UnitedHealthcare Community Plan of New Jersey

2019

NJ FamilyCare/Medicaid and Dual Complete One Behavioral Health Provider Network Manual

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This provider manual is specific to UnitedHealthcare Community Plan of New Jersey FamilyCare/Medicaid and Dual Complete ONE FIDE SNP (fully integrated dual-eligible special needs plan) business. All information found in this manual supersedes the general non-plan specific information found in the National Network Manual.

NOTE: All orange font is an active link to the information referenced . You will not be able to access the links if the manual is hard-copied.>>>>>>>>>>>>>>

Introduction

Welcome

We are pleased to have you working with us to serve the individuals covered under the UHC Community Plan of New Jersey. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you. Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, **providerexpress.com**, where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often.

United Healthcare Community Plan & Optum

UnitedHealthcare New Jersey Community Plan works with Optum Behavioral Health to provide Mental Health and Chemical Dependence services that include Alcohol and Substance Abuse services for MLTSS, DDD and FIDE SNP. Optum will work with UnitedHealthcare Community Plan to make sure you get the services you need. You or your provider can call Optum Behavioral Health anytime for help at **1-888-362-3368**:

- All inpatient mental health and chemical dependence services (including alcohol and substance abuse) are covered for all NJ FamilyCare
- Most outpatient mental health services (contact plan for specifics) for MLTSS, DDD and FIDE SNP members

Network Participation Requirements

Providers must meet the Network Requirements as outlined in the Optum National Network Manual.

Optum is required to collect program integrity related information through the initial and re-credentialing process such as the Disclosure of Ownership and Control Interest statements. Optum also requires that providers not employ or contract with any employee,

subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

To Join the Network Individual clinicians can apply online at **providerexpress.com** click on "Join Our Network" under Quick Links.

Clinics/Agency - Must hold a license by the state at the group level to qualify. Both **Clinics/Agencies & Facilities** can apply by reaching out to the Network Manager at **njnetworkmanagement@optum.com**.

Individual Licensures

The individual licensures that Optum credentials for NJ are: please change the header color here from orange to bold black

License Type	License Description
APN	Advanced Practice Nurse
BCBA Certification	Board Certified Behavior Analyst
DO	Doctor of Osteopathic Medicine
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LP	Licensed Psychologist
LPC	Licensed Professional Counselor
MD	Medical Doctor
PA	Physician Assistant
RN	Registered Nurse

Optum also contracts with Licensed Clinics and Facilities/Hospitals.

Providers that are accredited by The Joint Commission (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) do not require an on-site Audit as part of the initial credentialing and re-credentialing process. Providers without an accreditation will be required to participate in an on- site audit as part of our credentialing process.

Network Requirements

Network providers are required to maintain availability to Members as outlined in the Access to Care standards noted below. A Network provider's physical site(s) must be accessible to all Members as defined by the Americans with Disabilities Act (ADA).

Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network providers are expected to provide Urgent care appointments within Twenty- four (24) hours of a Member's request and Routine care appointments within ten (10) days of the request.

Network providers must provide or arrange for the provision of assistance to Members in

emergency situations 24 hours a day, 7 days a week. You should inform Members about your hours of operation and how to reach you after hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Member regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician.

Network providers are required to notify us at *providerexpress.com* within ten (10) calendar days whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire). If your hours of operation change, contact Network Management at: **njnetworkmanagement@optum.com**.

Providers are prohibited from balance billing any Member for any reason for covered services. Providers are expected to follow-up with Members who miss their aftercare appointment and document and track their outreach in those cases.

Level of Care Guidelines

Providers are expected to review and be familiar with the **Level of Care Guidelines** and **Best Practice Guidelines** posted on Provider Express. Go to Provider Express "Home" page > Quick Links > Guidelines/Policies & Manual > Best Practice Guidelines or Level of Care Guidelines.

Additionally, providers who treat Substance Use Disorders should refer to the Level of Care guidelines found at: **asam.org/resources/the-asam-criteria.** Level of Care for Alcohol and Drug Treatment Referral: American Society of Addition Medicine (ASAM).

New Expanded Benefits Effective October 1, 2018

Effective October 1, 2018, there will be an expansion of the covered Behavioral Health benefits available to certain Members enrolled in United HealthCare Community Plan of New Jersey (UHCCPNJ). This will align behavioral health benefit coverage for:

- UHCCPNJ FamilyCare beneficiaries Medicaid Long Term Services **(MLTSS)**;
- Division of Developmentally Disabled **(DDD)**;
- Fully Integrated Dual Eligible Specialty Needs Plans **(FIDE SNP)**

What is new for MLTSS, DDD and FIDE SNP?

For the above 3 plans, all Substance Use Disorders (SUDS) will be covered under UHCCPNJ Behavioral Health benefit services, regardless of age including:

- Hospital Based Inpatient Services
- SUD Intensive Outpatient Services (IOP)
- SUD Partial Care
- SUD Residential Services
- Ambulatory Withdrawal Management
- Medication Assisted Treatment (MAT)

What is still a Fee for Service (FFS) responsibility?

The following services are still payable under Fee-For-Service (FFS): ***NOTE: FFS must be billed to NJ Medicaid*.**

- Targeted Case Management
- Programs in Assertive Community Treatment (PACT)
- Behavioral Health Homes (BHH)
- Community Support Services

What is new for NJ FamilyCare Members?

Additional benefits effective October 1, 2018 for all UHCCPNJ FamilyCare Members include:

- Acute Inpatient Hospital Coverage
- All admissions to a general acute hospital (including admissions to a psychiatric unit) will be the responsibility of the MCO for ALL MCO enrolled individuals. This is **NOT** limited to MLTSS/DDD/FIDE SNP

Effective for Dates of Service October 1, 2018 and after, all claim submissions for the above services should be submitted directly to UHCCPNJ:

- New to the DDD population, MH Partial Care will now be the responsibility of the MCOs, **NOT** Fee for Service

Prior Authorization Requirements

How do I obtain a Prior Authorization?

For any service that requires a Prior Authorization, (see list of services below) you can obtain a Prior Authorization by calling the following phone number: **1-888-362 -3368.** The prior authorization number is available after- hours during evening, weekends and holiday with care advocates processing initial higher level authorizations (e.g. IP MH, IP SUD, Resi-Detox, IP Detox) 24 hours a day/7 days a week. The after-hours care advocates do not process routine authorizations such as IOP, OP and PHP during after-hours. To access prior authorizations requirements please go: **providerexpress.com**

Prior authorization is required for the following behavioral health services:

Hospital based services:

- Inpatient (Non-Emergent MH and SUD)
- Mental Health Electroconvulsive Therapy ECT (Inpatient/Outpatient)
- Mental Health Partial Hospitalization PHP Program
- Substance Use Disorder (SUD) non hospital based detoxification – ASAM 3.7 - WM

Outpatient services:

- Mental Health Intensive Outpatient Program
- Substance Use Disorder (SUD) Intensive Outpatient Program – ASAM 2.1
- Ambulatory Withdrawal Management – ASAM 2 - WM
- Psychological Testing
- Mental Health Partial Care
- Substance Use Disorder (SUD) Partial Hospital – ASAM 2.5

Residential services:

- Substance Use Disorder SUD Short Term Residential – ASAM 3.7
- Adult Mental Health Rehabilitation (AMHR)

For specific prior authorization requirements, please refer to the Level of Care Guidelines, found on **providerexpress.com**. Please refer to your specific contract or fee schedule for your service codes.

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New Jersey Division of Medical Assistance and Health Services

2018 Mental Health and Substance Use Disorder Service Benefit Plan Comparison Chart

*****All Out of Network Providers must seek Prior Authorization for all services *****

		Service Description	DDD	FIDE SNP (without MLTSS)	MLTSS	Prior Auth Required (Y/N)
		Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment				
Substance Use Disorder Services	Hospital Based Services	Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) **ASAM 4 - WM**	MCO	MCO	MCO	Y
	Medication Assisted Treatment In OTPs	Non-Medical Detoxification / Non-Hospital based withdrawal management **ASAM 3.7 - WM**	MCO	MCO	MCO	Y
	SUD - Residential	Substance Use Disorder Short Term Residential (STR) **ASAM 3.7** *Subject to IMD exclusion	MCO	MCO	MCO	Y
	SUD - Residential	Residential Treatment Center Services *(prior authorization required, limited to under 21 years of age)*	FFS	FFS	FFS	Y
	OP - SUD	Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification **ASAM 2 - WM**	MCO	MCO	MCO	Y
	OP - SUD	Substance Use Disorder Partial Care (PC) **ASAM 2.5**	MCO	MCO	MCO	Y
	OP - SUD	Substance Use Disorder Intensive Outpatient (IOP) **ASAM 2.1**	MCO	MCO	MCO	Y
	OP - SUD	Substance Use Disorder Outpatient (OP) **ASAM 1**	MCO	MCO	MCO	N
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Methadone MAT)	MCO	MCO	MCO	N
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Non-Methadone MAT)	MCO	MCO	MCO	N
Mental Health Services	PES	Psychiatric Emergency Services (PES) / Affiliated Emergency Services (AES)	FFS	FFS	FFS	N
	Hospital Based Services	Inpatient Psychiatric Services (Acute Hospital based)	MCO	MCO	MCO	N: notification only within 24 hours
	Hospital Based Services	Inpatient Psychiatric Physician Services (Acute Hospital based)	MCO	MCO	MCO	N
	Hospital Based Services	Psychiatric Hospital - Inpatient (stand-alone)	MCO	MCO	MCO	Y
	Hospital Based Services	Partial Hospital *(prior authorization required for acute Partial Hospital only)*	MCO	MCO	MCO	Y
	MH - Residential	Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	MCO	MCO	MCO	Y
	OP - MH	Partial Care *(prior authorization required; 25 hour per week limit)*	MCO	MCO	MCO	Y
	OP - MH	Mental Health Outpatient (Clinic / Hospital Services) *Refer to Newsletter Vol.26 No.5	MCO	MCO	MCO	N
	OP - MH	Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN)	MCO	MCO	MCO	N
	Targeted Case Management	Targeted Case Management (Chronic Mental Illness)	FFS	FFS	FFS	N
Other Related Services	Care Management	Behavioral Health Home (Care Management)	FFS	FFS	FFS	N/A
	PACT	PACT (Program in Assertive Community Treatment)	FFS	FFS	FFS	N/A
	CSS	Community Support Services (Effective 7/1/17) *MFP not eligible	FFS	FFS	FFS	N/A

Administrative Days

If the individual does not meet the discharge planning needs and cannot be safely discharged or transferred to an alternate level of care, an administrative level of reimbursement shall be offered. Administrative days are reimbursed by Optum for all inpatient admissions that are determined to meet the state requirements for extended stays due to extenuating circumstances that prohibit the member from being discharged even though they are meeting medical necessity:

- A separate authorization will be required from the IP acute stay
- When prior authorized, administrative days will be reimbursed by Optum through a Single Case Agreement-accommodation process
- The Clinical team will load a single case agreement authorization
- Rev code 0199 will be utilized

Claim Information

Important claim information for NJ Medicaid and FIDE SNP providers:

- Unlike other plans, the UHC Community Plan Members do not bear the burden of any co-payment, coinsurance, or deductible. There are no Member expenses under this plan and they cannot be billed for any charges
- All information necessary to process claims must be received by Optum no more than 180 calendar days from the date of service

Coordination of Benefits (COB):

- If Coordination of Benefits (COB) is involved where UnitedHealthcare is considered a secondary payer, COB of claims should be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later
- Any corrections to a claim must be made within 365 days from the date of service

Clean Claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

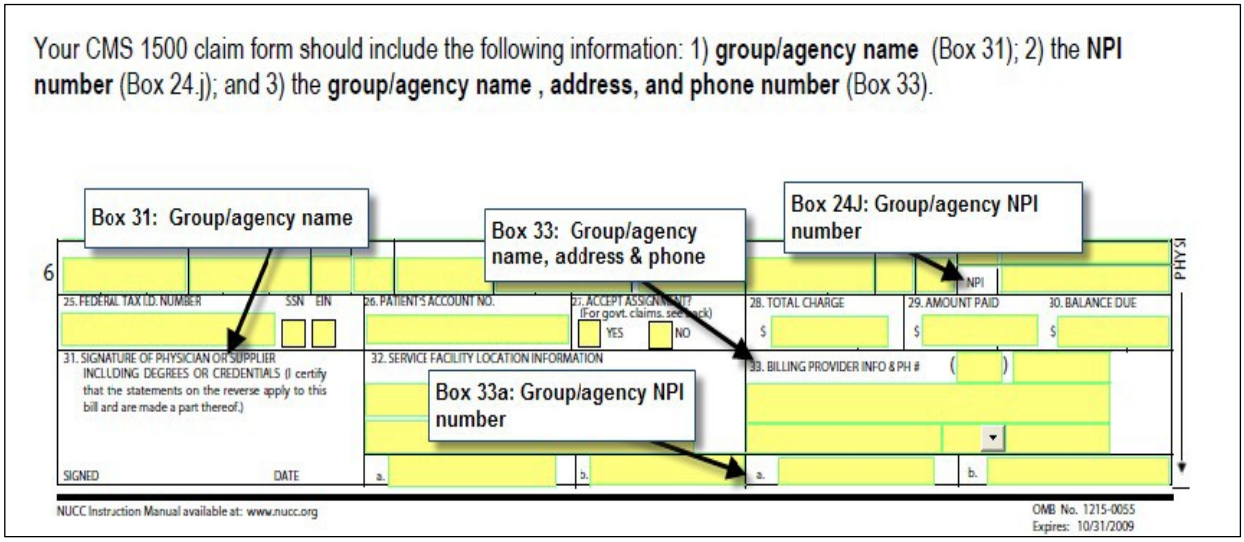
- All required fields are:
  - complete
  - legible

- All claim submissions must include but not limited to:
  - Member's name, Member's ID number and date of birth
  - Provider's Federal Tax ID number (TIN)
  - Taxonomy Code

- National Provider Identifier (NPI)
- A complete diagnosis

Claim Form Requirements

- Be sure to submit your claims on the proper claim form. Our Behavioral Health system requires a Form 1500 version 02/12 (formerly called CMS-1500 claim form) for all outpatient contracted services (this includes routine OP, Medication Management, IOP, Partial Care, and AMHR) and billed with the code found on the NJ Medicaid Fee Schedule. Services for higher levels of care contracted on a facility are billed with the appropriate code as listed in your facility agreement. Please do not use photo copied forms.
- If you are one of our **contracted clinics without rostered providers,** please be sure to submit your claims in the following manner:



Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is an electronic-based exchange of information:

- Transactions are conducted through a clearinghouse vendor
- Submit batches of claims electronically, right out your practice management system software:
  - Ideal for high volume providers
  - Can be configured for multiple payers
  - Clearinghouse may charge fee
- Payer ID – 87726
- Electronic Remittance Advice (ERA) Payer ID – 86047

EDI Support: **1-800-210-8315** or email: **ac_edi_ops@uhc.com**

Paper Claim submission:

Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Encounter Claims

UnitedHealthcare recognizes accurate, timely and complete encounter data submissions are evidence that we are fulfilling our responsibilities to New Jersey DHS, allowing use of the data as the foundation for determining premium payments in the future.

Our claims data is housed in our CSP Facets transaction processing system, which serves as the main data source for encounter data extracts. Based upon adjudicated claims data from CSP Facets, we collect encounter data in HIPAA transaction formats and code sets through our encounter data submission and reporting system, the National Encounter Management Information System (NEMIS). NEMIS processes encounter's across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses and provides error correction and resubmission of Medicaid encounters.

Member Appeals and Provider Disputes

The Appeal Process

There are two distinct processes related to non-coverage (adverse) determination (NCD) regarding requests for services or payment: (1) Member Appeals and (2) Provider Dispute Resolution. An NCD for the purposes of this section is a decision by Optum to deny, in whole or in part, a request for authorization of treatment or of a request for payment. An NCD may be subject to the Member Appeals process or Provider Dispute Resolution process depending on the nature of the NCD, Member liability and your Agreement. Providers must submit a separate Member Appeal or Provider Dispute for each Member.

Care Advocacy decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, the Coverage Determination Guidelines and the Behavioral Clinical Policies, as well as the terms and conditions of the Member's Benefit Plan. The **Level of Care Guidelines,** the **Psychological/Neuropsychological Testing Guidelines,** the **Coverage Determination Guidelines,** the **Behavioral Clinical Policies, the Reimbursement Policies** and the **Medicare Coverage Summaries** are available on **Provider Express** at **Guidelines/Policies & Manuals**. To request a paper copy of these guidelines, please contact Network Management at **1-877-614-0484**.

Optum expects that all treatment provided to Members must be outcome-driven, clinically necessary, rational, evidence-based, and provided in the least restrictive environment possible.

Optum offers no financial rewards or other incentives for Providers, utilization reviewers or other individuals to reduce behavioral health services, limit the length of stay, withhold or deny benefit coverage.

Important: A Member Appeal or Provider Dispute must be submitted separately for each Member to ensure compliance with HIPAA requirements.

Member Appeal

UnitedHealthcare reviews all the care you receive to make sure it's covered by UnitedHealthcare, FFS or the NJ FamilyCare program and is medically necessary. Any decision to deny or limit medical or dental care that requires an authorization will be made by a doctor or dentist at UnitedHealthcare. The doctor or dentist making the decision will talk to your doctor or dentist.

If you believe that UnitedHealthcare has incorrectly denied a service that requires an authorization, you, or your provider with your written consent, have the right to appeal that decision within 60 days of the date of your denial letter. This is called an Internal Utilization Management Appeal. If you are already receiving the services, and you want the services to continue automatically during the appeal, you must either request an Internal Appeal on or before the final day of the previously approved authorization, or request an Internal Appeal within ten (10) calendar days of the date of the denial letter, whichever is later.

You can do this by calling Member Services at **1-800-941-4647**, TTY 711. If you call you must follow up your phone request by writing to:

Grievances and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

UnitedHealthcare will write back to you within ten (10) business days to say we received your appeal. Doctors who have not been involved in the decision to deny the services will review your appeal. If necessary, doctors trained in the medical specialty that concerns your care will be part of the review. The panel will review your appeal as soon as possible, and always within 30 calendar days of getting your letter. If your appeal is about urgent or emergency care, they will respond within 72 hours. You will receive a letter telling you what UnitedHealthcare has decided. The letter will also tell you how to ask for an Independent Utilization Review Organization (IURO) external appeal.

You or your provider (acting with your written consent) has 60 days after you receive the decision of the Internal Appeal to ask an IURO to do another review of the case. If you want the services to continue during the appeal, you must ask for an appeal within ten (10) days of the internal appeal outcome notice or before the end of the previously approved authorization, whichever is later. The IURO is administered by the New Jersey Department of Banking and Insurance. UnitedHealthcare will send you the forms you need to appeal to an IURO panel when we write to you about the decision of the Internal Appeal.

If you are enrolled in NJ FamilyCare A or NJ FamilyCare ABP, you can ask for a Fair Hearing. You have 120 calendar days from the date of the Internal Appeal outcome letter to request a Fair Hearing. However, if you want your services to continue during the Fair Hearing, you must request that they continue within ten (10) calendar days of the internal appeals outcome letter or until the end of the prior approved authorization, whichever is later.

To appeal to an IURO panel, you or your provider must mail the form to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329

The decision of the IURO panel is binding. That means that neither you nor UnitedHealthcare may appeal their decision, except to the extent that other remedies are available to either party under State or Federal law. If the IURO panel decides you should get the care, UnitedHealthcare will provide it. UnitedHealthcare will never penalize you or your provider for filing an appeal or a Fair Hearing.

The External Appeal process is administered by the Division of Banking and Insurance (DOBI) and is used for the review of the appropriate utilization and medical necessity of covered health care services. The services below may not be eligible for the DOBI External Appeal process:

1. Adult Family Care
2. Assisted Living Program
3. Assisted Living Services — when the denial is not based on Medical Necessity
4. Caregiver/participant training
5. Chore services
6. Community Transition Services
7. Home Based Supportive Care
8. Home Delivered Meals
9. PCA
10. Respite (Daily and Hourly)
11. Social Day Care
12. Structured Day Program — when the denial is not based on Medical Necessity
13. Supported Day Services — when the denial is not based on the diagnosis of TBI

Provider Dispute Resolution

The Provider Dispute Resolution process is available to you, or your authorized representative, in a situation where the Member is not financially liable for the non-coverage (adverse) determination (NCD) issued by Optum, beyond the Member's normal cost share. That is, the payment dispute is between you and Optum, and regulated by the Agreement, rather than the Member's Benefit Plan. You, or your authorized representative, have the right to dispute any NCD made by Optum when the determination is adverse to you, rather than the Member.

The informal claim payment reconsideration/payment dispute process is the first step to resolve billing, payment, and other administrative disputes between the health care provider and UnitedHealthcare for any reason including, but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved services initiated by the care providers; or any other reason for billing disputes.

Any provider (participating or non-participating) must be submitted within 90 days from the receipt of the EOB/PRA Participating D-SNP (Dual Complete ONE) providers have ninety (90) days in which to file 1st level claim dispute/reconsideration from receipt of PRA/EOB. If the provider disagrees with our findings, he has sixty days from receipt of our determination to file an appeal.

Non-Participating providers have 120 days in which to file a claim dispute from receipt of the PRA/EOB if they disagree with the payment paid. If the non-participating provider disagrees with our determination to deny in full, they have 60 days to file an appeal.

Where to submit for FamilyCare:

- Online: via *UHCprovider.com*
- In writing:

  UnitedHealthcare Community Plan
  Attn: Appeals & Grievance Department
  P.O. Box 31364
  Salt Lake City, UT 84131 - 0364

Where to submit for Dual Complete ONE:

- **Par Providers**: in writing:

  UnitedHealthcare Community Plan
  Attn: Appeals Department
  P.O. Box 30512
  Salt Lake City, UT 84130-0512

- **Par Providers**: via fax

  1-855-312-1470

- **Non-Par Providers**: in writing:

  UnitedHealthcare Community Plan
  Attn: Appeals & Grievance Department
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

Should the provider disagree with the determination in the dispute/reconsideration process, an appeal must be done within 90 days of the most recent adverse determination on a claim or claim appeal PRA for NJ FamilyCare. For Dual Complete ONE, the formal appeal must be done within 60 days of the most recent adverse determination on a claim or claim appeal.

How to Submit an Appeal

A formal claim appeal must be submitted to UnitedHealthcare utilizing the New Jersey Department of Banking and Insurance approved form – **Health Care Provider Application to Appeal a Claims Determination** , located under “Provider Forms and References” at *UHCprovider.com.* Go to *UHCprovider.com* > select “Menu” in upper left > Health Plans by

State > Choose Your State: New Jersey > Medicaid (Community Plan) View Offered Plan Information > Provider Forms and References > New Jersey Appeals Form under “Provider Forms”.

If UnitedHealthcare Community Plan of New Jersey upholds the claim payment denial, the provider has the right to file an external Claims Arbitration via MAXIMUS online at: **njpicpa.maximus.com/njportal/** on or before the 90th calendar day following receipt of this determination. Note: This does not apply to non-participating providers providing services to Dual Complete ONE members.

Should you need to submit hard copy information to Maximus after submitting your request online, please use the address listed below:

MAXIMUS, Inc.
Attn: New Jersey Provider Appeals
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Provider Express

Link to Provider Express

We welcome you to visit our provider website, **providerexpress.com** which contains a wealth of information specifically designed for providers.

This site stores on-demand online video tutorials on the **Training** page. From there you can select “Webinars/Training Resources” under the Training section of the page and view content such as: *On-Demand Integrated Care Training for Psychiatrists* from the American Psychiatric Association.

Under the **Guided Tours** section of the page you can view content such as: *Auth Inquiry,* which reviews prior authorization training for Behavioral Health providers. Newly credentialed providers are encouraged to view the **Navigating Optum page** and view the **Navigating Optum Webinar Training** located under Provider Resources.

What can be found on Provider Express?

In addition to online training, Provider Express also allows a provider to:

- Make Demographic Updates
- View Guidelines / Policies & Manuals
- View Clinical Resources
- Read Level of Care Guidelines
- View Administrative Resources
- View Recovery & Resiliency Toolkit
- View Video Channel
- Read Best Practices Guidelines
- View Webinars / Training Resources

Contact Information

Network Management names and email box:

- United Health Care Community Plan – **1-888-362-3368**
- Network Management contact information:
  - **Barbara Pinkston Martinez**
    Network Manager
  - **Tamika Hunt**
    Network Specialist for Clinicians and Group Practices

  Email: **njnetworkmanagement@optum.com**

  Fax: **1-866-483-6254**

New Jersey Division of Medical Assistance and Health Services – 2018 Mental Health and Substance Use Disorder Service Benefit Plan

		Service Description	DDD	FIDE SNP (without MLTSS)	MLTSS
Substance Use Disorder Services	Hospital Based Services	Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) **ASAM 4 - WM**	MCO	MCO	MCO
	Medication Assisted Treatment In OTPs	Non-Medical Detoxification / Non-Hospital based withdrawal management **ASAM 3.7 - WM**	MCO	MCO	MCO
	SUD - Residential	Substance Use Disorder Short Term Residential (STR) **ASAM 3.7** *Subject to IMD exclusion	MCO	MCO	MCO
	SUD - Residential	Residential Treatment Center Services ***(prior authorization required, limited to under 21 years of age)***	FFS	FFS	FFS
	OP - SUD	Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification **ASAM 2 - WM**	MCO	MCO	MCO
	OP - SUD	Substance Use Disorder Partial Care (PC) **ASAM 2.5**	MCO	MCO	MCO
	OP - SUD	Substance Use Disorder Intensive Outpatient (IOP) **ASAM 2.1**	MCO	MCO	MCO
	OP - SUD	Substance Use Disorder Outpatient (OP) **ASAM 1**	MCO	MCO	MCO
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Methadone MAT)	MCO	MCO	MCO
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Non-Methadone MAT)	MCO	MCO	MCO
Mental Health Services	PES	Psychiatric Emergency Services (PES) / Affiliated Emergency Services (AES)	FFS	FFS	FFS
	Hospital Based Services	Inpatient Psychiatric Services (Acute Hospital based)	MCO	MCO	MCO
	Hospital Based Services	Inpatient Psychiatric Physician Services (Acute Hospital based)	MCO	MCO	MCO
	Hospital Based Services	Psychiatric Hospital - Inpatient (stand-alone)	MCO	MCO	MCO
	Hospital Based Services	Partial Hospital ***(prior authorization required for acute Partial Hospital only)***	MCO	MCO	MCO
	MH - Residential	Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	MCO	MCO	MCO
	OP - MH	Partial Care ***(prior authorization required; 25 hour per week limit)***	MCO	MCO	MCO
	OP - MH	Mental Health Outpatient (Clinic / Hospital Services)	MCO	MCO	MCO
	OP - MH	Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN)	MCO	MCO	MCO
	Targeted Case Management	Targeted Case Management (Chronic Mental Illness)	FFS	FFS	FFS
Other Related Services	Case Management	Behavioral Health Home (Care Management)	FFS	FFS	FFS
	PACT	PACT (Program in Assertive Community Treatment)	FFS	FFS	FFS
	CSS	Community Support Services (Effective 7/1/17) *MFP not eligible	FFS	FFS	FFS

* Refer to Medicaid Newsletter Vol. 25 No. 6 for other State funded services.

New Jersey Division of Medical Assistance and Health Services – 2018 Mental Health and Substance Use Disorder Service Benefit Plan

		Service Description	*Plan A (ABD) + ABP*	*Plan B (Children under 19 years of age)*	*Plan C/D (Children under 19 years of age)*
Substance Use Disorder Services	Hospital Based Services	Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital)	MCO	MCO	MCO
	Medication Assisted Treatment In OTPs	Non-Medical Detoxification / Non-Hospital based withdrawal management **ASAM 3.7 - WM**	FFS	FFS	FFS
	SUD - Residential	Substance Use Disorder Short Term Residential (STR) **ASAM 3.7** *Subject to IMD exclusion	FFS	FFS	FFS
	SUD - Residential	Residential Treatment Center Services ***(prior authorization required, limited to under 21 years of age)***	FFS	FFS	FFS
	OP - SUD	Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification **ASAM 2 - WM**	FFS	FFS	FFS
	OP - SUD	Substance Use Disorder Partial Care (PC) **ASAM 2.5**	FFS	FFS	FFS
	OP - SUD	Substance Use Disorder Intensive Outpatient (IOP) **ASAM 2.1**	FFS	FFS	FFS
	OP - SUD	Substance Use Disorder Outpatient (OP) **ASAM 1**	FFS	FFS	FFS
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Methadone MAT)	FFS	FFS	FFS
	Medication Assisted Treatment In OTPs	Opioid Treatment Services (Non-Methadone MAT)	FFS	FFS	FFS
Mental Health Services	PES	Psychiatric Emergency Services (PES) / Affiliated Emergency Services (AES)	FFS	FFS	FFS
	Hospital Based Services	Inpatient Psychiatric Services (Acute Hospital based)	MCO	MCO	MCO
	Hospital Based Services	Inpatient Psychiatric Physician Services (Acute Hospital based)	MCO	MCO	MCO
	Hospital Based Services	Psychiatric Hospital - Inpatient (stand-alone)	MCO	MCO	MCO
	Hospital Based Services	Partial Hospital ***(prior authorization required for acute Partial Hospital only)***	FFS	FFS	FFS
	MH - Residential	Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	FFS	Not Covered	Not Covered
	OP - MH	Partial Care ***(prior authorization required; 25 hour per week limit)***	FFS	FFS	FFS
	OP - MH	Mental Health Outpatient (Clinic / Hospital Services)	FFS	FFS	FFS
	OP - MH	Independent Practitioner Network or IPN (Psychiatrist, Psychologist	FFS	FFS	FFS
	Targeted Case Management	Targeted Case Management (Chronic Mental Illness)	FFS	Not Covered	Not Covered
Other Related Services	Case Management	Behavioral Health Home (Care Management)	FFS	FFS	FFS
	PACT	PACT (Program in Assertive Community Treatment)	FFS	Not Covered	Not Covered
	CSS	Community Support Services (Effective 7/1/17)	FFS	Not Covered	Not Covered