



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

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**TO:** Providers of Behavioral Health Services - **For Action**  
Managed Care Organizations (MCOs) - **For Action**

**SUBJECT:** Expanded Managed Care Coverage for Behavioral Health Services

**EFFECTIVE:** January 1, 2025

**PURPOSE:** To advise providers that certain behavioral health services previously covered under Fee-for-Service (FFS) will be covered by MCOs for all NJ FamilyCare populations beginning January 1, 2025.

**BACKGROUND:** Currently, only members enrolled with the Division of Developmental Disabilities (DDD), Managed Long-Term Services and Supports (MLTSS) program, and the Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP) have most behavioral health services covered by their MCO.

To prioritize whole-person care where all healthcare services across the care continuum are managed by the same entity, the NJ Division of Medical Assistance and Health Services (DMAHS) is integrating the coverage of certain mental health (MH) and substance use disorder (SUD) services into managed care for all NJ FamilyCare members.

The three main goals of this initiative are to:

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

**ACTION:** NJ DMAHS is pursuing a three-phase approach to transfer coverage and responsibility for certain behavioral health services from FFS to DMAHS-contracted MCOs. Integrating services in phases will enable DMAHS to test, learn, and continuously improve on the delivery of behavioral health services under managed care, including by working closely with MCOs, providers, members, and the broader stakeholder community to gather feedback on program design and implementation.

The services included in each phase and the timing of integration into managed care are summarized below.

## **PHASES OF INTEGRATION FOR BH SERVICES INTO MANAGED CARE:**

### ***Phase 1: Effective January 1, 2025***

The following outpatient BH services will be transferred from FFS to MCOs:

- MH outpatient counseling/psychotherapy services
- MH partial hospitalization
- MH partial care in outpatient clinics
- MH outpatient hospital and clinic services
- SUD outpatient counseling
- SUD intensive outpatient services
- SUD outpatient clinic services (including ambulatory withdrawal management, peer support services and SUD care management)
- SUD partial care

The full list of Phase 1 services and associated billing codes and prior authorization requirements are included at the end of this newsletter.

### ***Phase 2: Timing to be determined post-phase 1 implementation, but no sooner than January 1, 2026***

This phase will focus on residential services and opioid treatment programs (OTP):

- Adult MH rehabilitation services (AMHR)/MH supervised residential services
- SUD short-term residential programs
- SUD medically monitored inpatient withdrawal management
- SUD long-term residential programs
- Opioid treatment programs

### ***Phase 3: Timing to be determined post-phase 2 implementation***

DMAHS will be conducting further analysis, stakeholder engagement, and monitoring throughout Phases 1 and 2 to determine any additional BH services to be shifted to managed care in Phase 3. Examples of potential Phase 3 services that will be assessed include:

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

## **CONTRACTING & CREDENTIALING PROCESS:**

To continue providing Phase 1 services to Medicaid-enrolled members, current FFS providers (or their provider entity) must contract and credential with their members' MCOs

before January 1, 2025, to avoid any service and/or reimbursement disruptions. Providers who are not able to complete this process by January 1, 2025 may enter single case/out-of-network agreements with members' MCOs to ensure continuity of payment and care.

Providers not currently in-network with MCOs should begin the MCO contracting and credentialing process as soon as possible to be prepared for BH integration. Each MCO is required to contract with any willing provider for the first 24 months of Phase 1 integration, meaning that all MCOs must contract with any health care provider who is willing to meet the MCO's terms and conditions and cannot deny qualified, compliant providers from joining their network.

To support network development, DMAHS has given MCOs a list of all FFS providers currently billing Phase 1 services. MCOs have been instructed to reach out to these providers to complete the contract and credentialing process before January 1, 2025.

We encourage providers to contract and credential with all five MCOs to maximize patient reach and continuity of care as members may change MCOs.

Please see resources linked at the bottom of this document for training materials on MCO credentialing.

**Key MCO contact information for contract and credentialing processes:**

To understand contracting and credentialing requirements for your specific provider type/organization and to initiate the process with each MCO, click the "join" link for the corresponding MCO below. If you need clarification or assistance in completing the process, please reach out to each MCO's general network contact by email or phone.

**Aetna**

Network Relations  
(855) 232-3596 + press star (\*)  
[AetnaBetterHealth-NJ-ProviderServices@Aetna.com](mailto:AetnaBetterHealth-NJ-ProviderServices@Aetna.com)  
Credential with Aetna

**Fidelis Care**

Contract Negotiator  
(908) 415-3101  
[wc\\_njpr@fideliscarenj.com](mailto:wc_njpr@fideliscarenj.com)  
Credential with Fidelis

**Horizon**

BH Network Manager  
1(800) 682-9091  
[BHMedicaid@horizonblue.com](mailto:BHMedicaid@horizonblue.com)  
Credential with Horizon

**United Healthcare**

NJ Network Manager  
(877) 614-0484  
[Njnetworkmanagement@optum.com](mailto:Njnetworkmanagement@optum.com)  
Credential with United

**Wellpoint**

Carelon Provider Relations Line  
(800) 397-1630  
[provider.relations.NJ@carelon.com](mailto:provider.relations.NJ@carelon.com)  
Credential with Wellpoint

For specific contracting and credentialing points of contact at each MCO, please refer to the **NJ DMAHS MCO Resource Guide** on the DMAHS Behavioral Integration Stakeholder Website: <https://www.nj.gov/humanservices/dmhas/information/stakeholder/index.html>

## **PROVIDER AND MEMBER PROTECTIONS:**

In anticipation of the integration of Phase 1 BH services into managed care, DMAHS met with providers and members actively over the past year and identified common concerns and priorities.

New requirements have been included in the MCO contracts to safeguard members and promote a smooth transition for providers:

- **Payment:** MCOs must pay, at a minimum, the current FFS rate
- **Claims processing:** BH claims processing turnaround times have been reduced to require most clean claims to be processed within 15 days if submitted electronically or within 30 days if submitted non-electronically (e.g., by mail)
- **Network:** MCOs are required to accept any willing provider for the first 24 months of Phase 1 integration. MCOs are expected to contract and credential all active and willing FFS providers by January 1, 2025. If MCOs are unable to contract and credential with providers before January 1, 2025, MCOs must put in place single case/out-of-network agreements to ensure continuity of care and avoid delays in provider payments.
- **Credentialing:** MCOs must complete the credentialing process for BH providers within 60 days of submission of a complete application (reduced from 90 days).
- **Transition of active FFS authorizations to MCOs:** MCOs must honor any active Phase 1 service authorizations submitted via FFS before January 1, 2025 for up to 90 days post go-live (i.e., through March 31, 2025). DMAHS is sending MCOs a list of active FFS prior authorizations for their members, and MCOs are being instructed to add these requests to their systems so that providers do not need to take action to transfer these requests to MCOs.
- **Prior authorization transition period:** MCOs must auto-approve any new initial authorizations for Phase 1 services for the first 90 days of Phase 1 implementation. During this period (from January 1 to March 30, 2025), providers should still submit new authorization requests to MCOs for tracking purposes, but MCOs will not be able to deny the requests for medical necessity. After March 30, 2025, MCOs can apply medical necessity criteria.
- **Authorization durations:** For initial authorizations, MCOs must approve no less than:
  - 14 days of service for MH Acute Partial Hospital (APH), MH Partial Hospital (PH), MH Partial Care (PC), and SUD Short Term Residential (STR)
  - 30 days of service for SUD Partial Care (PC) and SUD Intensive Outpatient (IOP)
  - 60 days of service for SUD Long Term Residential (LTR)
- **Authorization turnaround time:** Certain BH services are considered urgent and require MCOs to process prior authorization requests within 24 hours during

weekdays and 1 business day on weekends and holidays. Non-urgent BH prior authorization requests must be processed within 7 calendar days (reduced from 14 days).

- **Initial SUD authorizations and extension requests:** Initial SUD prior authorization requests will be authorized using the interim managing entity (IME) standards for lengths of stay (i.e., mirroring existing FFS rules). To submit authorization requests for Phase 1 SUD services to MCOs, providers may send an electronic report directly from the NJ Substance Abuse Monitoring System (NJSAMS) portal to the appropriate MCO. Each MCO will be required to accept these reports as a complete SUD prior authorization request, reducing provider burden by eliminating the need to submit the required information in NJSAMS and additional documentation to MCOs.

## **MCO BEHAVIORAL HEALTH CARE MANAGEMENT**

MCO Care Management is a member-centered, whole-person approach to ensure that members receive needed services across providers/settings in a timely, effective manner. MCO Care Managers advocate for members and serve as an additional care coordination resource for providers, enabling more holistic and integrated care.

MCO Care Managers are responsible for identifying members in need of care management support, assessing members' risk factors, developing members' care plans, managing referrals, coordinating care to actively link members to needed physical/behavioral/social services, monitoring care plans and updating relevant providers, ensuring continuity of care, and tracking members' progress.

MCO Care Management is a free service for all eligible members of each MCO. If eligible, members will be assigned an MCO Care Manager to support their care needs. MCOs are required to conduct screenings and outreach to identify members in need of Care Management support, but providers can also proactively refer any members to MCO Care Management.

MCO BH Care Management focuses on serving members with a primary BH diagnosis. The state has made several enhancements to MCO BH Care Management requirements to drive BH integration goals:

- **Screening and assessment:** Adapted BH Care Management screening and assessment tools to better account for wider range of behavioral health needs
- **BH Care Manager qualifications:** Required BH Care Managers to have specific BH training and/or experience
- **Care Manager caseloads and outreach requirements:** Established caseload maximums for BH Care Managers and outreach requirement minimums, dependent on acuity of member need

## RESOURCES FOR PROVIDERS:

Providers can access additional resources and support through the following links:

- DMHAS' Behavioral Integration Stakeholder Information Website:  
<https://nj.gov/humanservices/dmhas/information/stakeholder/index.html>  
which acts as the main gateway to important program information and presentations for providers. Some key resources include:
  - Behavioral Health Integration Overview & FAQ
  - DMAHS Behavioral Health Integration Training Schedule
  - DMAHS Enrollment and Credentialing Training materials
  - Summaries and presentations of past Behavioral Health Integration Advisory Hub
- Additional DMAHS resources will be published on Stakeholder Information Website in the coming months, including:
  - Materials from forthcoming DMAHS provider trainings (including on Claims, Prior Authorization, and BH Care Management)
  - Provider readiness packet, with detailed program guidance for providers
- MCO specific information:
  - Aetna
    - <https://www.aetnabetterhealth.com/newjersey/providers/index.html>
  - Fidelis
    - <https://www.fideliscarenj.com/providers.html>
  - Horizon
    - <http://www.horizonnjhealth.com/providers>
  - UnitedHealth
    - <https://public.providerexpress.com/content/ope-provexpr/us/en.html>
  - Wellpoint
    - <https://www.provider.wellpoint.com/new-jersey-provider/home>

For further inquiries, please contact DMAHS Behavioral Health Unit: [dmahs.behavioralhealth@dhs.nj.gov](mailto:dmahs.behavioralhealth@dhs.nj.gov) or your MCO's behavioral health network representative above.

## PHASE 1 SERVICE BILLING CODES AND PRIOR AUTHORIZATION REQUIREMENTS:

To assist providers in obtaining timely authorization and payment from MCOs, the following table details billing codes and prior authorization requirements for Phase 1 services:

- **Billing codes:** The listed code should be used when submitting Phase 1 service claims to MCOs. These are the same billing codes used for FFS Medicaid.
- **Prior authorization requirements:** If prior authorization is not required (“No”), providers do not need to obtain prior authorization from MCOs to be reimbursed

for these services. If prior authorization is required (“Yes”), providers will need to obtain prior authorization from MCOs to be reimbursed for these services, in accordance with state/MCO requirements. Providers should refer to MCO specific provider manuals for information on prior authorization processes for BH services.

| <b>Phase 1 Services</b>                             | <b>Phase 1 Billing Codes</b> | <b>Prior Authorization Required?</b>         |
|---|------------------------------|--|
| Psychological evaluation/intake                     | 90791-90792                  | No   |
| Individual psychotherapy                            | 90832-90839                  | No   |
| Family therapy                                      | 90846-90847,<br>90849        | No   |
| Group therapy                                       | 90853                        | No   |
| Consultation with family                            | 90887                        | No   |
| MH Partial care services                            | H0035                        | Yes  |
| MH Partial care transportation (clinic only)        | Z0330                        | No   |
| Mileage reimbursement for MH partial care transport | A0425                        | No   |
| Ambulatory detoxification/withdrawal management     | H0014HF                      | Yes<br><i>(auto approved)</i> <sup>1</sup> . |
| SUD intensive outpatient program                    | H0015HF                      | Yes  |
| SUD care management                                 | H0023HF                      | Yes  |
| SUD peer support services                           | H0038HF                      | Yes  |
| SUD partial care                                    | H2036HF                      | Yes  |
| Transcranial Magnetic Stimulation (TMS)             | 90867-90869                  | Yes  |
| Electro Convulsive Therapy (ECT)                    | 90870                        | Yes  |
| Electro Convulsive Therapy (ECT)                    | REV 901                      | Yes  |
| Partial Hospitalization (PH)                        | REV 912                      | No   |
| Acute Partial Hospitalization (APH)                 | REV 913                      | Yes  |
| Individual psychotherapy                            | REV 914                      | No   |
| Group therapy                                       | REV 915                      | No   |
| Family therapy                                      | REV 916                      | No   |
| Psychological testing                               | REV 918                      | Yes  |
| Psychological service - other                       | REV 919                      | Yes  |

1. Auto approval for a minimum of 5 days for alcohol, opioids, and benzodiazepines. For continued treatment, provider must submit an additional authorization request

If you have any questions concerning this Newsletter, please contact the Division of Medical Assistance and Health Services, Behavioral Health Unit at [dmahs.behavioralhealth@dhs.nj.gov](mailto:dmahs.behavioralhealth@dhs.nj.gov). Additional resources can also be found at <https://nj.gov/humanservices/dmhas/information/stakeholder/index.html>.

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