:

- **24 hours** on business days and
- **1 business day on weekends / holidays¹ but not to exceed 72 hours² from submission** (to account for provider-MCO weekend communication)

For inpatient / residential services:

- **24 hours**



Non-urgent

Turnaround time is **7 calendar days**

Turnaround time for modified denials, auto approvals, extension requests, and retroactive authorizations should follow turnaround time for **initial authorizations**

1. Holidays defined as those officially observed by New Jersey State; 2. Reduced to 48 hours if submission is a modified PA with additional info requested by MCO

Some services are always urgent, and others depend on admission method or provider / MCO discretion

	Always urgent	Can be urgent <i>If referred from inpatient, residential or ER screening</i>
MH	<ul style="list-style-type: none"> Acute partial hospital (APH) Inpatient psychiatric hospital care 	<ul style="list-style-type: none"> Partial hospital (PH) Partial care (PC) Adult Mental Health Rehabilitation (AMHR)
SUD	<ul style="list-style-type: none"> Ambulatory withdrawal management (AWM) Residential detoxification / withdrawal management (ASAM 3.7 WM) Intensive outpatient (IOP) Short term residential (STR) Inpatient medical detoxification 	<ul style="list-style-type: none"> Partial care Long term residential
	Already carved in	Phase 1 service Phase 2 service

Any service can additionally be classified as urgent by provider / MCO discretion

Minimum duration

DMAHS has worked with MCOs to set minimum initial authorization durations for certain BH services to ensure that members receive care for an appropriate amount of time and to give providers sufficient time to develop and implement a treatment plan

Service	<u>Minimum</u> Authorization Duration ¹
MH Acute Partial Hospital and Partial Hospital	14 days
MH Partial Care	14 days
SUD Partial Care and IOP	30 days
Short Term Residential (Phase 2 service)	14 days
Long Term Residential (Phase 2 service)	60 days

1. These are required minimums. MCOs can grant longer durations based on member needs at MCO's discretion

Right to appeal and request continuation of benefits

Step 0: Receive PA decision letter

If an initial or extension authorization is denied, members and providers will receive a letter from MCO

For extensions, MCOs must send notice 10 days before end of service authorization

The letter outlines:

- **MCO decision** to deny or reduce request
- **Steps to appeal** and continue services
- **Representation options**

Step 1: Request Appeal (starting with first level)

Members have **60 days** from the denial date on decision letter to appeal (verbally or in writing).

Members can request appeals on their behalf through providers or authorized representatives

Step 2: Request continuation of benefits

Members or representatives must request continued benefits:

- On or before the last day of current authorization; or
- Within 10 days of receiving the denial letter.

Example: If the letter arrives 5 days before authorization ends, request continuation within 5 days after receiving it

Three levels of appeal

- 1 **Internal Appeal:** Formal internal review by MCO
- 2 **External/IURO Appeal:** External appeal conducted by an Independent Utilization Review Organization (IURO)
- 3 **Medicaid Fair Hearing:** This can take place in parallel with external/IURO appeal or afterwards if decision is not in member's favor

MCO Round Robin



5 mins x 5 MCOs

- Introduce PA team
- How to submit MH claims using portal
- Share training information / additional resources



Aetna Better Health of NJ (ABHNJ)

Presenter



Alyxandra Llorens

LCPC, Manager, Clinical Health
Services

Aetna | Meet our Prior Authorization team



Vincenza Stone, LMHC
Clinical Team Lead

- Oversight of IP and PA authorizations
- SME for BH UM



Michele Cinkewicz
UM Clinical Consultant

- Inpatient Authorizations
- Rapid Readmission Pilot



Stephanie Haney, RN
UM Clinical Consultant

- Inpatient Authorizations



Cristina Defuria, LMFT
UM Clinical Consultant

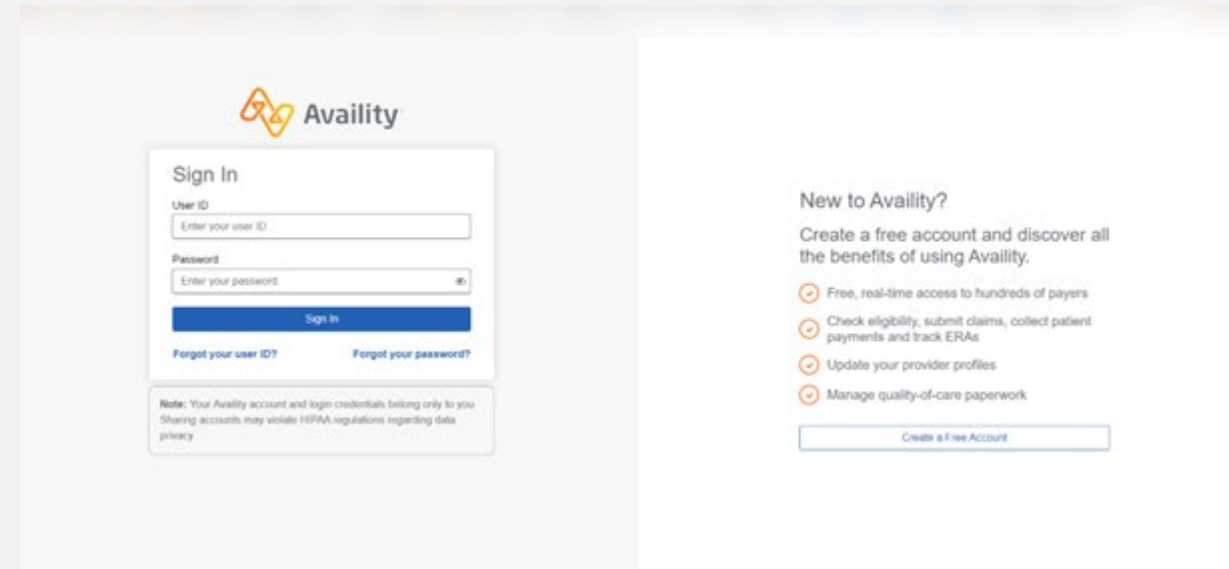
- Prior Authorizations



Maizel Quiva, MA, BCBA, LBA
UM Clinical Consultant

- ABA Authorizations

Aetna MH PA requests using our portal



The screenshot shows the Availity portal interface. On the left, there is a 'Sign In' section with fields for 'User ID' and 'Password', a 'Sign In' button, and links for 'Forgot your user ID?' and 'Forgot your password?'. Below this is a note about account security. On the right, there is a 'New to Availity?' section with a description of the portal's benefits, a list of features, and a 'Create a Free Account' button.

Availity

Sign In

User ID
Enter your user ID

Password
Enter your password

Sign In

[Forgot your user ID?](#) [Forgot your password?](#)

Note: Your Availity account and login credentials belong only to you. Sharing accounts may violate HIPAA regulations regarding data privacy.

New to Availity?

Create a free account and discover all the benefits of using Availity.

- ✓ Free, real-time access to hundreds of payers
- ✓ Check eligibility, submit claims, collect patient payments and track ERAs
- ✓ Update your provider profiles
- ✓ Manage quality-of-care paperwork

[Create a Free Account](#)

Submit PA using Availity Portal
[Access Availity Here](#)

Submitting Authorizations in Availity

1 Select Authorization Request

Home > Authorizations & Referrals

Authorizations & Referrals

Multi-Payer Authorizations and Referrals

- Authorization/Referral Inquiry
- Authorization Request** (highlighted)
- Authorization/Referral Dashboard

Additional Authorizations and Referrals

- Prior Authorization - Pharmacy Benefit Drugs (CoverMyMeds)
- New HAM React

2 Enter applicable info and click Next

Authorizations

SELECT A PAYER

Organization

Aetna Medicaid Administrators

Template(s) optional

No template selected

Select a template from the list or continue with Payer and Request Type fields.

Payer

AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

Request Type

Inpatient Authorization

Next

3 Enter the information for each asterisk being filled. Click Next

Start an Authorization Add Service Information Rendering Provider/Facility Add Attachments Review and Submit

Transaction Type: Inpatient Authorization
Organization: Aetna Medicaid Administrators
Payer: AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

PATIENT INFORMATION

Select a Patient (Enter one or more to search: patient name (first or last), DOB, or Member ID.)

Member ID *

Patient Date of Birth *

Relationship to Subscriber *

Self

REQUESTING PROVIDER

Select a Provider optional

Requesting Provider Type *

Provider

NPI *

Contact Name *

ABC

Contact Phone *

(555) 555-5555

Contact Fax *

(555) 555-5555

Next

4 Enter the information for the authorization. Click Next

Authorizations

Start an Authorization Add Service Information Rendering Provider/Facility Add Attachments Review and Submit

SERGIO Patient

Member ID: [redacted]
Date of Birth: [redacted]
Gender: Male
Eligibility Status: Active Coverage
Transaction Type: Inpatient Authorization
Group Number: NA
Organization: Aetna Medicaid Administrators
Plan / Coverage Date: NA
Payer: AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

SERVICE INFORMATION

Service Type *

Place of Service *

Admission Date *

Admission Type *

Quantity *

Quantity Type: Days

DIAGNOSIS CODE(S)

Diagnosis Code *

PROCEDURE CODE(S)

Procedure Code (optional)

MESSAGE

Provider Notes optional

Next

5 Enter the provider info and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer
Inpatient Authorization	Aetna Medicaid Administrators	AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

SERVICE PROVIDER ☐ Show Optional Fields

Select a Provider optional

Rendering Provider Role

NPI

SERVICE PROVIDER 2 ☐ Show Optional Fields

Select a Provider optional

Rendering Provider Role

NPI

FACILITY ☐ Show Optional Fields

Select a Provider optional

Rendering Provider Role

NPI

6 Add any attachments and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer
Inpatient Authorization	Aetna Medicaid Administrators	AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

ADD ATTACHMENT(S)

Attachments may be up to 80MB in size, but the total of all attachments cannot exceed 150MB.

Do not upload files which have embedded web links or information rights management. We will not be able to view them.

7 Verify all information and hit Submit

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender
Eligibility Status	Group Number	Plan / Coverage Date
Transaction Type	Organization	Payer
Inpatient Authorization	Aetna Medicaid Administrators	AETNA BETTER HEALTH ALL PLANS AND NJ-VA MAPD-DSNP

Member Information

Patient Name	Patient Date of Birth	Patient Gender
Member ID	Relationship to Subscriber	Subscriber Name

Requesting Provider

Name	NPI
Provider Role	Provider
Phone	Fax
(555) 555-5555	(555) 555-5555
Contact Name	ABC

Service Information

Service Type	Place of Service	Admission - Discharge Date
1 - Medical Care	21 - Inpatient Hospital	2024-11-13
Admission Type	Quantity	
Emergency	5 Days	

Diagnostic Code 1

Rendering Provider/Facility

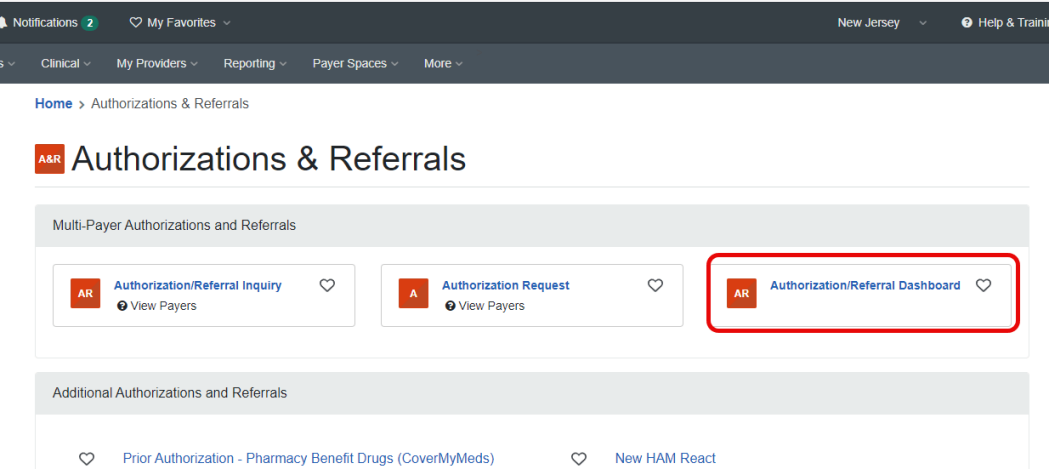
Provider 1	NPI
Name	
Provider Role	Attending
Provider 2	NPI
Name	
Provider Role	Admitting Services
Provider 3	NPI
Name	
Provider Role	Facility

Attachment(s)

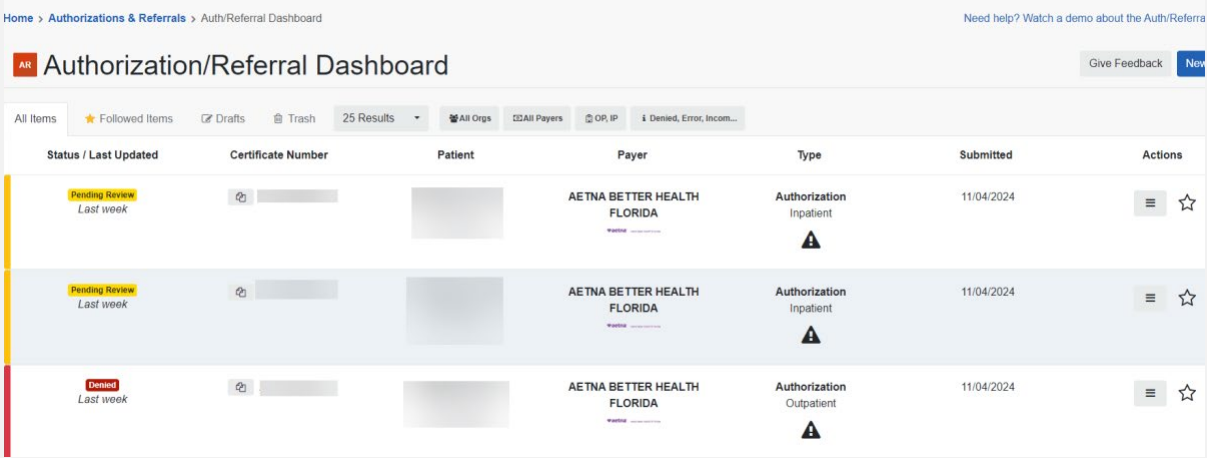
There are no attachments.

Checking Status of Authorizations Submitted via Availity

1. Click on Authorization/Referral Dashboard

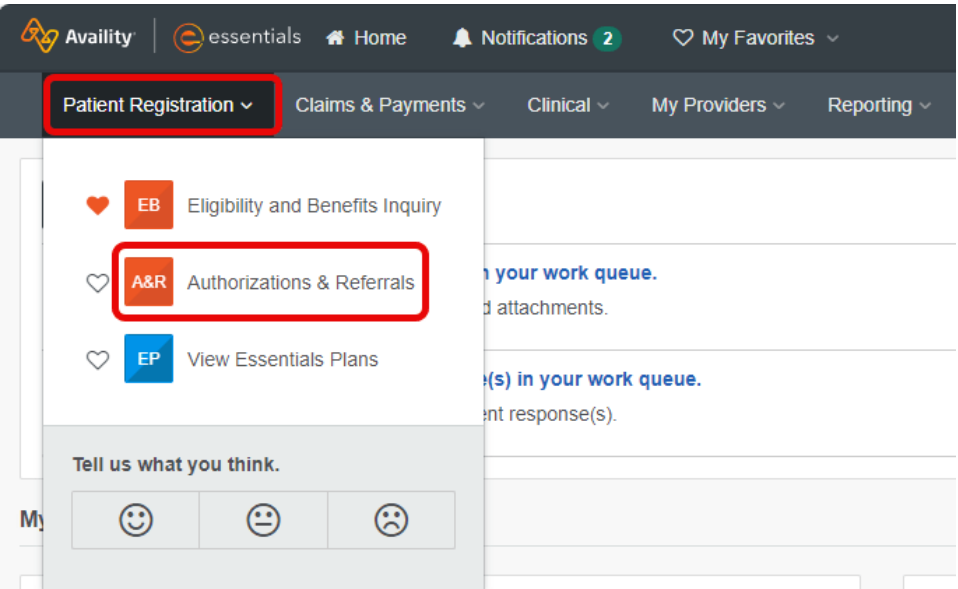


2 This will show status of those submitted in Availity only

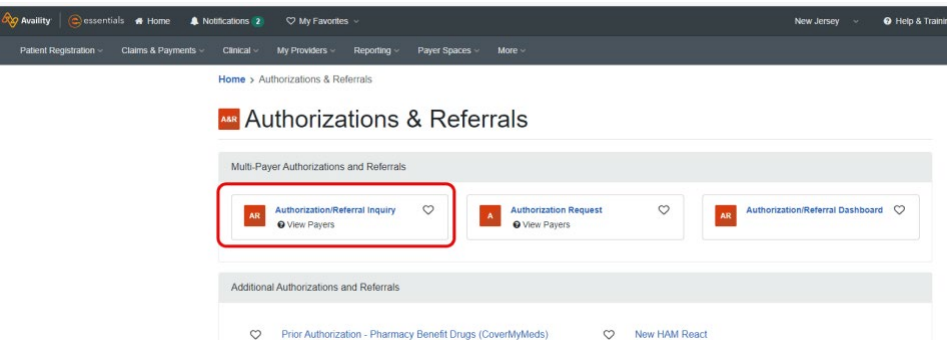


Authorization Inquiries

1 Once the provider is logged in, go to patient registration and authorizations & referrals.



2 For inquiries, select Authorization/Referral Inquiry



3 Enter all applicable data that has an asterisk *. Then click submit

4 Once you click submit, the auth information will populate.

Aetna | Other ways to request PA

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below

- **Fax:** 1-844-404-3972 (please include Prior Auth Form)
- **Phone:** 1-855-232-3596 – Follow prompts to BH
- **Availity Portal**
- **NJSAMS** (only for SUD authorization requests)

PA request form

<https://www.aetnabetterhealth.com/newjersey/providers/materials-forms.html>

BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

Aetna Better Health of New Jersey
3 Independence Way, Suite 400
Princeton, NJ 08540
Telephone Number: 1-855-232-3596
Fax Number: 1-844-404-3972
TTY: 711

Date of Request (MM/DD/YYYY):

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

SERVICE TYPE:

☐ PSYCHOLOGICAL / NEUROPSYCHOLOGICAL ☐ APPLIED BEHAVIOR ANALYSIS (ABA)

☐ ELECTROCONVULSIVE THERAPY (ECT) / TRANSCRANIAL MAGNETIC STIMULATION (TMS)

☐ OUTPATIENT TREATMENT REQUEST (OTR)

☐ URGENT – When a non-urgent prior authorization request could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function or that a delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested. Urgent requests will be processed within 24 hours.

☐ NON - URGENT STANDARD – Routine services processed within 14 days.

Visit our ProPAT search tool to determine if a service requested requires PA. <https://medicalportal.aetna.com/propat/Default.aspx>. A determination will be communicated to the requesting provider.

COMPLETE SECTIONS 1-3 IN THEIR ENTIRETY.

SECTION 1 - MEMBER INFORMATION

1. FIRST NAME	2. M.I.	3. LAST NAME
4. MEDICAID ID#	5. DATE OF BIRTH (MM/DD/YYYY)	6. MEMBER PHONE # (xxx-xxx-xxxx)
7. DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)		

SECTION 2 - ORDERING/REFERRING & SERVICING PROVIDER INFORMATION

8. ORDERING/REFERRING PROVIDER NAME	9. CONTACT PERSON (For questions)
10. TELEPHONE # (xxx-xxx-xxxx)	11. FAX # (xxx-xxx-xxxx)
12. NPI	
13. SERVICING PROVIDER NAME / FACILITY / AGENCY	14. CONTACT PERSON (For questions)
15. TELEPHONE # (xxx-xxx-xxxx)	16. FAX # (xxx-xxx-xxxx)
17. NPI	

SECTION 3 - DIAGNOSIS CODES AND SERVICE / HCPCS CODES

18. SERVICE START DATE (MM/DD/YYYY)	19. SERVICE END DATE (MM/DD/YYYY)
20. ICD 10 / DSM 5 CODE(S)	21. CODE DESCRIPTION(S) Include description of the service when uncertain of a code.

www.aetnabetterhealth.com/newjersey
3 Independence Way, Suite 400, Princeton, NJ 08540

Behavioral Health Std. PA Form

Aetna | Upcoming trainings and resources

Upcoming trainings

When	Training Topic	Target audience	Link
Dec 04 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/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](#)



Presenter



Enola Joefield-Haney

Manager, Behavioral Health
Utilization Management

Fidelis Care | Meet our Behavioral Health team



Enola Joefield-Haney
Manager, Behavioral Health
Utilization Management

- Oversees multiple business units and leads stakeholder discussions.
- Maintains expertise in contracts, policies, and performance standards; communicates updates
- Analyzes authorization data to identify trends, improvements, and future needs
- Collaborates with clinical teams and leadership to enhance processes and quality



Corinne Mor
Lead Utilization Review
Clinician - Behavioral Health

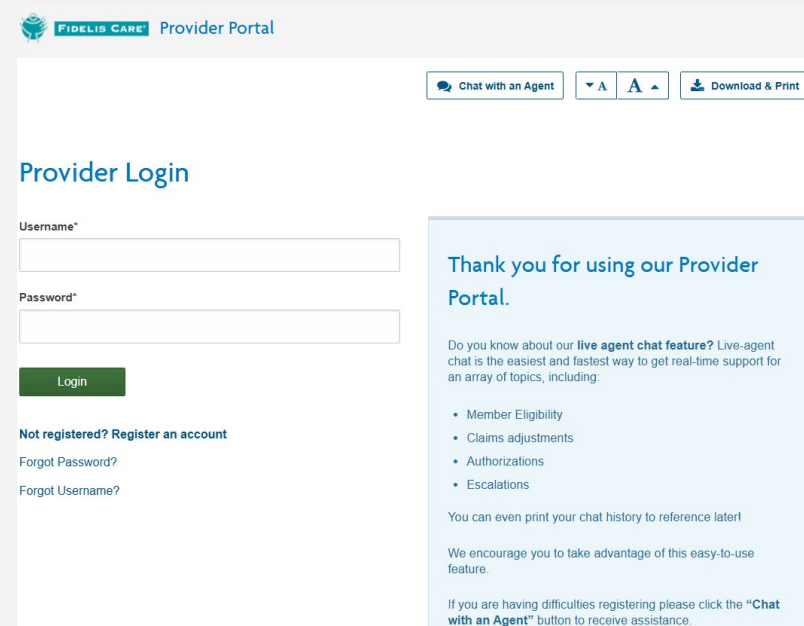
- Manages prior authorization processes of required authorizations to ensure compliance and proper handling.
- Ensures team adherence to contracts, policies, and performance standards.
- Reviews medical necessity to confirm care aligns with regulatory guidelines.



Bianca Mungaray
Utilization Review Clinician -
Behavioral Health

- Reviews authorization requests to assess medical necessity and care appropriateness.
- Collaborates with providers and teams to ensure timely service approvals.
- Supports discharge planning to facilitate smooth care transition

Fidelis Care MH PA requests using our portal



The screenshot shows the Fidelis Care Provider Portal login interface. At the top, there is a header with the Fidelis Care logo and the text "Provider Portal". Below the header, there are three buttons: "Chat with an Agent", a font size selector (A A A), and "Download & Print". The main section is titled "Provider Login" and contains a login form with fields for "Username*" and "Password*", a green "Login" button, and links for "Not registered? Register an account", "Forgot Password?", and "Forgot Username?". To the right of the login form, there is a blue box with a message: "Thank you for using our Provider Portal." followed by a paragraph about the live agent chat feature, a bulleted list of topics (Member Eligibility, Claims adjustments, Authorizations, Escalations), a note about printing chat history, and a final note about getting assistance via the "Chat with an Agent" button.

Fidelis CARE Provider Portal

Chat with an Agent A A A Download & Print

Provider Login

Username*

Password*

Login

Not registered? Register an account

[Forgot Password?](#)

[Forgot Username?](#)

Thank you for using our Provider Portal.

Do you know about our **live agent chat feature**? Live-agent chat is the easiest and fastest way to get real-time support for an array of topics, including:

- Member Eligibility
- Claims adjustments
- Authorizations
- Escalations

You can even print your chat history to reference later!

We encourage you to take advantage of this easy-to-use feature.

If you are having difficulties registering please click the "Chat with an Agent" button to receive assistance.

Submit PA using Fidelis Care Portal
[secure online provider portal.](#)

Option 1:

Navigate to the “**My Patients**” and search for the desired member. Then open the “**select action**” drop down. Here you will find the “**Request Authorization**” option:

The screenshot shows the 'My Patients' section of a web portal. At the top, there is a navigation bar with links: Home, My Patients (highlighted with a red box), Care Management, Claims, My Practice, and Resources. A search bar is also present. Below the navigation bar, the 'My Patients' title is displayed in a blue header. A 'Back To Home' link and utility buttons (Help, font size, download & print) are visible. The main heading is 'Check Member Eligibility', followed by a brief description of the section's purpose. Below this, there are search criteria fields: 'Select search criteria to find a member' (with a dropdown menu), 'Member ID', 'Medicaid ID', 'Medicare ID', and 'Check patient eligibility on this date' (with a date picker set to 07/12/2019). A 'Search' button is at the bottom right of the search area. The results section shows '54 Result(s)' and includes links for 'Filter Results' and 'Download Report'. A table displays the search results with columns: Member Name, Member ID, Eligible, Effective Date, Term Date, Plan Name, Care Gaps, Important Info, and PCP. The first three rows of the table are visible, all showing 'Eligible' as 'Yes' with a green checkmark. A 'Select Action' dropdown menu is open for the first row, showing options: 'View Details', 'Request Authorization' (highlighted with a red box), and 'Submit Referral'.

Member Name	Member ID	Eligible	Effective Date	Term Date	Plan Name	Care Gaps	Important Info	PCP
...	...	Yes	01-01-2016	N/A	...	N/A	N/A	...
...	...	Yes	01-01-2016	N/A	...	N/A	N/A	...
...	...	Yes	01-01-2016	N/A	...	N/A	N/A	...

Select “**Request Authorization**” to access the authorization request form.

Option 2:

From the “**Care Management**” tab, select “**Create New Authorization.**” You will then be prompted to enter the associated Member ID.

The image shows two overlapping screenshots of a web portal interface. The background screenshot shows the main navigation bar with tabs: Home, My Patients, Care Management (selected), Claims, My Practice, and Resources. A dropdown menu for 'Care Management' is open, showing options: QUICK TIP, Care Gaps Report, Find Authorizations and Referrals, **Create New Authorization** (highlighted with a red box), and Create New Referral. Below the navigation bar, there are two main sections: 'Find a Member' and 'Authorizations and Referrals'. The foreground screenshot shows the 'Create Authorization' page. It has a header 'Create Authorization' and a sub-header 'Find a Member'. Below this, there is a search form with a 'Search Type' dropdown set to 'Member ID' and a text input field for the Member ID. A red box highlights the 'Search' button. Below the search form, there is a table with columns: Patient Name, Date of Birth, Member ID, and Plan. The first row of the table has a red box around the first cell, which contains a magnifying glass icon. At the bottom right of the page, there is a 'Select Member' button, also highlighted with a red box.

Home | My Patients | **Care Management** | Claims | My Practice | Resources

Search the portal

QUICK TIP
Looking for a specific member?
Use the My Patients search to look up a member's medical profile, including authorizations, claims, pharmacy utilization, and more.

Create New Authorization
Start a new authorization request.

Create New Referral
Start a new referral request.

VIDEO: You Spoke, We Heard

Find a Member
Find your patients and check eligibility
Go To My Patients

Authorizations and Referrals
See recent authorizations, referrals and care plans
Go To Care Management

Create Authorization

Back To My Patients | Chat with an Agent | Download & Print

Find a Member

CME alert message

Search Type: Member ID | ID: [input field]

Search

Patient Name	Date of Birth	Member ID	Plan
[magnifying glass icon]	[input field]	[input field]	[input field]

Select a member from the list above

Select Member

Create Authorization

[Chat with an Agent](#)[Help](#)[A](#)[A](#)[Download & Print](#)

Member Information

[COLLAPSE](#)

i The following Member is attached to this Authorization

Member Name

Member ID

Date of Birth

Gender

Address

[Search a Member](#)

Requesting Provider Information

[COLLAPSE](#)

i The following Provider is attached to this Authorization

Provider ID

Provider Name

Phone Number

Specialty

Address

[Choose a Provider](#)

County

Requesting Provider Fax *

Is this a prescheduled service or an inpatient notification?

[COLLAPSE](#)

[Go Back to Modification](#)

[Go Back to Authorization including completed inpatient](#)

Next, insert a valid fax number using the following format: (111) 111-1111. Then make a selection to determine “**Inpatient**” or “**Outpatient**” for the request. Fields within the form will update, based on whether the authorization is identified as inpatient or outpatient.

Select **“Inpatient Notification”** or **“Prior Authorization including preplanned inpatient”** in the **“Is this a prescheduled service or an inpatient notification?”** field.

- Inpatient Notification – **Use for an inpatient/observation request**
- Prior Authorization including preplanned inpatient – **Use for an outpatient request or preplanned inpatient request for a future date of service**

Requesting Provider Information

The following Provider is attached to this Authorization

Provider ID	Provider Name	Phone Number	Specialty	Address	
					<div><div></div>Choose a Provider</div>
County	<div>Requesting Provider Fax *</div> <div>(111) 111-1111</div>				

Complete the fields in the following sections. For an outpatient authorization, you **must** check the “**View Auth Requirements**” button. (This is not necessary for inpatient authorizations.)

Servicing Provider InformationCOLLAPSE

Note: Select checkbox if same as the requesting provider

Provider Type *

Provider ID *

Advanced Search

Provider Name

Specialty

Fax

County/Island

Address

Facility

Advanced Search

(111) 111-1111

Authorization InformationCOLLAPSE

Service Type *

Subtype *

Place of Service *

Inpatient Services

Inpatient

21 - Inpatient Hospital

Place of Service Description

Inpatient Hospital

Planned Admit Date *

Requested Days

7/15/2019

1

Additional Service Information

Diagnosis Information

Date From

Date Thru

Diagnosis Code

Description

7/15/2019

7/16/2019

H21.221

DEGENERATION OF CILIARY BODY RIGHT EYE

CPT Codes

Date From

Date Thru

Procedure Code

Description

Requested Units

View Auth

Modifier

7/15/2019

7/16/2019

81297

MSH2 GENE DUP/DELETE VARIANT

1

Auth Required

Prior to submission, you will be prompted to review your selections, and given the options to “**Edit**” or “**Submit**”:

Create Authorization

Chat with an Agent

Help

Download & Print

This authorization has not been submitted. Please review the information and submit below.

Patient Information

Member Name

Member ID

Date of Birth

Gender

Address

Requesting provider Information

Provider ID

Phone Number

Fax number

Specialty

Address

Servicing Provider Information

Provider Type

Provider ID

Provider Name

Specialty

Fax

Address

County/State

Facility

Requester Contact Information

Name

Fax#

Phone#

Extension

Authorization Details

Received Date

Contact Channel

Service Type

Subgroup

Created Date

Place of Service

Place of Service Description

Inpatient Hospital

Additional Service Information

Planned Submit Date

Requested Days

Diagnosis Information

Date From

Date Thru

Diagnosis Code

Description

CPT Codes

Date From

Date Thru

Procedure Code

Description

Requested Units

Is Auth. Required?

Note

Attachment Information

File Name

Save Draft

Submit Authorization

Edit Authorization

A reference number will be provided once you submit the request. An authorization number will be sent to you via fax within state-regulated turn around times. You must use the authorization number to search for this authorization in the Provider Portal.

NOTE: An authorization cannot be viewed via the portal until it has moved to an in-progress state and the fax containing the authorization number has been sent.

There are several types of reference numbers:

ADMNT: This is a notice of admission

CR: This is a concurrent review. After the notice of admission, this is the clinical review that takes place. There can be multiple concurrent reviews for a single stay. Ex. If a member is admitted to the hospital, there will be an initial review and then one or more additional reviews confirming whether the member is ready for discharge.

PA: Prior authorization. This is an advance notice for outpatient services or for pre-planned inpatient services.

Authorization number: This number is required when submitting your claim(s) for payment.

Example of an ADMNT reference number:

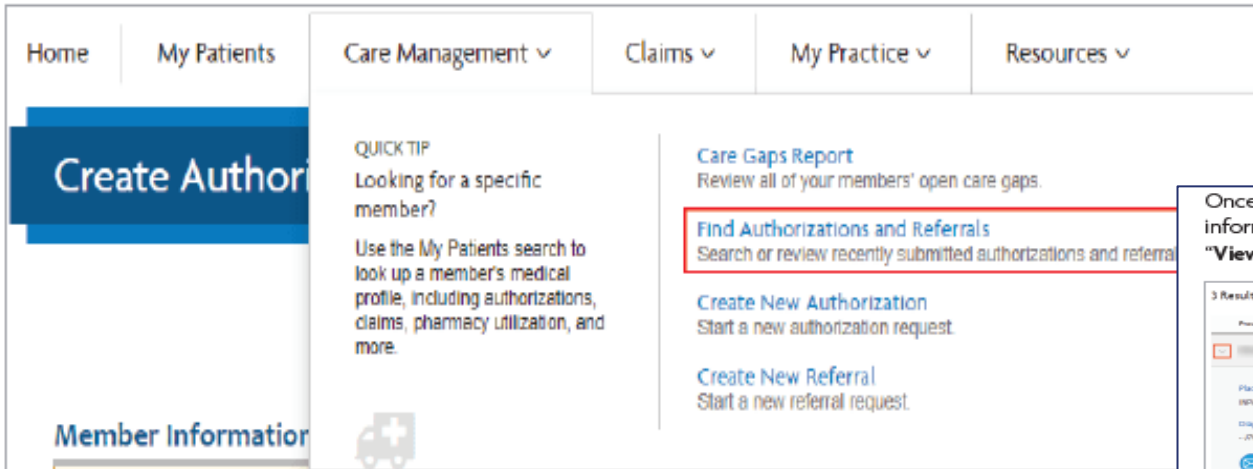
Create Authorization

Reference Number: PA-287189

Submission was successful

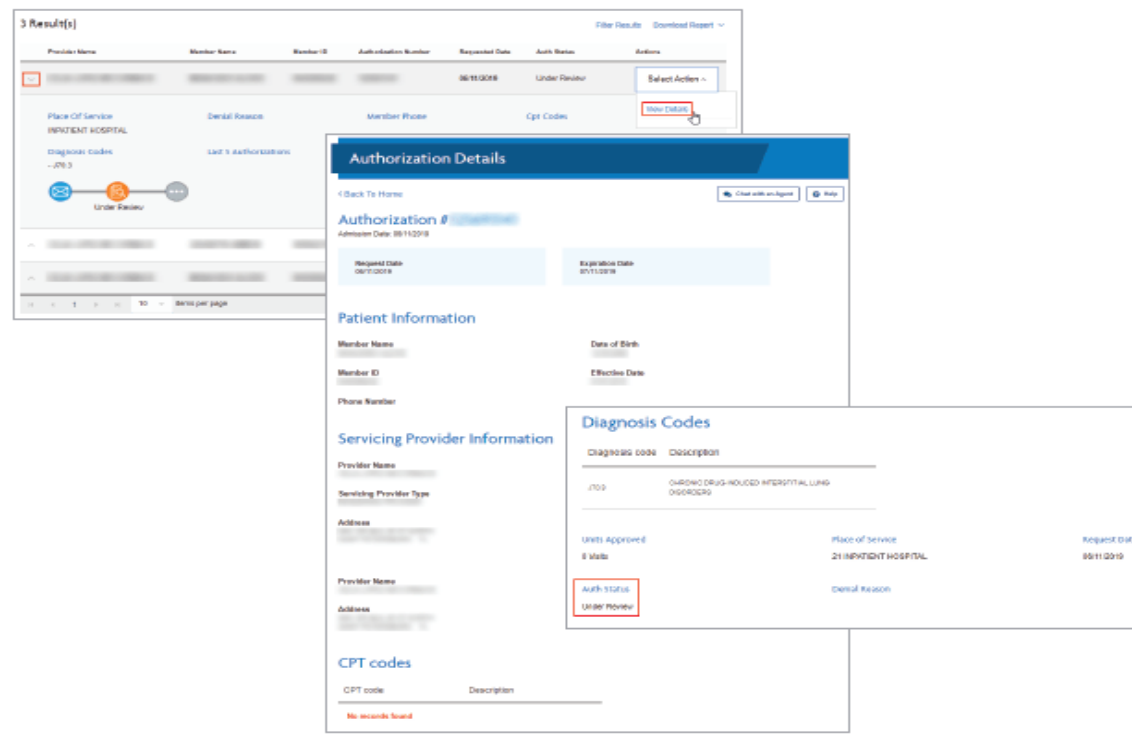
Check Authorization Status

Navigate to the “**Care Management**” tab and select “**Find Authorizations and Referrals**” to view the authorization status.



The screenshot shows the top navigation bar with tabs: Home, My Patients, Care Management, Claims, My Practice, and Resources. The Care Management tab is active. Below the navigation bar, there are three main sections: a 'Create Authorization' button, a 'QUICK TIP' section with text about using the My Patients search, and a 'Find Authorizations and Referrals' link highlighted with a red box. Other links include 'Care Gaps Report', 'Create New Authorization', and 'Create New Referral'.

Once search results are returned, each authorization has an expandable section that provides more detailed information about that authorization. You may also view the full authorization details by selecting the “**View Details**” from the “**Select Action**” drop down.



The screenshot shows the 'Authorization Details' page. It includes a table with 3 results, a 'Select Action' dropdown menu with 'View Details' selected, and a detailed view of an authorization. The detailed view includes sections for Patient Information, Servicing Provider Information, Diagnosis Codes, and CPT codes. The 'View Details' link is highlighted with a red box. The 'Authorization Details' section shows the authorization number, request date, expiration date, and status (Under Review).

Provider Name	Member Name	Member ID	Authorization Number	Requested Date	Auth Status	Actions
...	06/11/2019	Under Review	Select Action View Details

Authorization Details

Authorization # 0000000000
Admin Date: 06/11/2019

Request Date: 06/11/2019
Expiration Date: 07/11/2019

Patient Information

Member Name: ...
Member ID: ...
Phone Number: ...

Servicing Provider Information

Provider Name: ...
Servicing Provider Type: ...
Address: ...

Diagnosis Codes

Diagnosis code	Description
J70.9	COVID-19 DISEASE

Auth Status: Under Review

CPT codes

CPT code	Description
No records found	

Fidelis Care | Other ways to request PA

Prior authorization requests can also be submitted via phone or fax.

- Behavioral Health Phone: 888-453-2534
- Outpatient Auth Request Submissions: Fax 888-339-2677
- Inpatient Auth Request Submissions: Fax 855-703-8082

Criteria to determine medical necessity:

- InterQual
- ASAM

Fidelis Care will apply medical necessity criteria starting on **4/1/2025**.

Authorization Forms

To determine if a service requires authorization see our website: <https://www.fideliscarenj.com/en/New-Jersey/Providers/Authorization-Lookup>

Fidelis Care NJ | Upcoming trainings and resources

Upcoming trainings

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 more information on requesting PA, please contact:

Enola Joefield-Haney, Manager, Behavioral Health Utilization Management

Phone: 813-206-3367

Email: enola.d.joefeldhaney@centene.com

Links:

- [PA / MCO Portal](#)
- [MCO Provider Manual](#)
- [MCO Quick Reference Guide](#)
- [New Provider Orientation](#)



Presenter



Edward Elles, LCSW

Director, BH Medicaid Admin &
Clinical Ops

Horizon NJ Health | Meet our Prior Authorization team



Jessica Stagg Anderson, LCSW
Manager, Behavioral Health Clinical Operations

- Responsible for management of the Prior Authorization team



Perri Cohen, LCSW
Manager, Behavioral Health Clinical Operations

- Responsible for management of the Integration team



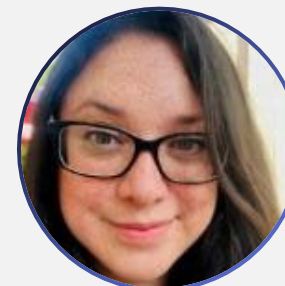
Carolyn Gama, RN
Manager of Outpatient Services, Navigational Assistant and ABA therapy for Behavioral Health

- Responsible for management of Outpatient and ABA services



Danielle Bowman, LPC
Supervisor, Behavioral Health Clinical Services

- Responsible for supervision of the Prior Authorization team



Victoria Frazier, LPC
Supervisor, Behavioral Health Clinical Operations

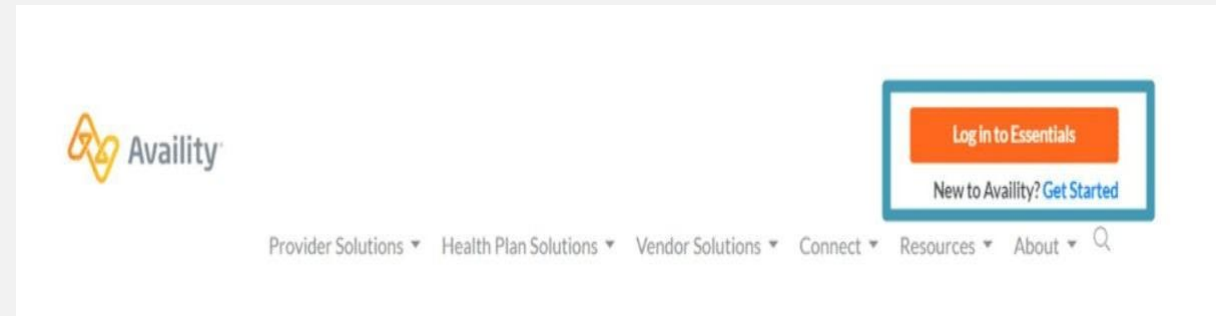
- Responsible for supervision of the Integration team



Stephanie Rose, LCSW
Supervisor Clinical Operations, Outpatient

- Responsible for supervision of the Outpatient Navigational Assistance team

Horizon NJ Health MH PA requests using Horizon's portal



Submit PA using Availity Portal

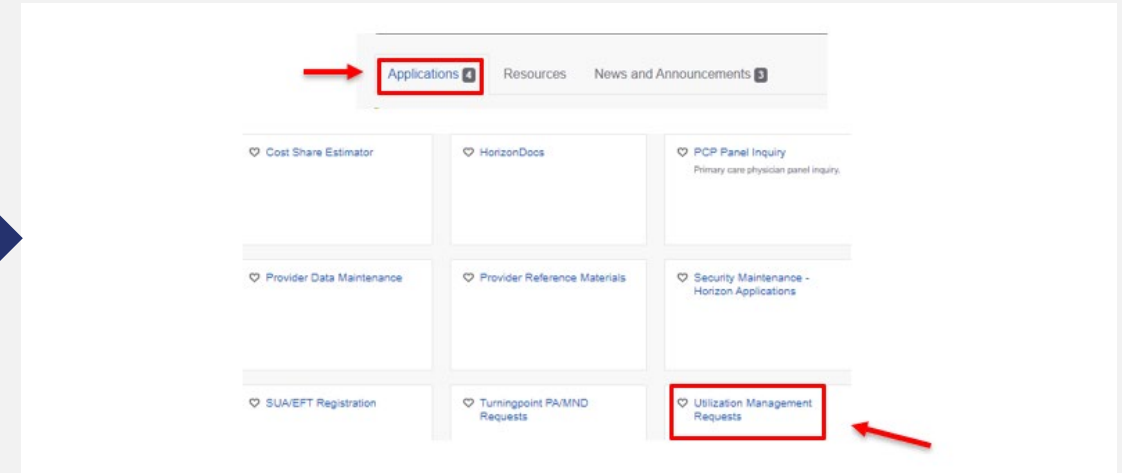
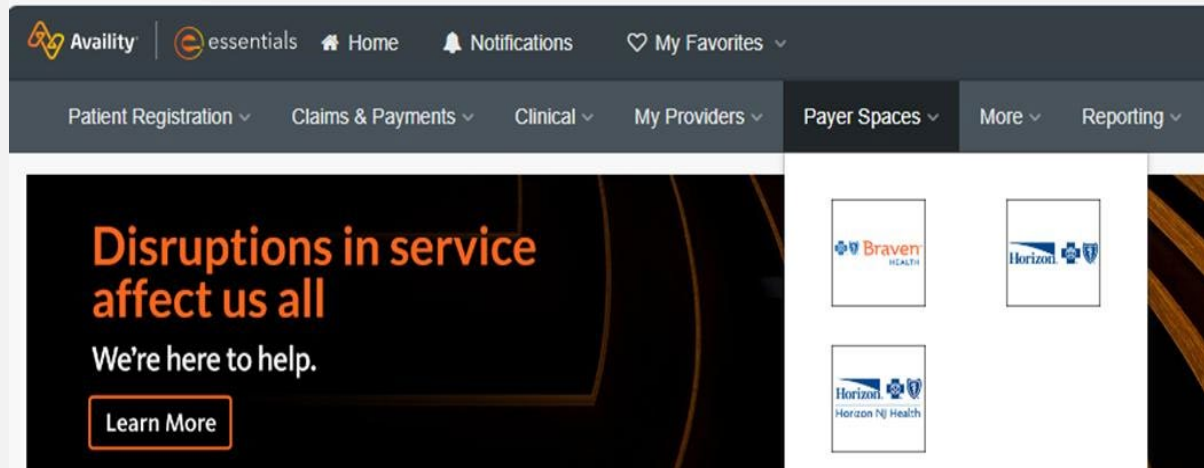
<https://availity.com/>

Learn about the Utilization Management Request
Tool Enhancements

[Self Study Guide](#)

[UM Tool Training Module](#)

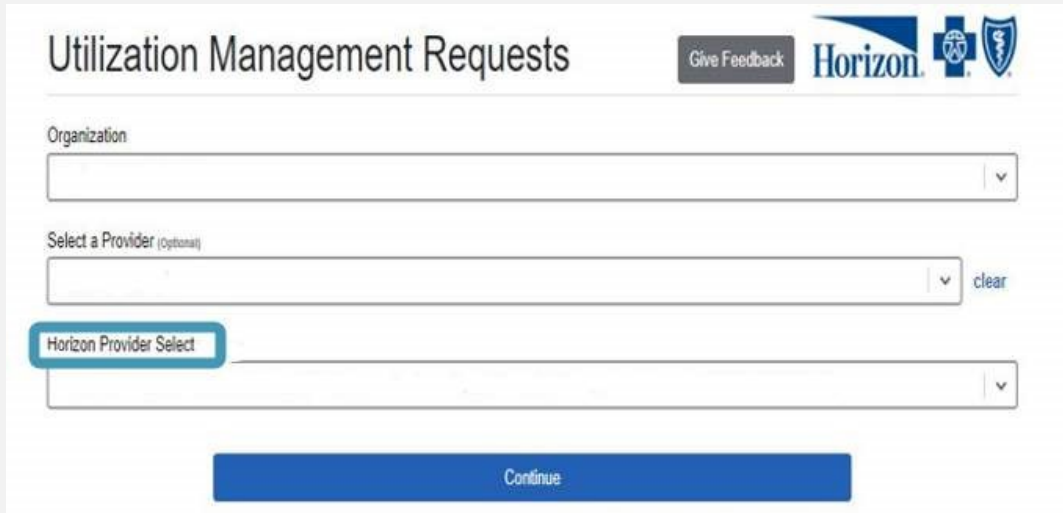
Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



Once logged into Availity, Click Payer Spaces dropdown and select plan type for member you are requesting services for.

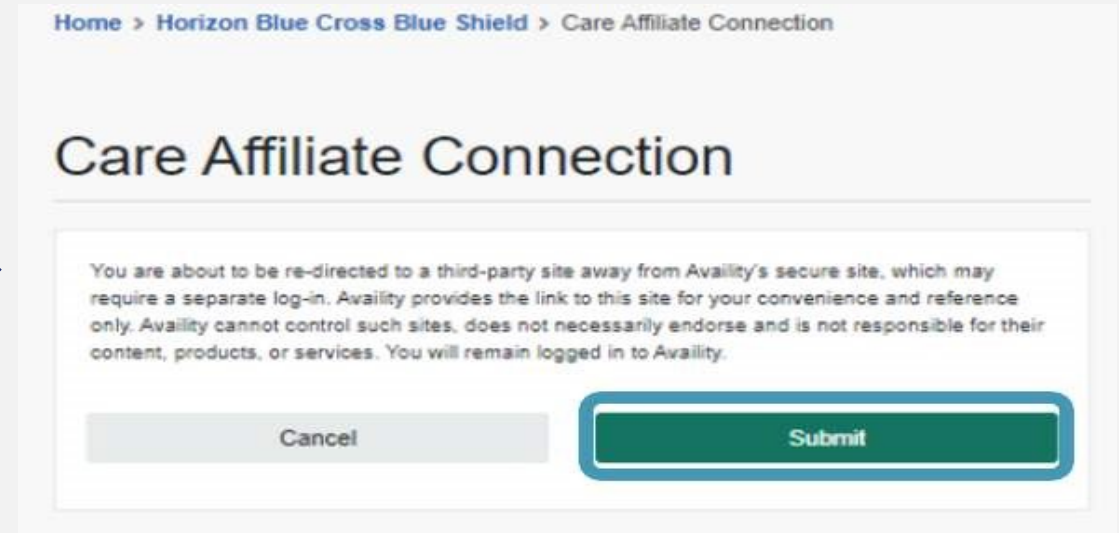
Scroll within Applications tab to Utilization Management Requests and click.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



The screenshot shows the 'Utilization Management Requests' page. At the top, there is a 'Give Feedback' button and the Horizon logo. The main form area contains three dropdown menus: 'Organization', 'Select a Provider (Optional)', and 'Horizon Provider Select'. The 'Horizon Provider Select' dropdown is highlighted with a blue border. Below the dropdowns is a large blue 'Continue' button.

Once you click Utilization Management Requests, you will need to select your organization and complete “Horizon Provider Select” field. Click continue.



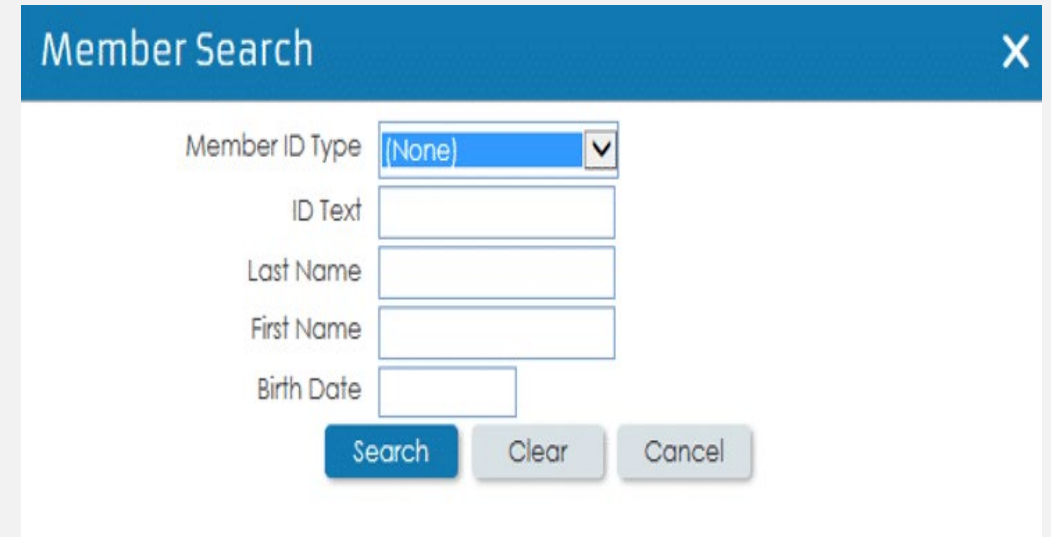
The screenshot shows the 'Care Affiliate Connection' screen. At the top, there is a breadcrumb trail: 'Home > Horizon Blue Cross Blue Shield > Care Affiliate Connection'. The main heading is 'Care Affiliate Connection'. Below the heading is a text box that reads: 'You are about to be re-directed to a third-party site away from Availity's secure site, which may require a separate log-in. Availity provides the link to this site for your convenience and reference only. Availity cannot control such sites, does not necessarily endorse and is not responsible for their content, products, or services. You will remain logged in to Availity.' At the bottom of the screen are two buttons: a grey 'Cancel' button and a green 'Submit' button.

This screen advises that you that you will be re-directed to a platform called CareAffiliate. Click Submit to proceed.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



The screenshot shows the CareAffiliate portal interface. At the top, there is a blue header bar with the CareAffiliate logo and navigation links for Home, Appeals, and Authorizations. Below the header, a central widget titled "Member Search" is displayed. This widget contains a "Member ID" text input field, a "Name" text input field with a placeholder "Format: Last, First M.I.", and a yellow "Look Up" button with a magnifying glass icon. A blue arrow points upwards to the "Look Up" button.




The screenshot shows the "Member Search" form. It has a blue header bar with the title "Member Search" and a close button (X). The form contains the following fields: "Member ID Type" (a dropdown menu currently showing "(None)"), "ID Text" (a text input field), "Last Name" (a text input field), "First Name" (a text input field), and "Birth Date" (a date input field). At the bottom of the form are three buttons: "Search" (blue), "Clear" (light blue), and "Cancel" (light blue).

Within CareAffiliate, from the Home tab, click the yellow Look Up button.

You will then see this screen. You can search by Member Name or Member ID.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

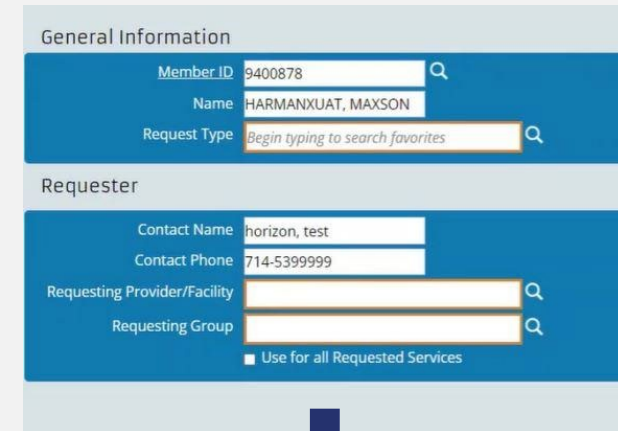


Member Search

Member ID: 2469533
Name: SCHMIDTXUAT, PAYNE
[Look Up](#)

Search Results [Clear](#)

- Appeals (0) [New](#)
- ▶ **Authorizations (4)** [New](#)
- Referrals (0) [New](#)
- Care Plans (0)
- Member Messages (0)
- Last Member Message(s) Received: N/A

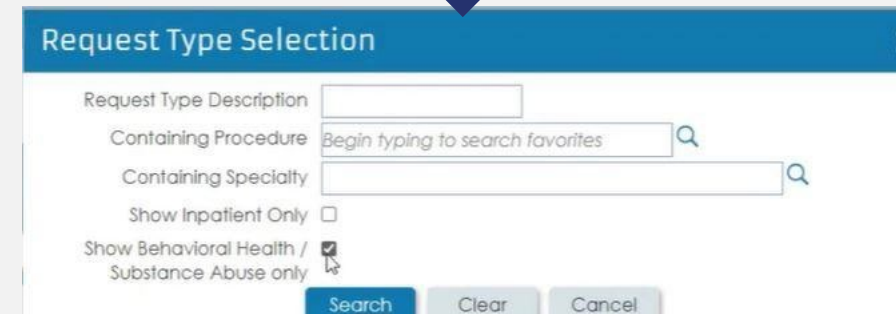


General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: [Begin typing to search favorites](#)

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility: [Begin typing to search favorites](#)
Requesting Group: [Begin typing to search favorites](#)
☐ Use for all Requested Services



Request Type Selection

Request Type Description: [Begin typing to search favorites](#)
Containing Procedure: [Begin typing to search favorites](#)
Containing Specialty: [Begin typing to search favorites](#)
Show Inpatient Only ☐
Show Behavioral Health / Substance Abuse only ☒
[Search](#) [Clear](#) [Cancel](#)

Once member has been found, an authorization can be initiated. Click the New button next to Authorizations option. *Note, if you click the Authorizations link, it will bring up prior submitted requests for selected member.

This step allows for entering request type selection. Click magnifying glass next to Request Type. A search box will populate. Click check box next to Show Behavioral Health/Substance Abuse Only, and hit Search. Then scroll through the list of options and select an option.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: Inpatient Psychiatric
Event Classification: Urgent Concurrent
Case Type: Inpatient
Plan Valid for Services From: To: Plan: (None)

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility:
Requesting Group:
☐ Use for all Requested Services



Individual Provider Search

ID Type: NPI
ID:
First Name:
Last Name:
Search

Institutional Provider Search

ID Type: (None)
ID:
Name:
Search

Additional search criteria



Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility: 1001632907-81840283 - CAVICCHIAKUAT
Requesting Group:
☐ Use for all Requested Services

Diagnoses

Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description

Next, enter 90-day date span under Plan Valid for Services From and To, which will prompt a benefit/eligibility check. Then, click on magnifying glass next to Requesting Provider/Facility or Requesting Group.

Search box will open. Fill in ID type and ID information, and hit Search. Choose the correct option through the search results.

Diagnosis codes can now be added. Click magnifying glass next to description, and search by F code. Up to 4 diagnoses can be entered in this section.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Authorizations

Authorization Request

Service 1
Inpatient Hospital/
Psychiatric - Inpatient

Notes (0)

Assessment (0)

Attachments (0)

General Information

Member ID 9400878

Name HARMANXUAT, MAXSON

Request Type Inpatient Psychiatric

Event Classification Urgent Concurrent

Case Type Inpatient

Plan Valid for Services From 10/01/2024 To 12/31/2024

Plan PREFERRED PROVIDER ORGA

Requester



Status Reason Electronic Submission

Place of Service Inpatient Hospital

Service Psychiatric - Inpatient

Service From

To

Provider

Group

Facility

Provider Role Attending

Actual Date Admitted

Admitting Diagnosis

Actual Discharge Date

Discharge Diagnosis

Disposition (None)



Provider Location Search

Individual Provider Search

ID Type (None)

ID

First Name

Last Name

Institutional Provider Search

ID Type (None)

ID

Name

Additional search criteria

Address

City

State

Postal Code

County

Search within (None)

Specialty

Provider Type (None)

Referral (None)

Ref Level ALL

Date Valid

Medical only

Search Clear Cancel

To initiate adding a service, click Service 1 in the Authorization Request box in upper left side of page.

When entering dates of service, they must fall within 90 day date span that was initially entered. Click Magnifying glass for Provider, Group or Facility, and repeat provider search steps previously described by searching individual or institutional provider. This time, you must enter rendering provider's information.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Procedure Low

Procedure High

Quantity

Total

Procedure Type Gender Both

Code Age

Description

There are no records to display.

Procedure Low

Procedure High

Modifiers

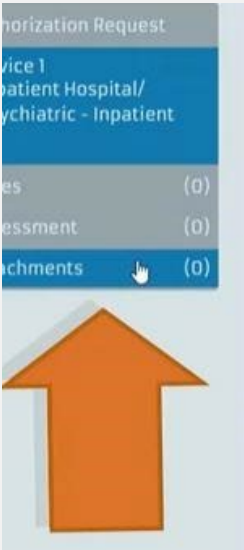
Quantity

Total

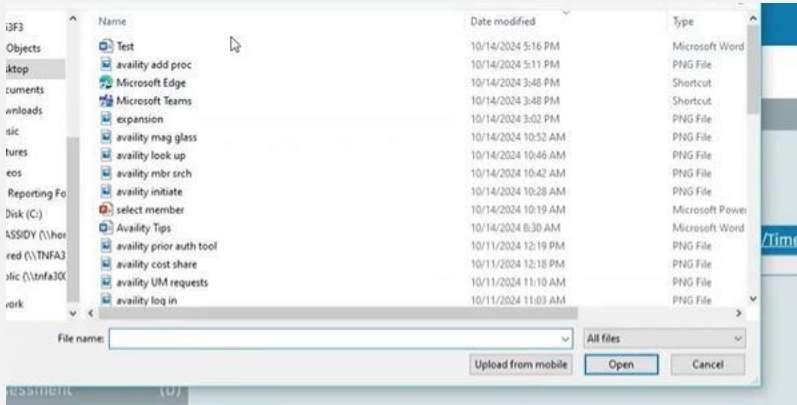
Next, procedure information should be added only for outpatient levels of care. Click add procedure tab toward bottom right of screen. A new window will open. Click magnifying glass next to Procedure Low to open search window.

Open drop down menu next to Procedure type. Make your selection and enter code. Click Search. You will be back at Add Procedure page. Procedure Low and High will be populated. Next, enter number of units requesting in Quantity field. Click drop down to right to select units. Then Click Add. *Note, if needing to add additional procedures, scroll up and click orange Copy Service Line.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



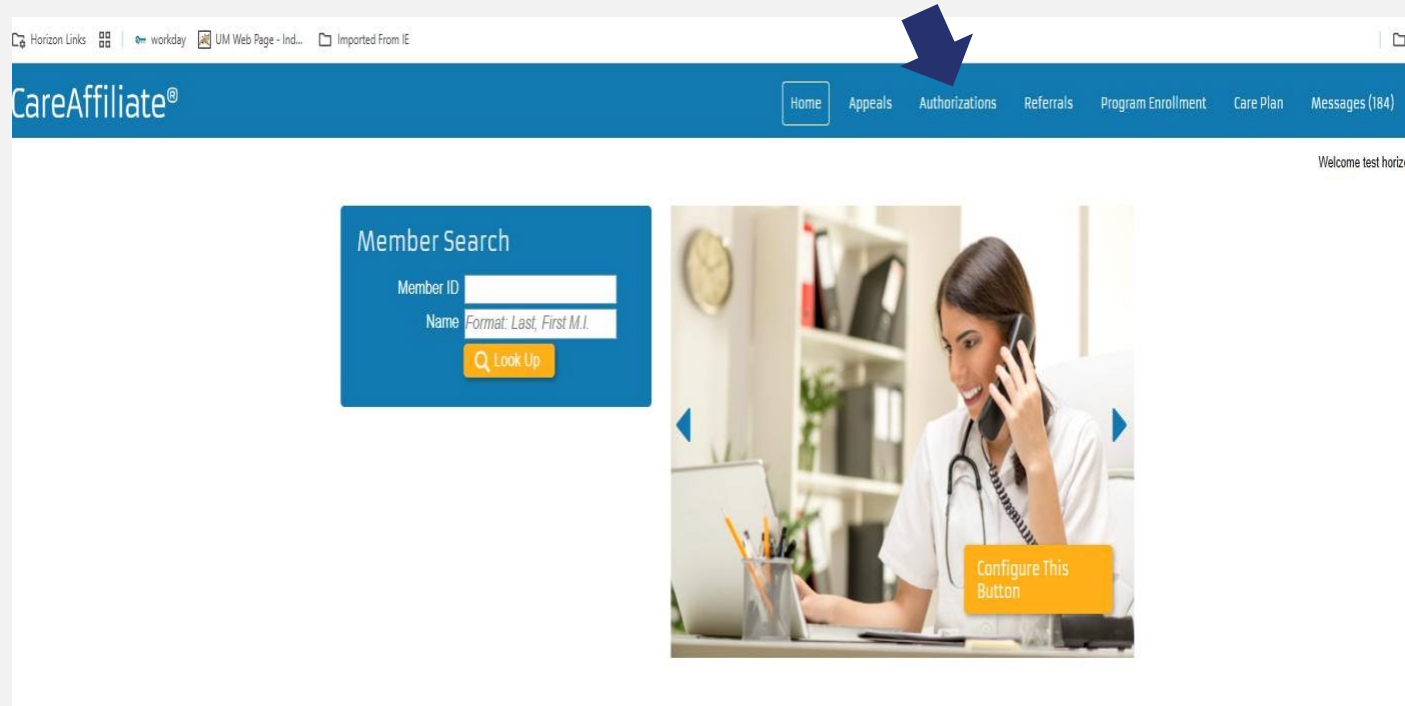
Attachments				
File Name	CDA Title	Date/Time Attached	File Size	Status
There are no records to display.				



CDA Title	Date/Time Attached	File Size	Status
	10/14/2024 5:37 PM	11 KB	Attached

Double click on the file to be attached and then click upload file. A status of Attached appears when files are uploaded successfully.

Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal



On the Home Screen, go to Authorizations section for Mental Health and Substance Use Disorders.

Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal

Authorizations

Search Existing Records

Search Criteria

Member ID
Name
Requesting Provider ID
Requesting Group ID
Name
Location
Include location as criteria
Servicing Provider ID
Name
Servicing Group ID
Name
Location
Include location as criteria
Servicing Facility ID
Name
Location
Include location as criteria

Reference #
Vendor Delegate Auth #
Diagnosis
Code
Description
Procedure
Begin typing to search favorites
Place of Service
(Any)
Service
Service Dates From
To
Submission Dates From
To
Status
(Any)

Input the Reference number given on initial submission and click on “Search Existing Records.”

Immediately you can review the Status. To get additional details, click onto the Reference number.

Reference #	Authorization #	Member ID	Member Name	Member DOB	Status	Diagnosis
0001416926		9400878	HARMANXUAT, MAXSON	10/01/1988	Not Certified	F32.9 : MDD, single episode, unspecified

Return To Search

Authorization Request

Service 1 - (Denied)
Free-standing Psychiatric Facility/
Psychiatric - Inpatient

Notes (0)
Assessment (1)
Attachments (3)

General Information

Member ID 9400878
Name HARMANXUAT, MAXSON
Request Type Psych Facility - IP
Event Classification Urgent Pre service
Case Type Inpatient

Plan Valid for Services From 01/01/2023 To 12/31/9999
Plan PREFERRED PROVIDER ORGANIZATION

Requester

Contact Name horizon, test
Contact Phone 714-5399999
Requesting Provider/Facility I1209100P135743000000001721676 - CAVICCHIAUXAT, TAYANA K

Diagnoses

Diagnosis ICD10 - F32.9 - Major depressive disorder, single episode, unspecified

To review documentation about decision, go to “Attachments.” Once in Attachments, letters are hyperlinked and viewable.

*Note: In order to get a print-out of the request and status, you can print screen.

Horizon NJ Health | How outcomes of PA requests are communicated to providers

Providers have availability to check outcomes of submitted PA requests via Horizon's CareAffiliate which can be accessed through Availity. In addition, a notice of determination letter is sent for each prior authorization request.

Horizon NJ Health | Who can providers contact for assistance?

Contact Provider Services

Phone: (800) 682-9091

Email: HBHProviderService_@horizonblue.com

Horizon NJ Health | Other ways to request PA

Prior authorization requests can also be submitted via phone or fax.

- HNJBH PA Phone: 1-800-682-9094
- OP Fax: 855-241-8895
- PA Fax: 732-938-1375

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
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 assistance, please contact Provider Services:

- Phone: **(800) 682-9091**
- Email: HBHProviderService_@horizonblue.com

For further information on PAs, please contact:

BHMedicaid_@horizonblue.com

Links:

- [PA/Availity Essentials™](#)
- [Credentialing Application Link](#)
- [HNJH Provider Manual](#)
- [HNJH Quick Reference Guide](#)
- [New Provider Orientation](#)



Scheanell Holland
NJ Network Manager

UnitedHealthcare| Meet our Prior Authorization team



Julia Codrington PhD, LPC,
CPCS

- Associate Director Care Advocacy



Jennifer Lilly, LPC

- Manager Care Advocacy



Brian Coover, LPC

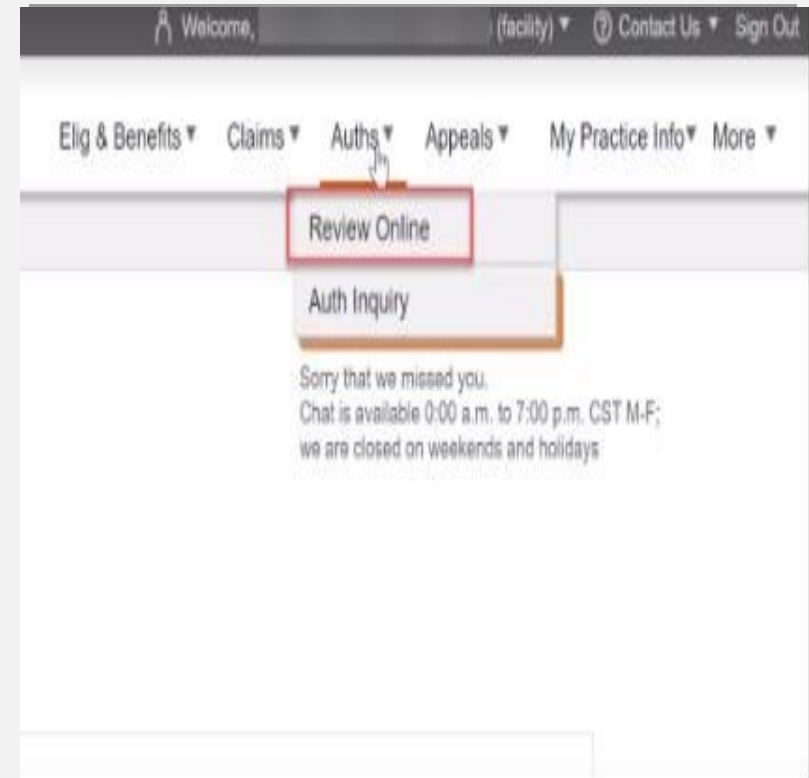
- Senior Care Advocate/Team Lead



Damon Wallis, LCSW

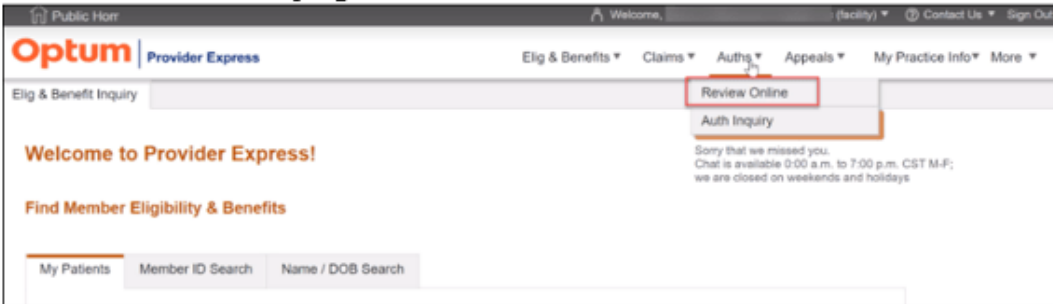
- Care Advocate

UnitedHealthcare MH PA requests using our portal



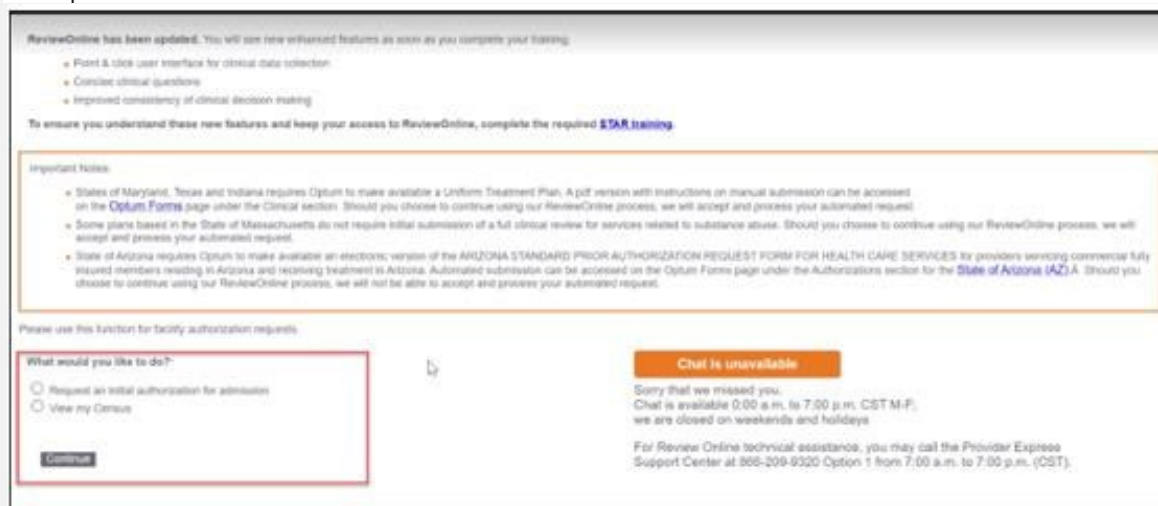
Submit PA using Providerexpress.com
[Optum - Provider Express Home](#)

UnitedHealthcare

Step	Action
1	Providers will sign into Provider Express. https://public.providerexpress.com/content/ope-provexpr/us/en.html
2	Click on Auths in the top right-hand corner and select Review Online . 

3 Now, there are two options for the provider at this point. Providers can

- **Request an initial authorization for admission**
- **View their Census** - This takes you to a list of all of the facilities, patients and admit status. The Census page will show if an action is required or just the status of where the authorization is. Providers can also click on the Census option for Concurrent Review.



ReviewOnline has been updated. You will see new enhanced features as soon as you complete your training.

- Point & click user interface for clinical data collection
- Consider clinical questions
- Improved consistency of clinical decision making

To ensure you understand these new features and keep your access to ReviewOnline, complete the required [STAR training](#).

Important Notes:

- States of Maryland, Texas and Indiana requires Optum to make available a Uniform Treatment Plan. A pdf version with instructions on manual submission can be accessed on the [Optum Forms](#) page under the Clinical section. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- Some plans based in the State of Massachusetts do not require initial submission of a full clinical review for services related to substance abuse. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- State of Arizona requires Optum to make available an electronic version of the ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES for providers servicing commercial fully insured members residing in Arizona and receiving treatment in Arizona. Automated submission can be accessed on the Optum Forms page under the Authorizations section for the [State of Arizona \(AZ\)](#). Should you choose to continue using our ReviewOnline process, we will not be able to accept and process your automated request.

Please use this function for facility authorization requests.

What would you like to do?

☐ Request an initial authorization for admission

☐ View my Census

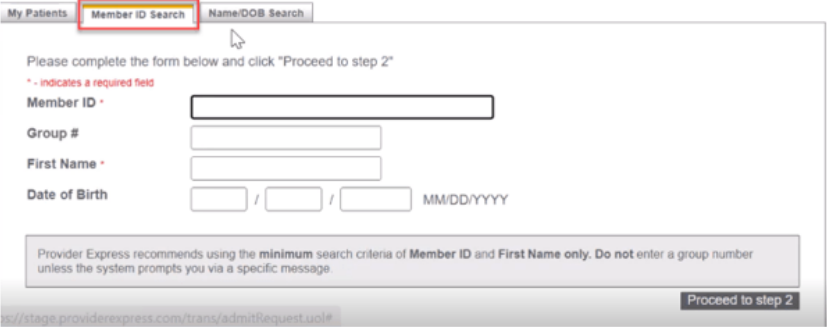
[Continue](#)

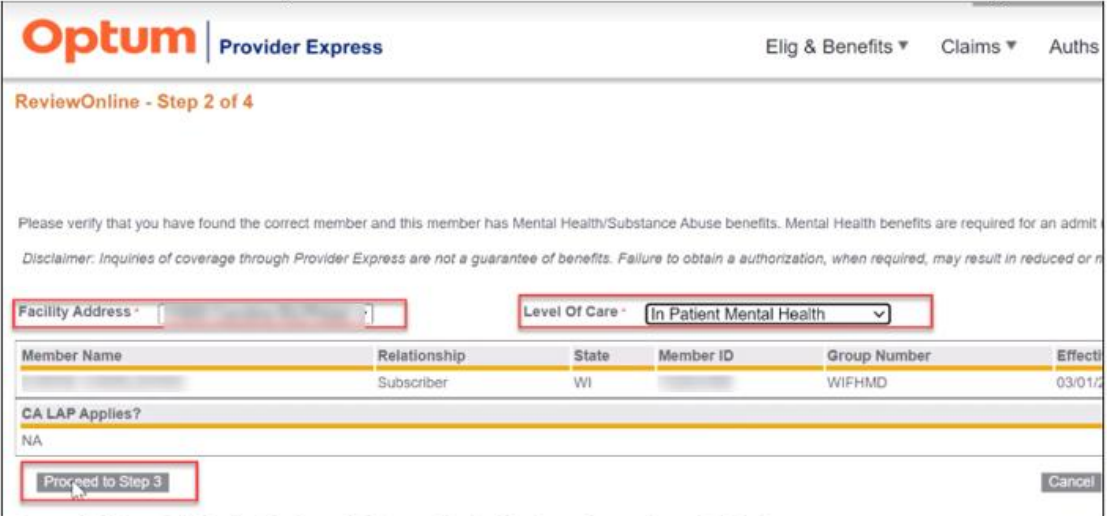
Chat is unavailable

Sorry that we missed you.
Chat is available 0:00 a.m. to 7:00 p.m. CST M-F;
we are closed on weekends and holidays.

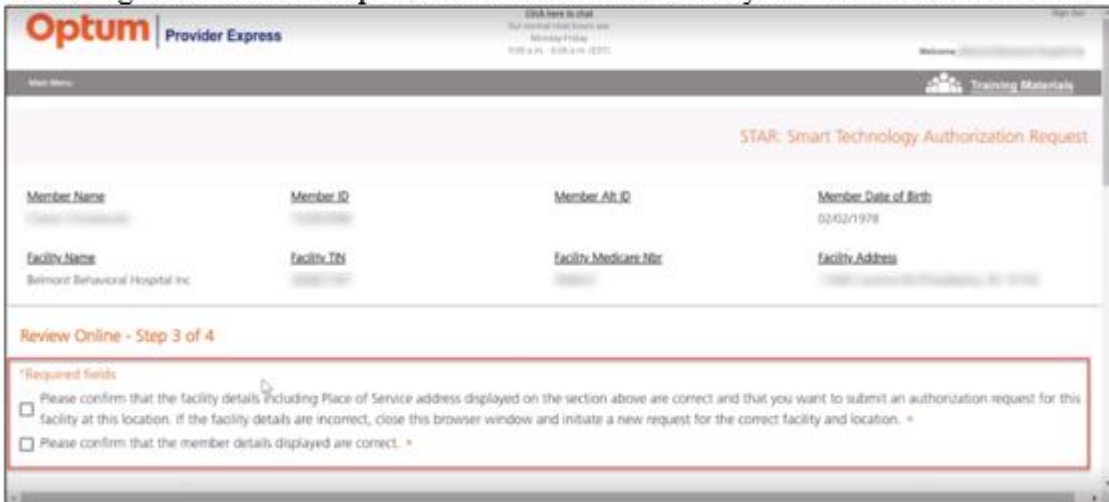
For Review Online technical assistance, you may call the Provider Express Support Center at 866-209-9325 Option 1 from 7:00 a.m. to 7:00 p.m. (CST).

UnitedHealthcare

Step	Action
1	<p>The provider will land on the ReviewOnline- On this page providers can locate a member 3 different ways.</p> <p>a. Member ID Search – search by Member ID.</p> <div></div>
2	Select Proceed to step 2 at the bottom of the page.

3	<p>This takes the provider to the ReviewOnline-Step 2 of 4. On this page the provider will select the Facility Address and Level of Care. Select Proceed to Step 3.</p> <div></div>
---	---

UnitedHealthcare

Step	Action
4	<p>This takes the provider to the ReviewOnline-Step 3 of 4. On this page begin answering the initial set of questions to confirm the facility and member information.</p>  <p>The screenshot shows the 'Review Online - Step 3 of 4' page. It contains a table with member and facility details. Below the table, there are two checkboxes under the heading '*Required fields':</p> <ul style="list-style-type: none"> <input type="checkbox"/> Please confirm that the facility details including Place of Service address displayed on the section above are correct and that you want to submit an authorization request for this facility at this location. If the facility details are incorrect, close this browser window and initiate a new request for the correct facility and location. * <input type="checkbox"/> Please confirm that the member details displayed are correct. *

- Enter the diagnosis
- Pick the Level of Care
- Answer the following questions
 - **Involuntary admission?**
 - **Is this request from an ER?**
 - **Member admitted?**
 - **Admit date**
 - **Has the member been discharged from the current episode of care?**

Select **Next**.

- 5 On the next page the provider will see a popup reminder letting the provider know that
The Draft is Saved. Incomplete drafts will be removed in 72 hours and no authorization will be created.

Select **OK**.

UnitedHealthcare

Step	Action
6	<p>On the next page the Provider will complete all of the required information in the following sections</p> <ul style="list-style-type: none"> • Member Information • Admission Information • Attending MD • Utilization Reviewer • Current Symptoms and Severity. • Risks • Proposed Treatment • Discharge Planning • Attestation <p>Note: Fields with a red asterisk are required.</p> <p>Click Next.</p>

7	<p>On the next page the provider will see the Confirmation pop-up. The pop-up will provide the following</p> <ul style="list-style-type: none"> • Authorization number • Number of days the level of care has been approved for <div data-bbox="1452 618 2453 1222"> <p>Confirmation</p> <p>Thank you for your submission. Your authorization # is unknown</p> <p>5 days have been approved for Inpatient.</p> <ul style="list-style-type: none"> • Please allow 1-2 hours for the authorization to be visible in your facility's census. • To request a level of care change, complete the Discharge online and initiate a new online request for the next level of care • To request additional days at the concurrent level of care, select "Concurrent" under the Action column for this member. • Medicaid Only: if this request is for court ordered treatment, please submit a copy of the court order via fax to 800-322-9104 <p>Please note this authorization is not a guarantee of payment. Coverage is still subject to all terms and conditions of the member's benefit plan.</p> <p>Authorizations apply only to services covered under the member's benefit plan, administered by Optum. Please call the number on the back of the member's ID card if you have questions.</p> <p>Ok</p> </div>
---	---

UnitedHealthcare Other ways to request PA

Electronic Submission – MH Partial Care	<ul style="list-style-type: none">• Electronic Prior Authorization for partial care mental health can be submitted through Provider Express. To access the request form, go to: Providerexpress.com > Our Network > State-Specific Provider Information > New Jersey > Authorization Template• Complete the online request form.• Use the “Attesting Individual’s Email Address” to track where the request is in the authorization process.
Telephonic – Available for all requests	<ul style="list-style-type: none">• Call Toll-free Provider Line (on the back of the Member’s ID card): 1-888-362-3368• Follow the below system prompts:<ul style="list-style-type: none">○ Enter TIN#○ Select option 3 (intake)○ Enter member ID/DOB○ Select option for “Mental Health”• After-hours care advocates available during evenings, weekends and holidays only for initial higher-level authorizations (e.g., IP MH, IP SUD, Residential Detox, IP Detox) 24 hours a day / 7 days a week.

UnitedHealthcare | Upcoming trainings and resources

Upcoming trainings

When	Link	Training Topic	Audience
2024		Provider Orientation	
• Dec 3, 2:00-3:30 pm	Register	Topics include NJ behavioral health benefit design, credentialing, clinical and utilization requirements, case management, billing & claims, appeals, Provider portals	Behavioral health providers
• Dec 19, 11:00-12:30pm	Register		
2025			
• Jan 7, 10:00-11:30am	Register		
• Jan 15, 2:00- 3:30pm	Register		

Additional resources

For more information on requesting PA, please contact:

Provider Service line – 1-888-362-3368

Links:

- [PA / MCO Portal](#)
- [Provider Manual](#)
- [Quick Reference Guide](#)
- [New Provider Orientation](#)



Presenter



Ann Basil, LCSW

Director of Behavioral Health Services

WellPoint | Meet our Prior Authorization team



Keren Robinson, LSW
NJ BH UM Team Lead -
Medicaid

- Team Lead for NJ BH UM Team – responsible for day-to-day operations of the team
- Responsible for inpatient hospital authorizations for Medicaid



Lisa Catanzarite, LSW
NJ BH UM - Medicaid

- Responsible for ABA/DIR Authorizations in addition to outpatient levels of care in Phase One integration



Joanna Brevan, LCADC
NJ BH UM - Medicaid

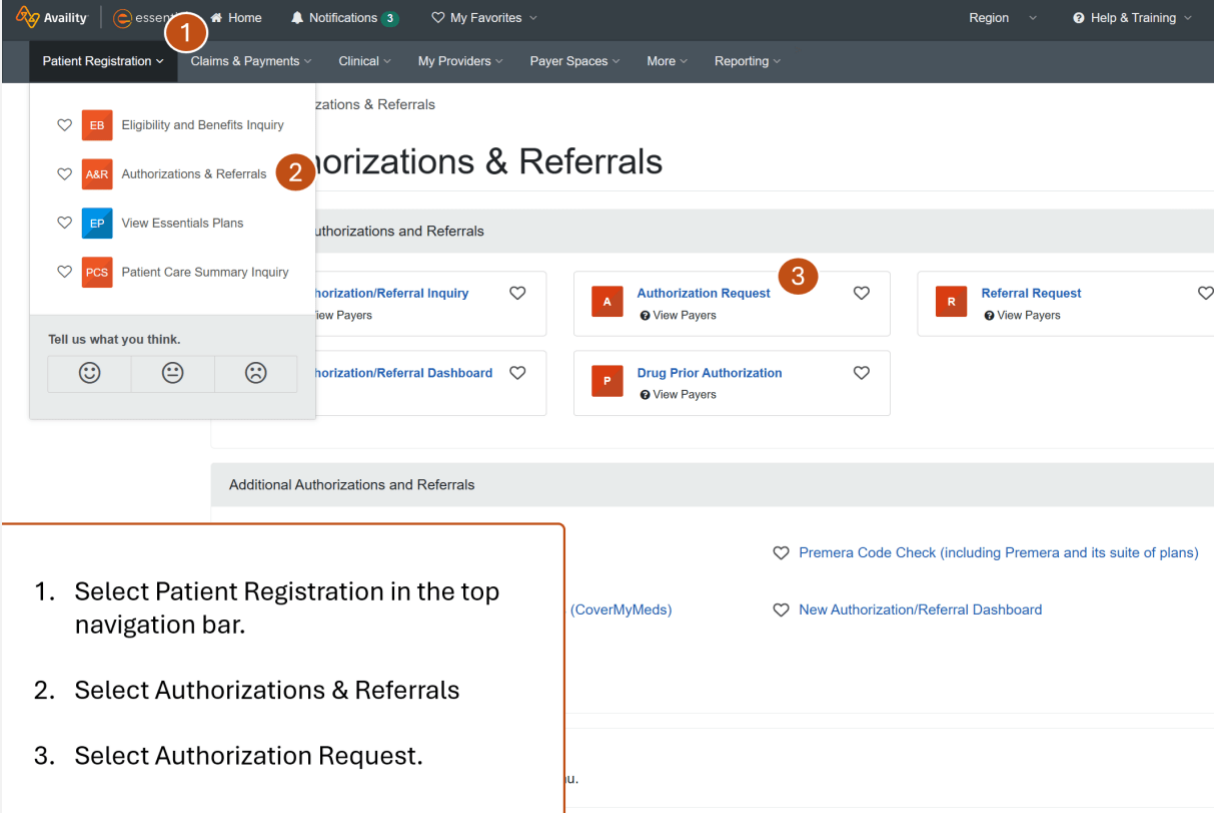
- Responsible for authorizations for all SUD levels of care, including outpatient levels of care in Phase One integration



Emily Brigman, LCSW
NJ BH UM – FIDE DSNP

- Responsible for authorizations for all outpatient levels of care for all NJ FIDE DSNP members

Wellpoint MH PA requests using our portal



The screenshot shows the Availity portal interface. The top navigation bar includes links for Patient Registration, Claims & Payments, Clinical, My Providers, Payer Spaces, More, and Reporting. A red circle with the number 1 highlights the Patient Registration link. The left sidebar contains links for Eligibility and Benefits Inquiry, Authorizations & Referrals, View Essentials Plans, and Patient Care Summary Inquiry. A red circle with the number 2 highlights the Authorizations & Referrals link. The main content area is titled 'Authorizations & Referrals' and contains several cards: Authorization/Referral Inquiry, Authorization/Referral Dashboard, Authorization Request, and Referral Request. A red circle with the number 3 highlights the Authorization Request card. Below the screenshot, a list of steps is provided:

1. Select Patient Registration in the top navigation bar.
2. Select Authorizations & Referrals
3. Select Authorization Request.

Submit PA using Availity Portal
[\(access here\)](#)

WellPoint | Other ways to request PA

- Phone – Provider Services – 833-731-2149
- Fax
 - Inpatient Medicaid and Urgent Services – 844-451-2794
 - Inpatient Medicare and Urgent Services – 844-430-1702
 - Outpatient Medicaid – 844-442-8007
 - Outpatient Medicare – 844-430-1703
- NJSAMS for Phase One SUD levels of care

WellPoint | Upcoming trainings and resources

Upcoming trainings

Date	Time	Topic	Link
November 20	11 AM	NJ Medicaid BH Carve-in Provider Orientation	Registration Link
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)

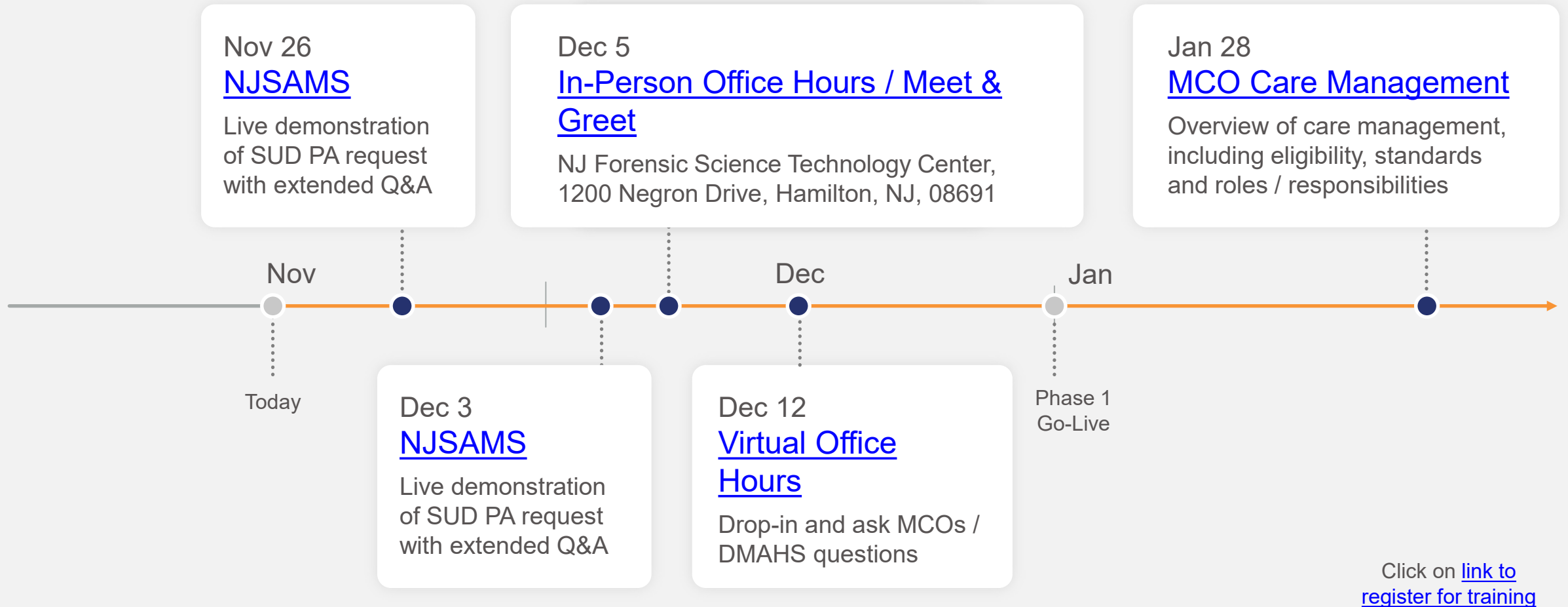
[Create a Case / Chat with Support](#)

Links:

MH PA Q&A

NJ FamilyCare Behavioral Health Integration

Register for upcoming DMAHS sessions



Next steps and key contact information

Next steps

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



Contact information

DMAHS for general PA 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

SUD PA Process

SUD PA process training agenda

- | | | |
|---|--|--------|
| 1 | NJSAMS introduction and goals
Vicki Fresolone | 2 Min |
| 2 | SUD PA submission process flow
Vicki Fresolone | 10 Min |
| 3 | Required SUD PA fields through NJSAMS
Vicki Fresolone | 2 Min |
| 4 | Video of SUD PA submission process
Nitin Garg, Chandra Akenapalli | 15 Min |
| 5 | NJSAMS contacts and additional resources
Vicki Fresolone | 1 Min |

Additional NJSAMS trainings

11/26 and 12/3: 1-hour NJSAMS trainings hosted by DMHAS, with live demonstration of SUD PA request and Q&A

NJSAMS integration will minimize provider burden for SUD PA



Context

- NJSAMS is online state system all licensed SUD providers required to use to submit member data
 - 20 years of client data in system
 - Determines member level of care
 - Fulfills SAMHSA reporting requirements
 - Enables reporting on performance / capacity
- Today, SUD providers submit **duplicative info** for MCO SUD prior authorization (PA) requests, vs. for FFS, NJSAMS info routes to relevant systems
- Goal to **leverage NJSAMS data** for MCO SUD PA requests to reduce provider burden



Plan for NJSAMS SUD PA Request

- Near term plan: NJSAMS routes electronic report to MCOs for complete SUD PA request
 - DMAHS, DMHAS and MCOs on track to implement near term plan with go-live date of January 3, 2025
- Long term plan: Two-way system integration between NJSAMS and MCO PA portal

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

Services	Population Type	PA processed by MCO or IME? (as of Jan '25)	Providers submit via NJSAMS or MCO process?
Phase 1 services <ul style="list-style-type: none"> Intensive Outpatient Partial Care Ambulatory Withdrawal Management <i>Note: Includes Recovery Court</i>	General population	MCO	NJSAMS
	Presumptive eligibility	IME	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP¹) population	MCO	NJSAMS
Phase 2 and Phase 3 services <ul style="list-style-type: none"> Short term residential Long term residential Residential withdrawal management (ASAM 3.7 WM) <i>Note: Includes Recovery Court</i>	General population & presumptive eligibility	IME	NJSAMS
	Specialty (MLTSS, DDD, FIDE-SNP) population	MCO	MCO portal

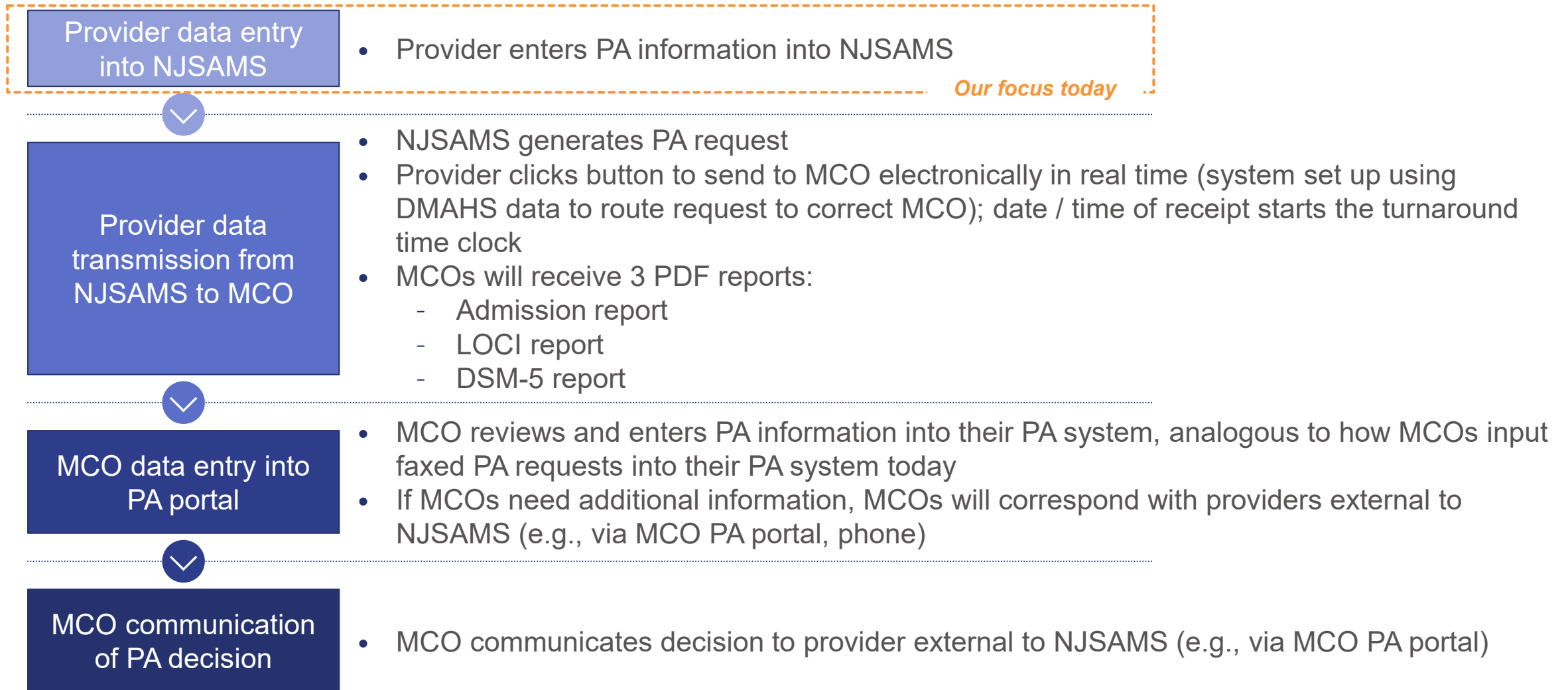
NJSAMS will go live on **January 3**.

Authorizations required for submission to MCOs on January 1-2 should be held until **January 3** and will be eligible for retroauthorization

1. Work underway to confirm inclusion of MLTSS and DDD in NJSAMS for Phase 1

Note: All Medicaid PE (Presumptive Eligibility) will continue to be processed through the IME as it is today. Work is still being done to confirm if FIDE-SNP prior authorizations can be identified through NJSAMS for MCOs

SUD PA submission through NJSAMS



Path forward across components of provider data entry into NJSAMS

Component	Path forward
PA request fields	<ul style="list-style-type: none"> • MCOs to use NJSAMS fields as full SUD PA request, details follow • 3 PA reports: <ul style="list-style-type: none"> - Admission - Level of care - DSM-5
Initial auth vs. extension request	<ul style="list-style-type: none"> • Providers to select "extension" checkbox if submission is an extension request; by default, submissions will be "initial" • File naming convention identifies extension request • Note: NJSAMS not responsible for validating / addressing errors, thus providers are urged to review checkboxes prior to submitting
Urgent designation	<ul style="list-style-type: none"> • File naming convention to automatically include level of care – SUD intensive outpatient and ambulatory withdrawal management are "always urgent" • If providers want to designate SUD partial care as urgent, they must notify MCO external to NJSAMS (e.g., fax, phone call)
Modified level of care	<ul style="list-style-type: none"> • Providers will first discharge the member from current level of care within NJSAMS • Providers will re-submit request to MCOs (applicable information from previous submission will pre-populate into new request) with updated level of care report (ASAM LOCI) and select "modified level of care" checkbox • File naming convention identifies modified level of care request
Discharges	<ul style="list-style-type: none"> • Providers to discharge member through NJSAMS and inform MCOs through MCO portal

Standard fields for SUD PA request in NJSAMS

Category	Fields required
Patient information	<ul style="list-style-type: none"> Name, phone #/address, DOB, member NJSAMS ID and Medicaid #, SSN/citizenship Admission date and site location
Provider information	<ul style="list-style-type: none"> Provider Name Provider Medicaid #
Clinical information	<ul style="list-style-type: none"> Admission report: <ul style="list-style-type: none"> Facility / agency NPI # Patient demographic information Details on living arrangement, household, employment, income, legal status Details on current substance use Comment section to include medication history option
	<ul style="list-style-type: none"> LOCI report to assess appropriate level of care for patients across: <ul style="list-style-type: none"> Acute Intoxication/Withdrawal Biomedical conditions/complications Emotional, behavioral, or cognitive conditions and complications Readiness to change Relapse, continued use, or continued problem potential Recovery environment Level of care indicated / recommended, discharge plan, recommendations / clinical justifications, medications planned
	<ul style="list-style-type: none"> DSM-5 report, specifying how a member meets criteria for 1+ of 12 SUD DSM diagnoses with special notation section to include last date of substance use, includes CIWA and COWS

Field not required by NJSAMS but required by MCOs:



NJSAMS video demonstration

Watch recording here

NJSAMS resources and contact information

When to contact IME	When to contact MCO	When to submit NJSAMS ticket
<p>Process related issues, e.g.:</p> <ul style="list-style-type: none"> • Providers are unsure if PA should be submitted to MCO or IME • Providers have questions about how to properly complete an NJSAMS admission file <p>IME can be contacted at #844-276-2444 or imeum@ubhc.rutgers.edu</p>	<p>MCO communication regarding PA decision, e.g.:</p> <ul style="list-style-type: none"> • Providers submitted the PA request to MCO and needs clarification on next steps • Providers have not had a response from the MCO in the required time frame 	<p>Technical issues, e.g.,:</p> <ul style="list-style-type: none"> • Providers have encountered an error message on their NJSAMS screen • Providers cannot start a client record due to a data correction issue <p>To access NJSAMS ticket system, log in and in the Help Menu, select option for Ticket Management. Note the response time is 72 hours</p>

For a live NJSAMS demonstration with extended Q&A, providers are encouraged to attend upcoming one-hour NJSAMS sessions on 11/26 and 12/3

SUD PA Q&A

NJ FamilyCare Behavioral Health Integration



Appendix

BH Integration Overview

PA Process

Transitioning Prior Authorizations from IME to the MCOs

Appendix

- BH Integration Overview

PA Process

Transitioning Prior Authorizations from IME to the MCOs

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 (NJMMIS) 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)**

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.

BH Integration Overview

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

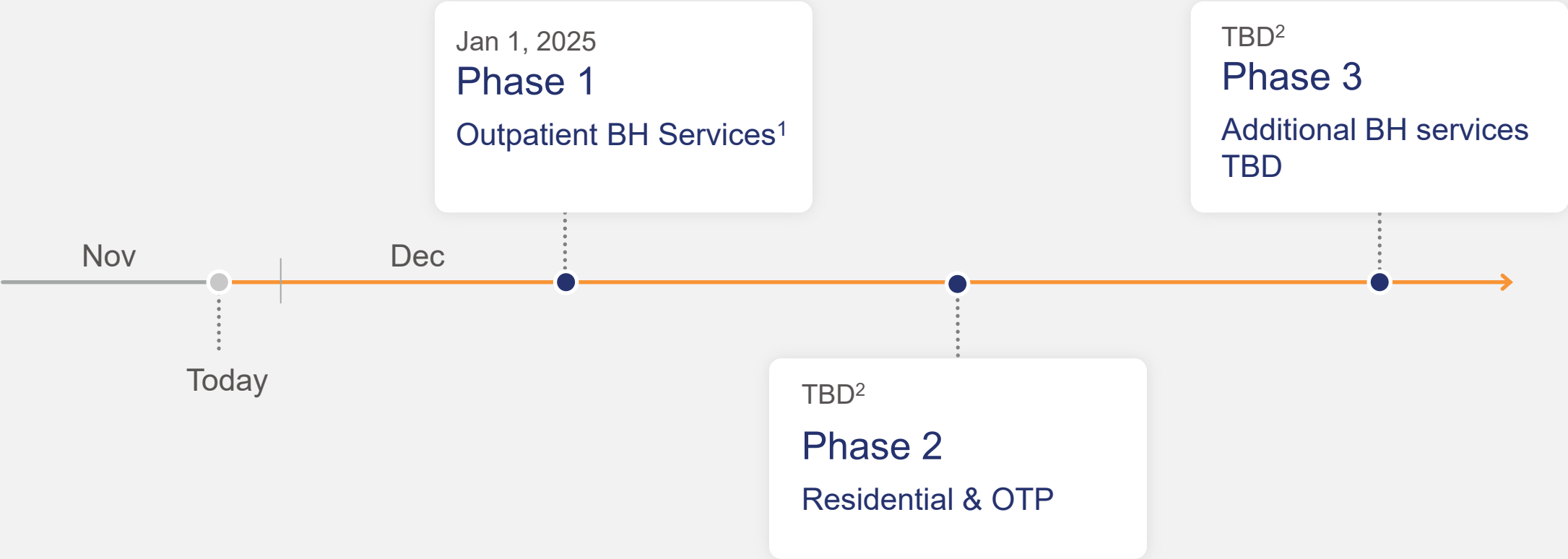
To prioritize whole-person care where all healthcare services across the care continuum are managed under the same entity, NJ is embarking on BH integration by shifting BH services from FFS to managed care

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 1.5 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

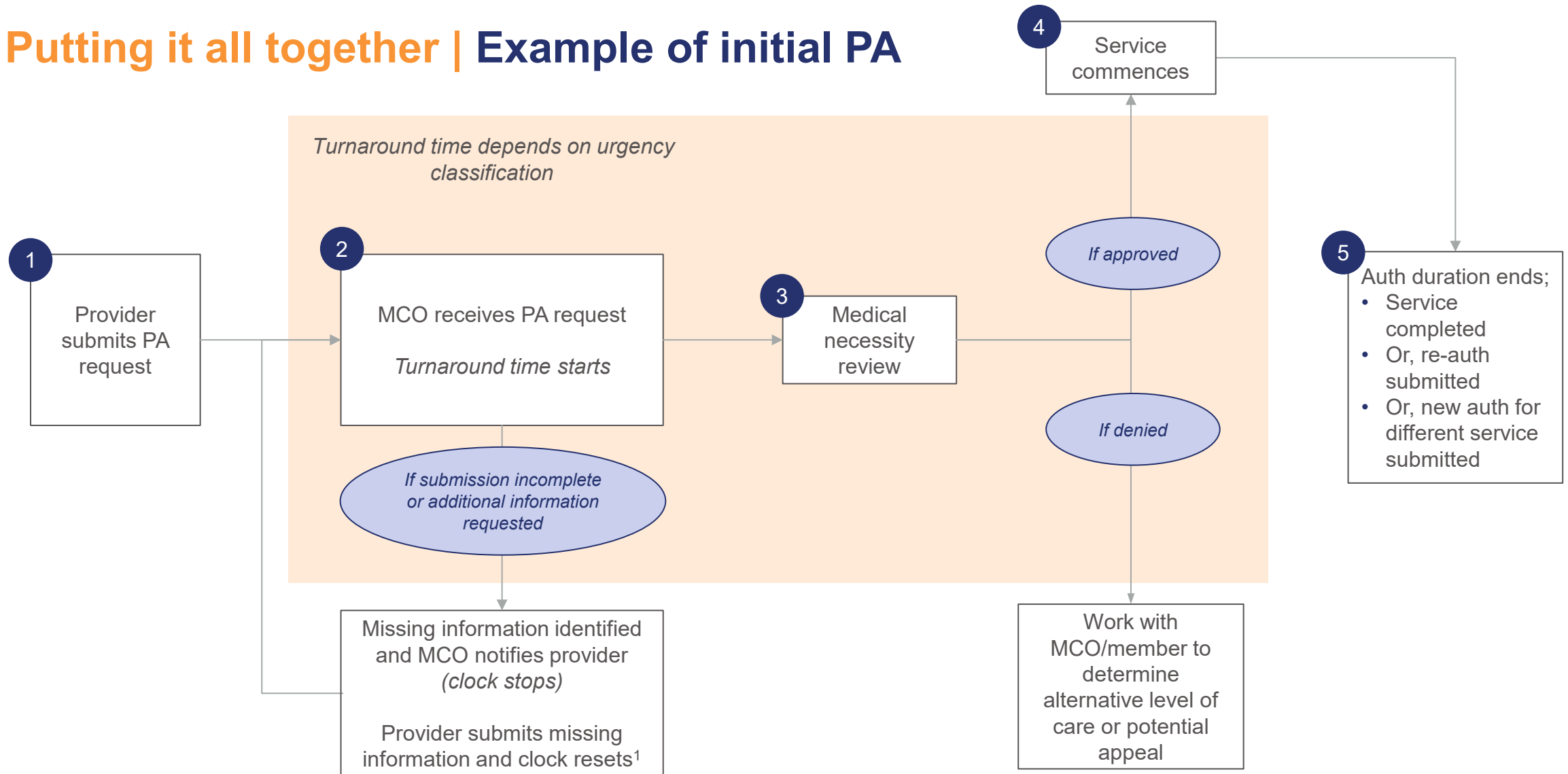
Appendix

BH Integration Overview

➤ PA Process

Transitioning Prior Authorizations from IME to the MCOs

Putting it all together | Example of initial PA



1. Must not exceed CMS 72hr cap for urgent services

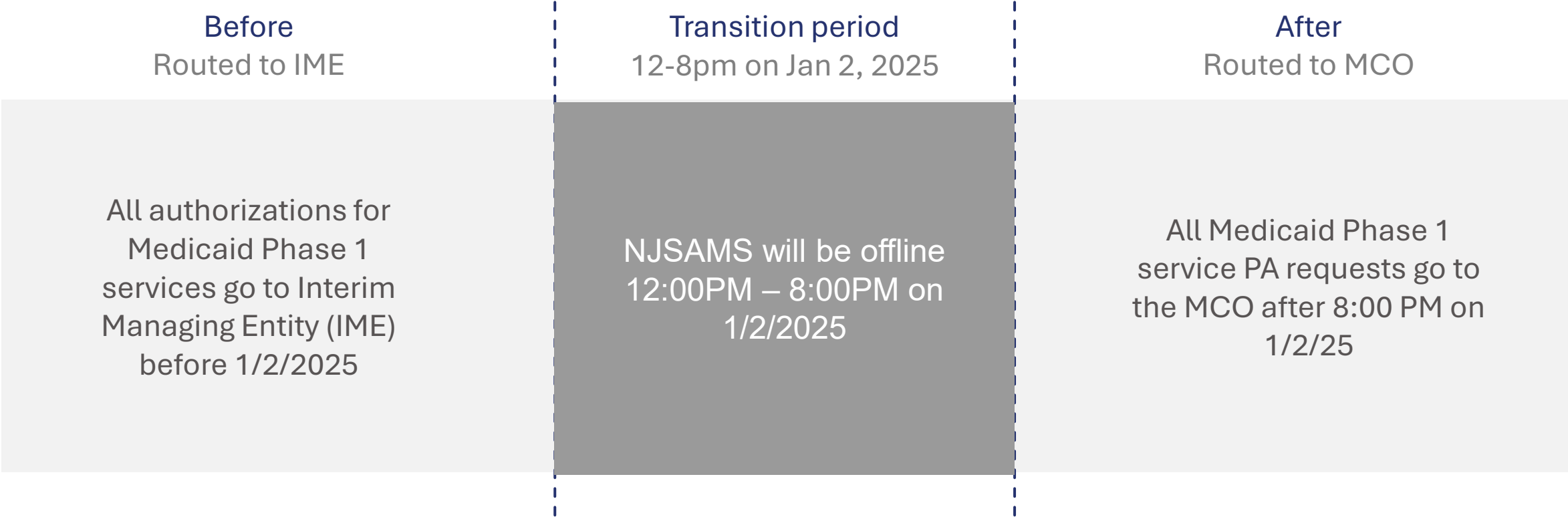
Appendix

BH Integration Overview

PA Process

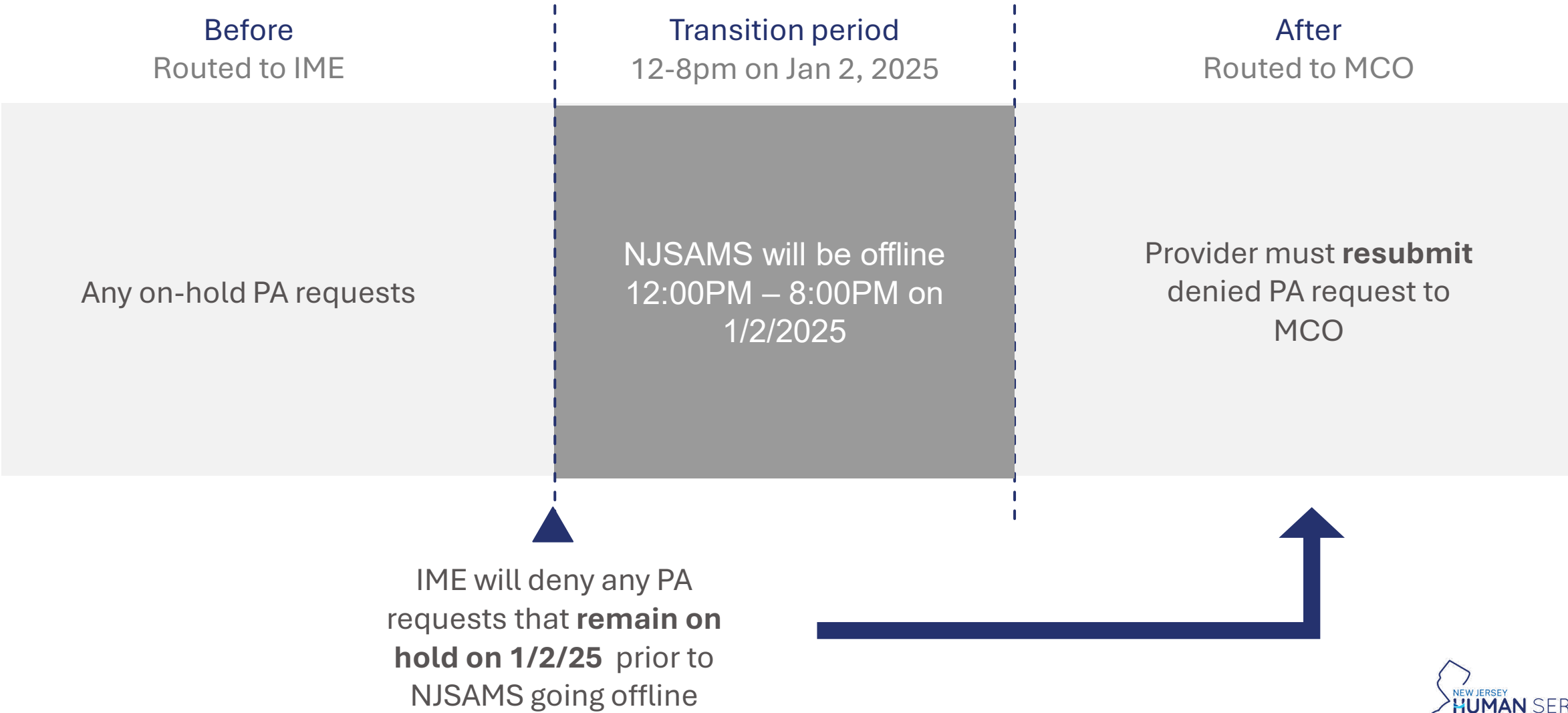
- Transitioning Prior Authorizations from IME to the MCOs

NJSAMS will transition to MCO for Phase 1 services on Jan 2, 2025

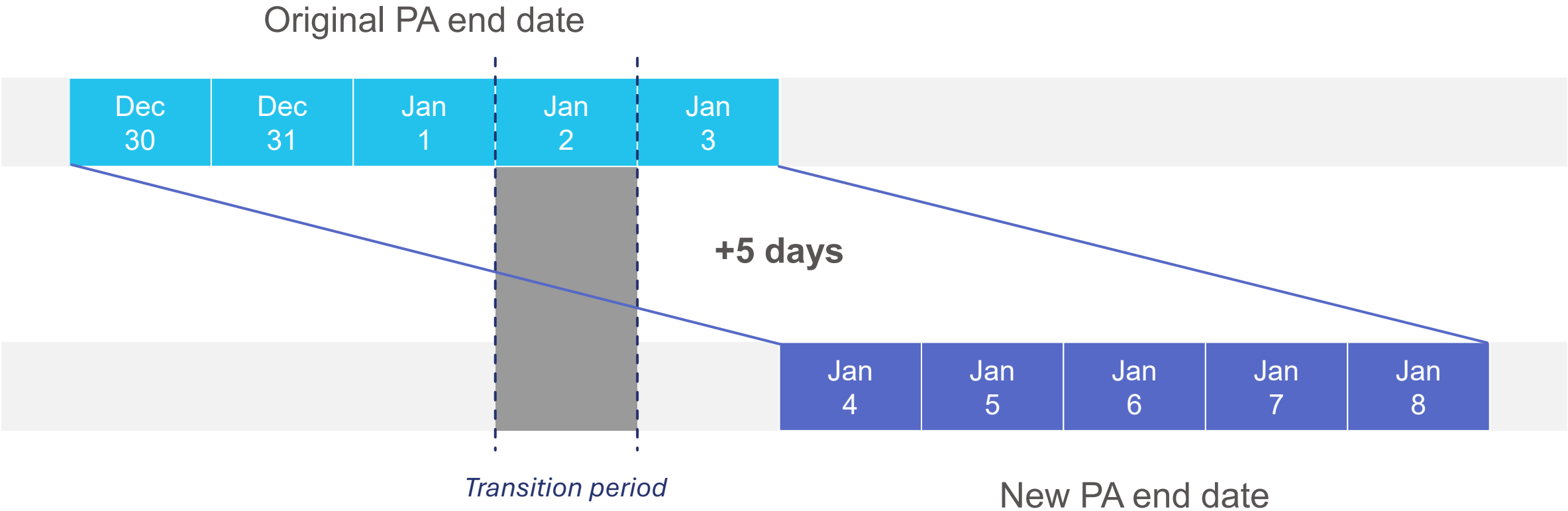


All PA requests (new and Extension Request LOCI) will be **cleared by IME** on 1/2/25 **before 12:00** for all ambulatory Medicaid PA requests

On-hold PA requests will be denied, and providers must resubmit to MCO



Going forward, PA requests with end date 12/30 - 1/3 will be extended 5 days



- The IME will add the additional units that correspond with the extended end dates
- When these PAs end any further requests for that treatment episode must go to the MCO

In Phase 1, providers will not get extension request notifications in NJSAMS



Prior to integration

Before Jan 1, 2025

Providers **notified** of PA end date and need for extension



Phase 1

After Jan 1, 2025

Providers **will not get a notification** through NJSAMS of need for extension



Phase 2 and beyond

TBD but no sooner than Jan 26

Two-way integration with MCO system to **automate extension notification**