LTSS Home and Community-Based Medical and Non-Medical

New Jersey Department of Human Services

Division of Medical Assistance and Health Services

July 2014

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Presentation Topics

1. Provider Enrollment Process

2. Service Billing codes include as part of MLTSS HCBS

1. Claim Submission Requirements

2. Prior Authorization Parameters

3. Questions

Provider Enrollment Process for Managed Care

- Managed Care Organization (MCO) offers an application for providers

- MCO completes credential/re-credential process of provider

Steps for Home and Community Based Medical and Non-Medical Providers to become Network Providers with the individual MCOs

1. Submit Application

2. Complete Credentialing Requirements

3. Secure contract if plan and provider reach agreement

Note: Residential Providers-AL, CRS, NF SCNP any willing provider clause in MCO Contract till July 2016

LTSS – Home and Community Based Services Service and Billing Codes

Refer to MLTSS Dictionary for specific information regarding contractual limits

MLTSS HCBS Services – below is sample of HCBS Services

Former Waiver Service	Former Code (s)	MLTSS Service	MLTSS Code			MLTSS Code Description
			Code	Mod	Method/ Unit	
Adult Family Care (GO)	Y7573	Adult Family Care	S5140		Per Diem	Foster care, adult; per diem
Assisted Living Residence - 1 day (GO)	Y9633, T2031	Assisted Living Services (ALR - Assisted Living Residence)	T2031		Per Diem	Assisted living, waiver; per diem
Comprehensive Personal Care Home - 1 day (GO)	Y7574	Assisted Living Services (CPCH-Comprehensive Personal Care Home)	T2031	U1	Per Diem	Assisted living, waiver; per diem

LTSS – Home and Community Based Services Service and Billing Codes

MLTSS Service	MLTSS Code			MLTSS Code Description
	Code	Mod	Method/ Unit	
Home Delivered Meals	S5170		Per Service - One meal per day	Home delivered meals, including preparation; per meal
Medication Dispensing Device (Set Up)	T1505		Per Service	Electronic medication compliance management device, includes all components and accessories, not otherwise classified
Medication Dispensing Device (Monthly Monitoring)	S5185		Monthly	Medication reminder service, nonface-to-face; per month

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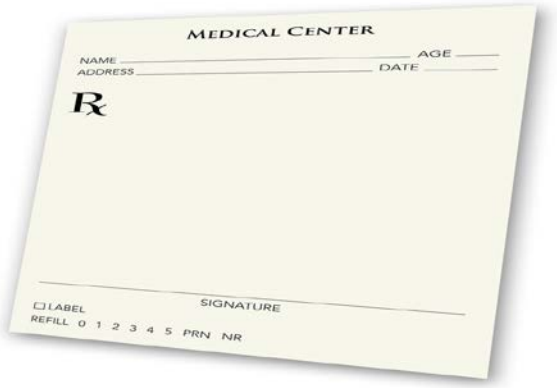

Prior Authorization parameters must comply with "Health Claims Authorization, Processing and Payment Act“ (HCAPPA) P.L. 2005, c.352

PRIOR AUTHORIZATION PARAMETERS

Prior Authorization Parameters

Individual MCOs will identify Prior Authorization process and requirements for individual services

Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

Prior authorization decisions for non-emergency services shall be made within 14 calendar days

Source: Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352.

Claims Processing Comply with "Health Claims Authorization, Processing and Payment Act“ (HCAPPA) P.L. 2005, c.352 for HCBS Medical Services

Claim Submission Parameters

Claim Submission Requirement

MCO claims are considered timely when submitted by providers within 180 days of the date of service as per (HCAPPA) P.L. 2005, c.352

Universal Billing Format for MLTSS Services Paper Submission

- Providers need to use the 1500 for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.
- Providers need to use the “UB-04” lite for NFs and SCNFs.

Universal Billing Format for MLTSS Services Electronic Submission

- Providers need to use the 837 P for AL facilities, HCBS service providers, and non-traditional providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.

- Providers need to use the 837 I for NFs and SCNFs.

Claim Submission Requirements with Explanation of Benefits

- Providers are to submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

MCO Claims Processing

- MCO contract specifies that MLTSS service claim should be processed by MCO within 15 days of clean submission

- MCO contract specifies that claims for non-MLTSS services should be processed by MCO within 30 days of clean submission

State Resources for Providers

Department of Human Services	
Division of Aging Services Care Management Hotline	1- 866-854-1596
Division of Disability Services Care Management Hotline	1-888-285-3036
NJ FamilyCare Member/Provider Hotline	1-800-356-1561
NJ FamilyCare Health Benefits Coordinator (HBC)	1-800-701-0710
NJ FamilyCare Office of Managed Health Care, Managed Provider Relations	MAHS.Provider-inquiries@dhs.state.nj.us

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