UnitedHealthcare Community Plan of New Jersey

2024 NJ FamilyCare/Medicaid and Dual Complete One Behavioral Health Provider Network Manual Addendum

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NOTE: 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.

Introduction

Welcome

We are pleased to have you working with us to serve the individuals covered under the UnitedHeathcare 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 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. All NJ Medicaid and NJ FIDE-SNP Behavioral Health providers are expected to follow the policies in both the *NJ UnitedHealthcare Community Plan Care Provider Manual* and 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 "Our Network". **Clinics/Agencies** - Must hold a license by the state at the group level to qualify. Both **Clinics/Agencies & Facilities** can apply by reaching out to a Network Manager at njnetworkmanagement@optum.com.

Individual Licensures

The individual licensures that Optum credentials for New Jersey are:

License Type	License Description
APN	Advanced Practice Nurse
BCBA Certification	Board Certified Behavior Analyst
DO	Doctor of Osteopathic Medicine
LCADC	Licensed Clinical Alcohol and Drug Counselor
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.

Optum Guidelines and Clinical Criteria

On the Guidelines/Policies & Manuals page of Provider Express, you can find information regarding various guidelines and clinical criteria used by Optum, including:

- LOCUS/CALOCUS-CASII/ECSII clinical criteria
- ASAM criteria
- Behavioral clinical policies
- Clinical practice guidelines
- State/contract specific criteria
- Supplemental clinical criteria

Expanded Benefits

Effective 10/1/2018, there was an expansion of the covered Behavioral Health benefits available to certain members enrolled in UnitedHealthcare Community Plan of New Jersey (UHCCPNJ). This aligns behavioral health benefit coverage for:

- UHCCPNJ Family Care beneficiaries Managed Long Term Services and Supports **(MLTSS)**
- Division of Developmental Disabilities **(DDD)**
- Fully Integrated Dual Eligible Special Needs Plans **(FIDE SNP)**

What is covered for MLTSS, DDD and FIDE SNP?

For the above 3 plans, all Mental Health and Substance Use Disorder (SUD) services are covered under UHCCPNJ Behavioral Health benefit services, regardless of age. Please reference the Behavioral Health Benefits Table beginning on page 14 for complete information.

What is still a Fee for Service 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 (CSS)

Effective for Dates of Service October 1, 2018 and after, all claim submissions for the services listed in the Behavioral Health Benefits table should be submitted directly to UHCCPNJ.

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 evenings, weekends and holidays with care advocates processing initial higher-level authorizations (e.g., IP MH, IP SUD, Residential Detox, IP Detox) 24 hours a day / 7 days a week. **NOTE:** The after-hours care advocates do not process routine authorizations such as IOP, OP, and PHP during after-hours.

Prior authorization **is required** for the following BH services:

Hospital based services

- Inpatient (Non-urgent MH and SUD)
- Mental Health Electroconvulsive therapy ECT (Inpatient/Outpatient)
- Mental Health Partial Hospitalization Program (PHP)
- Substance Use Disorder (SUD) nonhospital based detoxification - ASAM-3.7WM

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)
- Long Term Residential (LTR) – ASAM 3.5

For specific prior authorization requirements, please refer to the Behavioral Health Benefits Table found on page 14. Please refer to your specific contract or fee schedule for your service codes.

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 (SCA) accommodation process. To obtain an SCA call **1-888-362-3368**
- 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

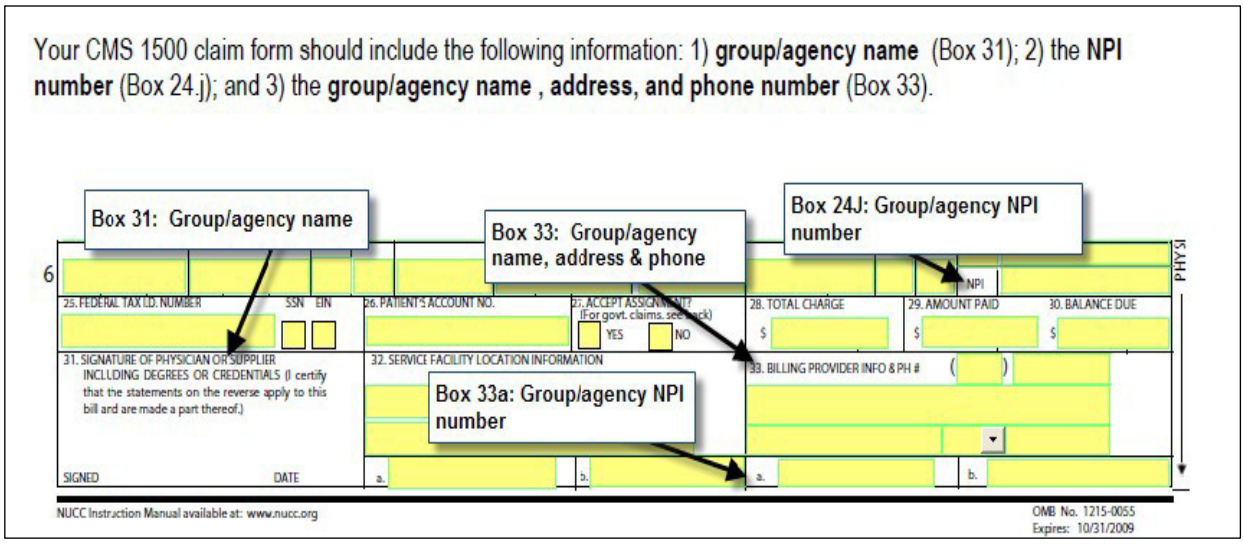
A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

- 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 outpatient, Medication Management, Intensive Outpatient, 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 photocopied 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) 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 encounters across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses and provides error correction and resubmission of Medicaid encounters.

Members Appeals and Provider Disputes

There are two distinct processes related to non-coverage 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 Clinical Criteria. These criteria include LOCUS, CALOCUS-CASII, ECSII, the APA Psychological and Neuropsychological Testing Billing and Coding Guide, The ASAM Criteria, and any state or contractually required criteria, as well as the terms and conditions of the Member's Benefit Plan. Information regarding the Clinical Criteria are available on Provider Express at Guidelines/Policies & Manuals. To request a paper copy of Optum documents, please contact the Provider Service Line at **1-877-614-0484**.

Optum expects all treatment provided to Members be outcome-driven, clinically necessary, evidence-based and provided in the least restrictive environment possible. Optum does not reward its staff, Practitioners, or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

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

Member Appeals

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:

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

UnitedHealthcare will write back to you within 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 get 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) have 60 days after you get 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 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 90 days in which to file 1st level claim dispute/reconsideration from receipt of PRA/EOB. If the provider disagrees with our findings, the provider has 60 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, the provider has 60 days to file an appeal.

Where to submit for **FamilyCare**:

- Online via UHCprovider.com
- In writing:

UnitedHealthcare Community Plan
ATTN: Appeals & Grievances 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

- Via fax: **1-855-312-1470**

Non-Par providers:

- In writing:

UnitedHealthcare Community Plan
ATTN: Appeals & Grievances 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:

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 (HCAPPA), located under the – Provider Forms Tab at UHCprovider.com > Menu > Health Plans by State > Choose Your State: New Jersey > Go to: UnitedHealthcare Community Plan of New Jersey Homepage > Provider Forms and References: uhcprovider.com/content/dam/provider/docs/public/commplan/nj/forms/NJ-State-Application-to-Appeal-Claims-Determination.pdf

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: Welcome to Maximus 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 or fax number listed below:

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

Provider Express

Link to Provider Express

We welcome you to visit our provider website, providerexpress.com. This site has numerous on-demand video tutorials for you on a variety of subjects to help you work more efficiently with Optum. See Home > Video Channel. Newly credentialed providers are encouraged to view the Navigating Optum webpage created to provide a single page with tools to drive efficiency and create a better working experience with Optum.

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
- View Administrative Resources
- Access Recovery & Resiliency Toolkit
- View the Optum Video Channel
- Access Webinars / Training Resources

Contact Information

Network Management names and contact information

- UnitedHealthcare Community Plan – **1-888-362-3368**
- Network Management contact information:
  - **Kisha Rose**
    Network Manager for large Groups and Facilities
  - **Scheanell Holland**
    Network Manager for Clinicians and Group Practices

Email: njnetworkmanagement@optum.com

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

Behavioral Health Benefits Table

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Mental Health						
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered.	Covered by FFS.	**Not covered for NJ FamilyCare B, C, and D members.**	**Not covered for NJ FamilyCare B, C, and D members.**	**Not covered for NJ FamilyCare B, C, and D members.**	Y
Inpatient Psychiatric	Inpatient Psychiatric services are covered by UnitedHealthcare for members in DDD, MLTSS, or FIDE SNP.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF)**, or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF)**, or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF)**, or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF)**, or critical access hospital.	Y
Applied Behavior Analysis (ABA)	Covered with Prior Authorization.	Covered with Prior Authorization.	Covered with Prior Authorization.	Covered with Prior Authorization.	Covered with Prior Authorization.	Y
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	N

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Developmental Relationship Based Intervention (DRBI) including but not limited to DIR, DIR Floortime and Greenspan approach	Covered.	Covered.	Covered.	Covered.	Covered.	Y
Outpatient Mental Health	Covered.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	N

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Partial Care (Mental Health)	Covered.	Covered by FFS. **Limited to 25 hours per week (5 hours per day, 5 days per week).** **Prior authorization required.**	Covered by FFS. **Limited to 25 hours per week (5 hours per day, 5 days per week).** **Prior authorization required.**	Covered by FFS. **Limited to 25 hours per week (5 hours per day, 5 days per week).** **Prior authorization required.**	Covered by FFS. **Limited to 25 hours per week (5 hours per day, 5 days per week).** **Prior authorization required.**	Y
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered.	Covered by FFS. **Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge.** **Prior authorization required for Acute Partial Hospitalization.**	Covered by FFS. **Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge.** **Prior authorization required for Acute Partial Hospitalization.**	Covered by FFS. **Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge.** **Prior authorization required for Acute Partial Hospitalization.**	Covered by FFS. **Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge.** **Prior authorization required for Acute Partial Hospitalization.**	Y
Psychiatric Emergency Services (PES)/ Affiliated Emergency Services (AES)	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	NA

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Substance Use Disorder Treatment **The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).**						
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification **ASAM 2 – WM**	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y
Inpatient Medical Detox/ Medically Managed Inpatient Withdrawal Management (Hospital-based) **ASAM 4 – WM**	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.	Y
Long Term Residential (LTR) **ASAM 3.5**	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Office-Based Addiction Treatment (OBAT)	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	N
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management ASAM 3.7 - WM	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Opioid Treatment Services	Covered.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment**. Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment**. Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment**. Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment**. Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	N

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D	Prior Auth Required? NOTE: Prior auth is always required for OON services
Peer Recovery Support Services (PRSS) provided by Independent Clinics Drug/Alcohol	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	N
Substance Use Disorder Care Management	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	N
Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y
Substance Use Disorder Outpatient (OP) ASAM 1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	N
Substance Use Disorder Partial Care (PC) ASAM 2.5	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y
Substance Use Disorder Short Term Residential (STR) ASAM 3.7	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Y