NJ Division of Medical Assistance and Health Services

BH Integration Phase 1 Implementation Provider

Frequently Asked Questions (FAQs)

Last updated: May 9th, 2025

Claims and Billing

1. **Are active fee-for-service (FFS) providers expected to hold all claims until the 60-day credentialing / contracting process is completed?**
   - No – for the first 180 days of Phase 1 implementation (through June 30, 2025), MCOs are required to pay claims for Phase 1 services regardless of a provider's credentialing / contracting status

2. **Which NPI code should I use to bill for services?**
   - Type I NPI codes are assigned to an individual healthcare provider, whereas Type II NPI codes identify a healthcare organization or business entity
   - For providers who provide services within an agency, hospital, clinic, or group practice:
     - Billing provider field: use entity's Type II NPI code
     - Rendering provider field: varies by MCO; some MCOs require the rendering provider's individual Type I code while others allow for the entity's Type II code
   - For providers who are independently rendering and billing for services:
     - Use personal Type I NPI in both the billing and rendering provider fields
   - For more information on MCO-specific practices, please refer to MCO training materials

3. **What are the procedures around billing for services provided by supervised interns?**
   - Interns are not able to be listed as the billing provider on a claim
   - Interns may perform only the functions that are allowable as determined by their profession's licensing board. The board shall establish the functions that require supervision and the level of supervision that shall be provided
   - For more information on intern billing, please reference Volume 28, No. 9 of the DMAHS newsletter and Volume 28, No. 21 of the DMAHS newsletter
   - To access the DMAHS newsletter, providers should visit the NJMMIS website, go to the "Newsletters & Alerts" tab

4. **What is the claims process for the adolescent SUD IOP programs?**
   - Providers should bill the MCO using the same codes that they were using for FFS adolescent services

- DMAHS is addressing issues providers have reported in reimbursement for these services

5. **How do I bill for mental health IOP?**
   - Mental health IOP is not currently a NJ Medicaid covered service. Providers can bill for 1 unit of group, family or individual psychotherapy per day for a total of 5 units per calendar week. Medication management can be billed on an as needed basis. Other components of Mental Health IOP such as psychoeducation and life skill building services are not covered

6. **How will claims be paid for patients without an MCO or with presumptive eligibility?**
   - A member without an active MCO in the system or with presumptive eligibility will continue to be FFS. If an authorization is requested, it will be processed like it was before the integration, and providers should bill FFS for claims

7. **Are there finalized interim guidelines for billing MH non-emergency transportation codes for partial care providers?**
   - DMAHS is currently working with MCOs to address issues around billing non-emergency transportation for partial care providers. Communication is to come soon on finalized guidance for providers

8. **Should providers bill to Medicaid or MCO for Mental Health partial care transportation and mileage?**
   - MH partial care transportation and mileage should be billed together to the MCO

9. **How do we bill claims for telehealth? Do we use UC modifier along with a telehealth modifier for OP services?**
   - Each MCO has different policies for telehealth billing. Providers should outreach each plan and determine what their process is for telehealth

10. **What should we do if our MCO claims are coming back at lower rate than FFS?**
    - DMAHS is currently working with MCOs to address reported issues that some providers are being paid rates lower than the FFS floor
    - Providers should first contact MCOs to find out the process for reimbursement if they believe their claims are coming back at rates lower than the FFS floor
    - If providers cannot reach a resolution, then please contact Office of Managed Health Care (OMHC) with specific details regarding the claim, including but not limited to the MCO, service provided, service date, units, and rate paid

Prior Authorization

1. **What is the grace period for submitting retro prior authorization (PA) requests in NJSAMS?**
   - Retro PA requests must be submitted within 5 days of the first date of service

2. **How should prior authorizations that were submitted within the 180-day pre-approval time frame be processed?**
    - For the first 180 days of Phase 1 implementation (through June 30, 2025), MCOs are required to auto-approve all prior authorizations for Phase 1 services
    - Providers should still submit PA for services requiring PA during this period to MCOs in order to ensure member continuity of care and learn MCO processes/systems

Enrollment

1. **Do I need to re-enroll if I am already enrolled in NJ FamilyCare as a FFS provider?**
    - No, providers who are already enrolled with NJ FamilyCare do not need to re-enroll

2. **Can individuals licensed under supervision (e.g., LSW, LACs, CADCs) independently enroll to provide outpatient counselling services?**
    - Individuals must be licensed clinicians (e.g., LCSWs, LPCs, LMFTs and LCADCs) to enroll in NJ FamilyCare. Individuals who do not hold a clinical license cannot enroll in NJ FamilyCare as an individual practitioner but can be part of an enrolled group/facility

Credentialing

1. **Do all individual practitioners need to credential?**
    - Independent practitioners / groups: MCOs typically require each practitioner to credential individually using their Type 1 NPI, even if contracting with MCO as a group. Some MCOs then require each licensed practitioner to be listed on a group roster in order to associate the individual with the group for billing purposes
    - Licensed facilities / agencies: MCOs typically credential the licensed facility or agency as an entity using its Type 2 NPI. Typically, MCOs do not require the individual employees working in the facility or agency to credential individually but may require licensed practitioners and peers to be listed on a facility/agency roster
    - Please refer questions to MCOs to confirm requirements for your circumstances

2. **Do I have to join all five MCOs' networks?**
    - Providers should seek to join all MCOs that their patients are enrolled with however, providers are encouraged to join all five MCOs to ensure continuity of care, as members often change health plans

3. **Where can providers locate the contracting contact information for each MCO?**
    - Providers should refer to the DMAHS BH Integration Points of Contact document to locate contact information